VA National Standards of Practice (NSP) Listening Session 5: Transcript

September 21, 2023

0:02

Moderator: Good afternoon. Thank you for joining the Veterans Affairs National Standards of Practice listening session number 5. Today's session we'll run from 2:00 to 4:30 p.m. Eastern Daylight time. My name is Elizabeth, and I will be your moderator for this session. I will now go over a few housekeeping items to keep in mind during this session. The session will be recorded and closed captioning is available on the bottom left corner of your webinar platform. The session recording and transcript of the recording will be made available on the Veteran Affairs National Standards of Practice website at a later date upon completion of all our sessions. If you experience any technical difficulties at any time, during this session, you may notify our technical team using the Q and A function located at the bottom right-hand corner of your webinar platform. Speaking time will be allocated based on the number of people who requested to comment during this session. All attendees will be placed on mute. If you indicated upon registration your intent to present, a VA representative will turn the mic over to you during your allotted time to provide a comment. You will be unmuted during your period of comment and muted upon completion. Each speaker will be allocated 3 minutes to present. Allocation time is based on the number of people who requested to present. If you sent any materials to us ahead of this listening session to support your comments, they will be displayed on the webinar platform. If are you are scheduled to present and use a phone to join today's session, we will call your name during your allocated speaking time and request you to raise your hand by dialing star 3 to identify yourself on the line. I will then give you the capability to unmute your phone line and you will hear a prompt to press star 6 to unmute your mic. Please announce your name and affiliation upon being unmuted. We will mute your microphone upon completion of your allocated time. If you did not indicate your interest to share a comment upon registration but are still interested in doing so today, please write it in the Q and A function located

at the bottom right-hand corner of your webinar platform. Time will be allotted as available at the end of the session. Any participants unable to speak during today's session may submit written comments after the session to VA.NSP@va.gov. Participants have until October 5, 2023, to submit comments. We ask everyone to please be respectful during your period of comment and while others are speaking.

3:11

Moderator: I will now introduce Dr. Erica Scavella to begin our session. Dr. Scavella the floor is yours.

3:20

Dr. Erica Scavella: Thank you, Elizabeth. Good afternoon. My name is Dr. Erica Scavella, Assistant Under Secretary for Health for Clinical Services, and the Chief Medical Officer for Veterans Health Administration. I'm joined today by Dr. Christopher Saslo and Mr. Ethan Kalett. Thank you for joining the 5th and final VA National Standards of Practice listening session focused on certified registered nurse anesthetists, psychologists, peer specialists, registered nurses, practical and vocational nurses, rehabilitation counselors, mental health counselors, marriage and family therapists, and addiction therapists. We greatly appreciate your input today on variance between State licenses for these health care occupations, and your recommendations on what should be included in their standard of practice. Your comments today will inform and guide our decisions moving forward. We would like to note that during these sessions, we will not directly respond to your presentations, but we are actively listening. Additionally, please note that the proposed national standard of practice for each occupation will be posted on the Federal Register once ready for a 60-day public comment period. We also have several VHA clinical representatives on the line who may ask clarifying questions. I'd like to welcome Mr. Ethan Kalett, as I said earlier, the Executive Director of the Veterans Health

Administration, the Office of Regulation Appeals and Policy; and from the Office of Mental Health and Suicide Prevention, the following: Dr. Joseph Liberto, the National Mental Health Director for Substance Use Disorders; Dr. Patricia Sweeney, the National Director for Peer Support Services; Dr. Christopher Loftis, the National Director for VA and Department of Defense Mental Health Collaboration Office. And Dr. Shana Bakken, National Director, VA Vocational Rehabilitation Service. I would also like to welcome Dr. Kathy Rugen, Acting Director of Clinical Practice for the Office of Nursing Services; Dr. Christina Matadial, Director of the National Anesthesia program office. And lastly, Dr. Penny Jensen, the Associate Director of the National APRN practice. If anyone I just mentioned, would like to introduce others from their office, please do so at this time. Thank you once again for attending today's listening session, your participation and attendance demonstrates your commitment to enabling VA health care professionals to provide the best care to our nation's Veterans. I will now hand it back over to our moderator.

6:02

Moderator: Thank you. As a reminder, if you indicated upon registration your intent to present, we will turn the mic over to you during your allotted time to provide comment. They'll be unmuted during your period of comment and muted upon completion. Please note, there may be a delay during this unmute process and your patience is appreciated. Each speaker will be allocated 3 minutes to present. Allocation time is based on the number of people who requested to present. If you send any materials to us ahead of this listening session to support your comments, they will be displayed on the webinar platform. If you are scheduled to present and use a phone to join today's session, we will call your name during your allocated speaking time and request that you raise your hand by dialing star 3 to identify yourself on the line. I will then give you the capability to unmute your phone line and you will hear a prompt to press star 6 to unmute your mic. Please announce your name and affiliation upon being unmuted. We will mute your microphone once upon

completion of your allocated time. If you did not indicate your interest to share a comment upon registration but are still interested in doing. So today, please write it in the Q and A function located at the bottom right-hand corner of the webinar platform. Time will be allotted as available at the end of the session. Any participants unable to speak during today's session may submit written comments after the session to VA.NSP@va.gov. Participants have until October 5, 2023, to submit comments. We ask everyone to please be respectful during your period of comments. And while others are speaking, speakers should be fully aware that you may experience delays during the unmute mute process. So, once you are unmuted, it will take roughly 3 to 5 seconds before we can hear you.

8:20

Moderator: We will begin with certified registered nurse anesthetist. I will now call about upon Bob Carey from the National Defense Committee, who will comment on this occupation. He will also be commenting on peer specialists, psychologists, addiction, therapists, and registered nurses.

9:10

Bob Carey: Can you hear me?

Moderator: Yes, sir. You may proceed.

9:14

Bob Carey: Okay, thank you very much. Sorry about that for some reason it wouldn't let me unmute myself. I'm Bob Carey from the National Defense Committee. Here's the fundamental issue that I think is at hand here and that is we do not believe that the VA has the authority to standardize these types of standards of care, in aggregation of State requirements, absent specific congressional law. And I don't think you've gotten that yet. And the fact of the matter is that licensing and standards of

care are set at the State level and to then go in and utilize the supremacy clause of the Constitution to attempt to say that that allows you to set a federal standard is in fact, I believe misreading of the supremacy clause and, in fact, when you read the supremacy clause at first and foremost says that the treaties are the supreme laws of the land not congressional acts. And if a congressional act violates that constitution, for example, in terms of the 10th amendment, or the or overriding the commerce clause, then I would say that it doesn't matter. If the unconstitutional federal law is supreme, it's still unconstitutional. And the fact matter is, is that we have held licensing and standard of care at the State level, and for the VA to then go in and say, specifically that they are going to set new levels based upon a federal standard does not seem to me to be reasonable. The other part is specifically regarding nurse anesthetists. Hold on a second, I just lost my notes. I'm sorry- well, I can't find it right now, but here's the fundamental line. I'm a patient. I am scheduled for VA surgery. If a nurse anesthetist turns out to be my anesthesiology- my anesthetist for my surgery, I'll refuse surgery. To believe that- and as the American Medical Association said in their testimony yesterday or the day before yesterday at the House Veterans Affairs Committee- for the VA single handedly say yeah, we realize that most medical professions in most States believe that this level of medical training, this level of medical experience, this level of experience is necessary in order to be able to do this specific type of job, we're going to use our superior federal knowledge and we're going to reset that ostensibly to save money is not in accordance with what I believe the best interest of Veterans are. So, I'm going to leave it at that I'll give additional comments later on in the other ones. But I think the most dangerous here overall is the idea of using nurse anesthetists in the place of doctor anesthesiologists and I think it's going to be very dangerous for Veterans.

12:45

Moderator: Thank you. I will now call upon Dru Riddle from the American Association of Nurse Anesthesiology to present their comment.

13:02

Dru Riddle: I'm Dr. Dru Riddle, President of the American Association of Nursing Anesthesiology. I had the honor of serving 10 years in the U.S. Army reserves as a practicing CRNA. The majority of that time spent in Army hospitals where I was the sole provider of anesthesia, and they support the VA's efforts to establish national practice standards. And I strongly urge the VA to develop national standards, that place emphasis on the education and training of, which is evidence based and where each provider must demonstrate competency before being permitted to practice. To show competency, CNRAs are required to be board certified, and the AANA recommends board certification requirements for both physician anesthesiologists and CRNAs as a condition to practice that to be the gold standard, rather than State law. State laws not necessarily based on science, but it is influenced by politics. The political influence is evident as the AANA itself has boasted about providing over three and a half million dollars to limit CRNA and other APRN scope of practice. The practice of anesthesia by a CRNA is a practice of nursing, any attempt to denigrate or disregard the education and training of to provide safe high-quality care is disingenuous fearmongering. There is a wealth of research on CRNA practice where studies empirically validating that CNRAs practicing autonomously are safe. I would like to provide some context regarding State laws. Across the country, CRNAs can administer all levels of anesthesia in every State, and 24 States have opted out of Medicare supervision requirements with three being partial opt outs. Typically, the State laws that require physician, involvement in practice are consistent, and that they do not require a physician anesthesiologist to fulfill these rather requirements can be fulfilled by a surgeon or a procedure list and in many cases, a dentist or podiatrist. How does this make sense? Except to show that supervision is a farce meant to limit CRNAs who do not require a burden, additional burdensome and costly supervision. I would be remiss if I didn't address the misinformation and fearmongering being done by our medical colleagues. I understand that the education and training of CRNAs has been brought up at VA listening sessions related to national standards from other provider groups. They like to quote a recent study of the Hattiesburg clinic, which does not include

CRNAs. Most recently, they're touting by the, touting the American Legion survey, which had misleading questions and such a low number of respondents that the results should not be valid. The AMA accurately states that physician anesthesiologists are more highly trained than CNRAs. All the quality evidence shows CNRAs provide the highest quality care, regardless of practice setting. I would also like to address another myth in that our medical colleagues are raising- that national standards for CNRAs will be the basis for replacing physician anesthesiologist with CNRAs at VA facilities. This is not true. AANA believes that the facility should be provided an opportunity to staff their anesthesia needs in a way that works best for that facility, and we maintain the physician anesthesiologist should be utilized in direct patient care to ensure all Veterans have access to the care they need. I urge the VA to dismiss the dishonest assertions of inferior care, lack of training, and insufficient experience and develop national standards that reflect the education and training provided, excuse me, education, and training, rather than the often-politicized State scope of practice. Autonomous practice has been tried and proven effective in our military system. And there's no reason it should not be adopted by the VHA. We thank you for your tireless work on this issue, and we look forward to being a continued resource.

16:40

Moderator: Thank you. I will now call upon Dr. Ronald Harter from the American Society of Anesthesiologists.

16:58

Dr. Ronald Harter: Hello, can you hear me?

Moderator: Yes. Sorry, you may proceed.

17:04 [MATERIALS: American Society of Anesthesiologists]

Dr. Ronald Harter: Thank you for the opportunity to speak about proposal to change its anesthesia policy. The VA's current policy is the right policy. VA got it right and the final APRN rule of 2016 and in Directive 1123. The policies defer to State law, which effectively preserves the most common model of anesthesia care in the US, the team-based model we are concerned the VA proposal would supersede State law and advance the CRNA-only model despite conflicting with most State laws and regulations. We hope you will share the Temple University information you mentioned Tuesday. Previously, VA had indicated 19 to 20 States, allow CRNAs, quote, full practice authority and quote, as you can see on the first slide, we don't believe those numbers are accurate. ASA has identified only four of the States VA listed as permitting CRNA-only anesthesia: Alaska, New Hampshire, Montana and Oregon. We would also add recent opt outs, Delaware, and a partial opt out State in Utah. The other 44 States require some level of physician involvement or clinical oversight of the CRNA in order for a CRNA to deliver anesthesia care as you can see on the map. For a State to allow the CRNA-only model requires both an opt out of the Medicare supervision requirement and permissive State laws and regulations. Next slide, please. Most importantly neither Medicare, nor the States require an anesthesiologist as the only type of physician, who can provide the necessary oversight. Under Medicare and in virtually all States in the absence of an anesthesiologist, the surgeon, obstetrician or physician proceduralist may provide the medical management of the patient and the supervision of the CRNA. The laws and regulations were written this way so that a physician maintains the responsibility for the medical management of the patient. Let me share a random example. Let's say there's a blizzard near a VA hospital. A patient needs immediate surgery. Miraculously, the CRNA was able to get to the hospital, but the anesthesiologist got caught in the snow. Can the surgery proceed? Yes, in virtually all States, the surgery can proceed with the CRNA working under the supervision of the operating practitioner provided that the operating practitioner determines it is safe to proceed. Do we think this is the optimal model of care? No, but that is what the laws in virtually all States allow. In the vast majority of scenarios, it is an anesthesiologist leading

the team. VA's existing policy is the right policy. It appropriately recognizes roles for both the anesthesiologists and CNRAs in VA and is sufficiently flexible to address virtually any situation. It should be affirmed. Thank you.

20:11

Moderator: Thank you. I will now call upon Ian Black from the American Society of Anesthesiologists. As a reminder if you used a phone to join today's session, please raise your hand by dialing star 3.

20:49

Moderator: In the best interest of time, we will move on. I will now call upon Michael Lewis from the Society of Academic Associations of Anesthesiology and Perioperative Medicine.

21:33

Moderator: In In the interest of time, we will move on.

Michael Lewis: Good afternoon.

Moderator: Oh, there we go.

21:36

Michael Lewis: Yes. Hi. Sorry about that.

Moderator: It's ok, proceed.

21:40

Michael Lewis: Good afternoon. My name is Michael Lewis and today I'm here to speak to you in my capacity as the president of the Society of Academic Association of Anesthesiology and Perioperative Medicine. Our society represents a coalition of the academic chairs, the core residency program, directors, subspecialty fellowship directors, and educational administrators committed to the shaping of next generation of leaders and anesthesiology. And my goal this afternoon is to illuminate some potential ramifications surrounding the proposed role changes for CRNAs for within the VA system. While my primary emphasis today is on the educational impact, it's pivotal to note that broader concerns, particularly related to patient care, also loom large in our in our scope. As an organization we believe in the utility and superiority of the team care model in providing anesthesia to patients. There is an absence of data to support alternative models of care. However, given my capacity as the SAAAPM president, I will be focusing on educational facets of the proposed changes. A long start standing care team model enriched by over 75 years of practice has cultivated an environment of academic excellence and multidisciplinary corporations. Residents and fellows have benefited immensely. And this synergistic approach, gaining diverse insights and clinical acumen. Yet the suggested transition to a model, where CRNAs are working independent of the care team risks disrupting this balance. This proposal threatens three main areas: First of all, it creates inconsistency. The harmonized educational experiences across VA facilities and the residents home institutions governed by State law made of diverge. For instance, residents may miss out on certain crucial, procedural experiences at the VA or interdisciplinary collaborations that are currently available. Secondly, they could confuse learning paths. Residents, while transitioning between different models during their rotations, could think challenges and adapting the disparate clinical roles and expectations, which may lead to confusion and potential delays in achieving their learning milestones. And lastly, there is a potential supervisory gap. Although, per se, the independency on RNA practice might not directly alter resident supervision. It can introduce potential gaps. As a result

of the changes, for example, there may be a flux of physicians out of the VA system making meeting these ratios challenging. In essence, while change isn't an inherent aspect of progress, it is vital that any alteration strengthens not weakens. The educational bedrock has been so meticulously crafted over decades. More than 70% of anesthesiologists in the U.S. during their training engage with a VA medical facility reflecting the symbiotic relationship between the VA services and now, the academic anesthesiology community. This partnership doesn't merely offer training; it's a reciprocal relationship where innovations and standard care are mutually enhanced. Consequently, I urge you to…

25:24

Moderator: Thank you, we do apologize for cutting you off. In the essence of time, we will move on to our next individual as a reminder participants may submit written comments to after the session to VA.NSP@va.gov. I will now call upon Michael Little from the U.S. Coast Guard Chief Warrant Officers Association. As a reminder, if you joined today, using a phone, please press star 3 to identify yourself and you on mute. Please press star 3 to identify yourself and press star 6 to unmute your mic when prompted. It looks like we may be having some technical difficulties if you can press star 6 to get, unmute your mic.

26:54

Michael Little: Hi, am I on now?

Moderator: Yes, thank you.

26:57

Michael Little: Okay, I apologize. Hi, my name is Michael Little. I'm a combat disabled Navy veteran of the wars of Iraq and Afghanistan. I'm also, sorry, my phone is like, talking to me. I'm also the

Executive Director of the Chief Warrant Officers Association. I'd like to start out by asking the VA, can you name a single top rated civilian hospital in the U.S. that allows CRNA-only anesthesia care? If no one answers, then I'm pretty sure I know what that answer is. Given that you were wrong about CRNA-only care being safe Veterans could needlessly die on the operating table. Has any VA official on this call ever talked to any of the top-rated civilian hospital ministers to ask why they prohibit CRNA-only care? I would also add like, to ask VA: What about the other VA anesthesia policy, Directive 1123 in place at VA? Prohibits the flexibility you need to provide care to Veterans. Simply put, why are you changing the current policy as it is? Our understanding that, while it is physician with care-based team, it also provides the flexibility needed to adapt to rule areas and crisis situations. While I've heard access has been cited as a need to change the policy as I understand it, the VA data shows that there is no systemic shortage of VA anesthesiologists or access to anesthesia care. Unless the VA can conclusively show there's a shortage of VA anesthesiologists or a serious anesthesia access problem then it would be irresponsible for the VA to change to a CRNA-led model of care that could potentially put the health and lives of my fellow Veterans at risk. That there's not a shortage of anesthesiologists, then the responsible approach for VA would be to take Directive 1123 developed after years of review the National Standard of Practice for Anesthesia Care. That standard requires highly trained anesthesiologists to oversee anesthesia care while still allowing for flexibility in rural areas that might not have enough anesthesiologists. In all the public testimony I have seen so far, VA, has not even come close to proving that there is an access problem for anesthesia care. In fact, the USAJOBS shows that on Monday of this week, there was less than 2% vacancy rate, which is less than the civilian sector. Second, the next question the VA must answer is whether it has met a strong burden of proof that can CRNAs can provide anesthesia care as safely as physician anesthesiologists. The VA cannot clearly prove that point and it is irresponsibly and dangerously being- a putting my fellow Veterans lives at risk. Finally, the CEO of a VSO we ask that the VA who works with the VSO to adopt the changes that are needed for the VA to actively take care of their Veterans. Thank you.

30:05

Moderator: Thank you so much for your comment. I will now call upon Antonio Hernandez Conte from the California Society of Anesthesiologists.

30:35

Antonio Hernandez Conte: Can you hear me?

Moderator: Yes, yes.

30:39

Antonio Hernandez Conte: Good afternoon, my name is Dr. Antonio Hernandez Conte and I'm the president of the California Society of Anesthesiologists, a physician organization representing over 6,000 California anesthesiologists dedicated to promoting the highest standards of the profession of anesthesia. I'm honored to speak with you on such an important issue for America's Veterans. United States Veterans have served and sacrifice for this country in ways many of us civilians will never be able to understand. Throughout my 30-year career as an anesthesiologist, I've had the opportunity to care for numerous Veterans before, during and after surgery. Veterans' medical needs are often more complex and require a heightened level of involvement and oversight by a team of physicians. With that in mind, I strongly urge you to continue protecting our nation's Veterans by maintaining our current deference to State law and licensure and the endorsement of the physician-led anesthesia care team at VA health care facilities. The California Society of Anesthesiologists strongly believes in and promotes a physician-led anesthesia care team model, which consists of the physician anesthesiologist or operating room surgeon, delegating appropriate medical tasks to and directing non-physician anesthesia providers such as nurse anesthetists. Veterans undergoing surgery with anesthesia remains a complex and potentially dangerous medical undertaking and is most safely performed by physician or physician supervised nurse anesthetists.

The VA, like some States, does allow advanced practiced registered nurses to provide primary care without the clinical involvement of a physician, regardless of State law. But consistent with State law in 44 States, the Department of VA does not allow nurse anesthetists to practice in a nurse only independent model. California, like most of the United States, requires position oversight and involvement when a non-physician anesthesia provider administers anesthesia. California laws do not specifically use the term supervision, which is not uncommon, and many States use phrases or terms other than supervision, which still require and necessitate position oversight or involvement for CRNAs. In California, nurse anesthetists can only administer anesthesia under the order of physicians, and this is for good reason. Every patient must be medically optimized to ensure the best chances of recovering from anesthesia and surgery. And this is true for our Veterans. If the VA's current proposal moves forward, the VA will create a standard of practice in conflict with California State laws and regulations. This conflict will be most pronounced in California's outstanding academic institutions such as Stanford, UCLA, UC San Diego that have formal and longstanding service agreements with VA facilities. Physicians and nurses will practice and train under one standard and academic facilities and another in a VA. Conflicting standards are not consistent with safe, high-quality VA care. Our Veterans have earned and deserve the highest standard of care possible. I appreciate your time and welcome questions.

33:42

Moderator: Thank you, I will now call upon Sherif Zaafran from the Texas Society of Anesthesiologists. You may proceed. It looks as though you have…you are unmuted. However, we do not hear anything from your microphone.

34:47

Sherif Zaafran: Hello, can you hear me?

Moderator: Yes, we can hear you now. Please proceed.

34:52

Sherif Zaafran: Alright, thank you. Yeah, my name is Sherif Zaafran with the Texas Society of Anesthesiologists. We have 3,000 members here in the State of Texas. I just wanted to highlight that in Texas we do have a robust regulatory and regulatory process as it relates to anesthesia. And that is because here in Texas, we do consider that anesthesia to be the practice of medicine, which was actually very specifically delineated by an attorney general opinion recently where that was very specifically noted also. The process includes delegations an anesthetic to either a CRNA, or a CAA, where, and when it's appropriate, with the appropriate amount of oversight from the delegating position. In fact, the State of Texas makes it very clear, that it has to be indicated who the delegating physician is. This was something that was also highlighted in our new anesthesia consent which is promulgated by the Texas Medical disclosure panel. Where the name of the delegating physician has to be indicated on the consent form. So that there is a lot of clarity with everybody that there is a responsible physician when the anesthetic is being delegated either to a CRNA or to a CAA. Our concern is that regulatory agencies in Texas would look at what's going on at the VA, as opposed to what's outside of the VA, and look at the point that there will be two different standards of oversight in two facilities. And these facilities, maybe across the street from each other. This will certainly create a tremendous amount of confusion. Consistency in oversight would be valuable in preventing any kind of confusion, especially when it comes to oversight. It was mentioned already earlier that that State law should proceed and be noted when you're looking at oversight, especially as the VA promulgates rules, it is not a one size fits all. It has to fit within the State's own rules and its own laws. Thank you.

36:44

Moderator: Thank you so much. I will now call upon a Christian Campbell from the Association of Veteran Affairs Nurse Anesthetists. Good afternoon, it looks like your mic is on, however, we cannot hear you.

37:26

Christian Campbell: Can you hear me now?

Moderator: Yes, I can hear you now. Thank you, you may proceed.

37:30

Christian Campbell: Excellent, thank you. Hello everyone. My name is Christian Campbell, and I serve as the president of the Association of VA Nurse Anesthetists. I'd like to thank the VA for hosting these listening sessions and for actively engaging its stakeholders for the past two years in this process. As the president of the Association of VA Nurse Anesthetists, I represent the CRNAs in the Department of Veterans Affairs taking care of some of the most complex patients in the country every day. Over 1,100 VA CRNAs are standing by fully trained and fully capable to increase access and pain services to our Veterans when we need to. In fact, CRNAs have always answered the call from the VA to do whatever is necessary. Most recently during the pandemic, nurse anesthetists did everything from staffing our overburdened ICUs to placing invasive lines and intubating COVID patients. While the nation's health care system nearly buckled under the strain of COVID, the VA lifted restrictions on CRNAs and we leaped into action. We were a force multiplier for VA hospitals all across the country. To me, having one national standard for the VA, is not a radical idea, but it seems more like common sense. With a different standard of care in every State we don't have the flexibility to respond when there is another pandemic or a natural disaster. Just, as an example, personally, I hold both a Florida license and a California license. Let's say there's a natural disaster

and I deploy to assist in a VA in Texas during this crisis. Which standard of care am I following? Florida? California's? Texas? They're all completely different. It's confusing and it limits the ability of the VA to increase access to care right when it needs to the most. Lifting restrictions on CNRAs could also allow us to open up another operating room to start an emergency case immediately if the alternative is delaying care for that veteran. If the VA wants an efficient and effective increase in access to care, that is the answer. The bottom line is that our main goal as VA CNRAs is to provide quality anesthesia to our Veterans. We are ready to accomplish whatever mission the VA requires of us. Thank you.

39:48

Moderator: Thank you for your comment. I will now call upon Lisa Wolterman to present their comment.

40:27

Lisa Wolterman: Are you able to hear me?

Moderator: Yes, you may proceed.

40:32

Lisa Wolterman: Sorry about that. I want to also thank the VA for these listening sessions. I'm the Chief CRNA at VA Central Iowa. I'm located in Des Moines, Iowa. Iowa was the first opt-out State and CNRAs are independent licensed practitioners here in Iowa to scope of practice and licensure. We are not supervised by anesthesiologists, nor surgeons as stated by Representative Miller Meeks in the hearing on Monday. That was inaccurate. As an Iowa community as well as most of the VISN 23 CRNAs, we are all LIPs. The majority of us take care of ASA threes and fours. And with several emergencies that come in as five E's. We do this solo. At the Des Moines VA, we are solo. During our

on-call shifts as well as during the case, because our anesthesiologist is also performing cases at the same time in order to be able to improve access to care for our Veterans. I would like to read an excerpt from a letter that Dr. Pearson wrote on behalf of our department, and it was based on an inquiry about our staffing model, and he said, "VA Central Iowa anesthesia providers are functioning at the full capacity of their training and licensure and do not fall under the definition of advanced practice provider as defined by Directive 1220. As defined in VA Directive 1123, all anesthesia providers practice anesthesiology, the science and anesthesia and anesthetics, including the full continuum. From minimal installation to general anesthesia. The specific administration oversight and moderate sedation, deep sedation and emergency airway management is performed by anesthesia professionals which are four independently practicing CRNAs and a chief anesthesiologist. Therefore, we do practice as a team, but we are independent practitioners taking care of Veterans independently. And as I already said, providing appropriate access to care. Thank you.

43:26

Moderator: Thank you, I will now call upon Jessica Shanahan from the Association of VA Anesthesiologists.

44:05

Jessica Shanahan: …Shanahan, president of the Association of VA Anesthesiologists, elected to represent the over 1,500 anesthesiologists who work for VA. To provide anesthesia means that we are providing sedation with critical care within the dynamic context of a procedure. Any physician anesthesiologist or CRNA can readily provide examples where emergencies have arisen during low-risk procedures in low-risk patients. This renders anesthesia care different from other medical specialties. Seconds of critical decision making may mean the difference between life and death of a

patient. To eliminate a veteran's access to a physician for their anesthesia renders the VA unable to provide the highest level of expertise and training available to our patients. It has been claimed that allowing CRNAs to practice in the VA, without a physician. Anesthesiologists will address an access to care problem. But AVA has repeatedly done our own independent analysis, evaluating anesthesia service needs and the VA anesthesiologists have always been ready, willing, and able to serve. During the peak of the pandemic, there were no cancellations or delays in surgery due to lack of availability of physician anesthesiologists. In fact, quite the contrary. As our physician anesthesia colleagues were getting laid off in the private sector due to OR room closures, our physician anesthesiologists were serving critically ill COVID patients with intubation, line placement and medical management. We were doing whatever needed to be done. When surgeries resumed cases were not delayed or canceled due to a lack of physician anesthesiologist availability. The annual report showed no shortage of CRNA or physician anesthesiologist in the VA. There is actually a high rate of retention for these professionals in VA. Another reflection of adequate physician staffing is that physician anesthesiology is not on the national hard-to-recruit list and therefore, the education debt repayment program is not automatically granted for these professionals. The Military Times reported on Monday that the VA has reached its annual medical staffing hiring goal one month early; this included 30,000 individuals in critical need occupations, including physicians and nurses. We already know that allowing nurse anesthetists to practice without a physician does not improve access. A health economics review article in 2017 evaluated States where independent practice had been granted to nurse anesthetists in Medicare as far back as 2001. There was no expansion of health care access. No reduction in costs. No difference in distance traveled by patients for care. This is because physician anesthesiologists and nurse anesthetists work in the same facilities and live where their patients are. The finding is that has privileges to practice without a physician does not improve access to care. Most importantly, the Veterans want access to a physician anesthesiologist when they are most vulnerable. The American Legion conducted a nationwide survey of our Veterans. When asked if it was important that anesthesia be provided by an anesthesiologist, 74%

said yes. Additionally, 52% of Veterans said they would seek care outside of the VA. if their only choice was to have a nurse administer anesthesia. Thank you for your courtesy.

47:18

Moderator: Thank you. I will now call upon Brooke Trainer from the Association of VA Anesthesiologists.

47:45

Brooke Trainer: So, I am here to speak on behalf of myself as an Air Force veteran and VA physician anesthesiologist and critical care intensivist. I served in the OIF/OEF war from 2011 to 2015 as a critical care air transport team physician and anesthesiologist. I was stationed in Landstuhl, Germany has an anesthesiologist, and then medical director at Langley Air Force base. Overseeing CRNAs and residents as well as every labor and delivery in the ICU. I deployed three times to Afghanistan flying critical care air transport missions, picking up wounded soldiers from all over Europe, the Middle East, forward operating bases, Africa, and beyond. I flew combat medical missions as leader of a physician nurse and respiratory therapy team. CRNAs are not offered CCAAT billet slots, only physicians. You see, even the Air Force understands that when it comes to critically ill, wounded, young soldiers in combat, that a physician is needed to get them home safely. Even in areas where CRNAs are sent far forward to austere, remote environments without a physician beside them, they are following strict JTTR guidelines, protocols, and standards. Tourniquet on; give a gram of TXA; start whole blood; package them up. Ship them out and move them back to a higher level of care where there are physicians, anesthesiologist or surgeons who are leading the care. And if the patient deteriorates, you better believe they're calling back to physicians and asking for guidance. They are not alone. VA on the other hand, cares for mostly disabled patients, a requirement necessary to be service connected and seen in the VA. The median age of the Veterans is 68 years old. The average

number of medical problems is four to five. Seventy percent of Veterans, undergoing surgery are ASA threes and fours, which are serious and constant threat to life designations. Veterans are unique patient populations, and as Veterans we voluntarily signed up to serve our country and we're put in harm's way, but were promised certain benefits, especially in circumstances where we may be injured in combat or exposed to toxins. And we're promised that we will receive the highest level of care and benefits available when we return home, separate, or retire from the military. Are we really going to choose to strip our Veterans, some of our most vulnerable population, from their right to be seen and cared for by a physician? Is this how we thank our Veterans for their service? I urge VA to consider the impact a radical change to the way anesthesia care is currently delivered will have on future generations of youth, signing up for service to our country, knowing that if they're injured, they will receive a lower standard of care than their civilian counterparts. I yield back.

50:36

Moderator: Thank you, I will now call upon Ralph Harding from the Association of VA Anesthesiologists. I am calling upon Ralph Harding from the Association of VA Anesthesiologists. If you joined in via phone, please raise your hand so we can identify you and press star 3. In the interest of time, we will move on. I will now call upon Khurram Ghori from the Association of Anesthesiologists.

52:20

Moderator: As a reminder, if you called in via phone today, please raise your hand by dialing star 3 to identify yourself on the line. We will then ask you to press star 6 to unmute yourself. I'm calling upon Khurram Ghori from the Association of VA Anesthesiologists. In the interest of time, we will move forward.

52:49

Moderator: I will now call upon Joseph Keck to present their comment.

53:09

Joseph Keck: Good afternoon. Thanks for hearing my thoughts this afternoon. Are you able to you hear me, Ms. Gonzalez?

Moderator: Yes. Yes, you may proceed.

53:17

Joseph Keck: Okay, thanks for sharing my thoughts this afternoon. As a practicing CRNA within the VA for the last 15 years, it's been a little odd to see primarily paid special interest in lobbyists commenting on VA practice. I've been in the VA for the last 15 years, and I've worked at 6 different facilities across the entire code, entire United States. I wanted to describe two patients. One I took care of on the West Coast. Well, the patient was in pain after chest surgery. I had to wait for another practitioner to insert an epidural. Simply a function of the VA bureaucracy. Once the epidural was actually inserted, I was able to write the orders for medication to be infused and relieve the pain for the veteran. However, on the East Coast, I took care of a very similar patient who had had chest surgery. I was able to independently insert that epidural because the bureaucracy was different. But I was unable to actually order the pain medication infusion, the exact opposite of the problem that was going on the West Coast. Both of these patients suffered in pain for significant period of time because the nonstandard practice standards. And both suffered, because of overzealous supervision requirements established by the VA. My current practice has CRNA's and physicians working collaboratively, which should be the standard throughout the entire United States. That's further endorsed by current VA procedures and VHA 1123, whereas it establishes collaborative supervision. And independent practice for CRNA's already in existence. But in summary, I support national

practice standards, supporting all practitioners, working to the maximum scope of their education. This is the best evidence-based care, improves access to care for Veterans and provides for maximum utilization of VA resources. Thank you for your time.

55:17

Moderator: Thank you. I will now call upon Andrew Forgay to present their comment. As a reminder, if you're using your phone, please press star 3 to raise your hand to identify yourself. I am now calling upon Andrew Forgay to present their comment.

55:42

Andrew Forgay: Thank you. Can you hear me?

Moderator: Yes, sir. You may proceed.

55:47

Andrew Forgay: Great. Well, thank you very much for this opportunity to speak today. My name is Drew Forgay, and I'm an anesthesiologist at VA, and also the Chief of Anesthesiology at the VA Medical Center in Augusta, Georgia. So, I'd like to start by saying that over the last 20+ years I've worked extensively with CRNAs while in the Army as well as in private practice and here at VA. I've also been involved in education for student CRNAs, and all those areas. I've got tremendous respect for CRNAs as colleagues and talents and anesthesia professionals and very much enjoyed working with them through the years. I also know that the issue of CRNA independent practice is a very fraught one and I certainly don't want any of my comments to convey anything, but deep respect for CRNAs. I really think the fundamental question to ask is how would limiting anesthesiologist involvement at VA improve the care of our Veterans. I think the clear answer is that it wouldn't.

Multiple studies have shown that the anesthesia care team model results in lower mortality, compared to a solo anesthesia provider model, regardless of whether that provider is an anesthesiologist or a CRNA, and I'd really like to emphasize that last point. And at VA, where our patient population is older with many more significant mental problems than the general population, I think the worst outcomes of a solo provider will only be amplified. So, to sum it up, at VA we currently have an anesthesia care team model that works that's based on collaboration and mutual respect and that's been shown to be superior to solo care models. I can't think of a good reason to change it. And thanks again for your time and attention.

57:45

Moderator: Thank you for your comments. At this time, I will call upon the individuals who may have experienced technical difficulties earlier when called upon. As a reminder, if you are using your phone, please press star 3 to raise your hand to identify yourself when your name is called, once we identify you press star 6 to be unmuted. I will call upon Ian Black from the American Society of Anesthesiologists.

58:26

Moderator: Moving on, I will call upon Ralph Harding from the Association of VA Anesthesiologists. As a reminder, please press star 3, if you are using your phone so we can identify you.

58:49

Moderator: I will move on to Khurram Ghori with the Association of VA Anesthesiologists. In the interest of time, I will move on. I will now call upon Jason Scull, with the American Medical Association to speak on certified registered nurse anesthetist and psychologist.

59:31

Jason Scull: Can you hear me?

Moderator: Yes, sir. You may proceed.

59:38

Jason Scull: Thank you for the opportunity to weigh in on the national standards of practice for certified registered nurse anesthetists and psychologists. The AMA's main concern with the Federal Supremacy project has been that it may allow non-physician providers to provide services and perform procedures independently that are outside the scope of their education, training, and licensure. This will undermine physician-led teams and ultimately lead to a lower standard of care for Veterans. Psychologists are not allowed to prescribe and manage medication independently without collaborating with the medical doctor in 87 including the VA because they do not have the record, the training or medical background to do so. To date no federal program allows the colleges to have independent prescriptive authority. Medicare specifically cites a lack of knowledge and ability in making a decision not to reimburse for E/M or pharmacologic management by prescribing psychologists. Only five States currently allow psychologists to prescribe, although several of these things still require collaboration or supervision with a physician or other medical provider. We encourage the VA to take this into careful consideration when drafting the national standards for practicing psychologists and not include prescribing privileges in such standards. Anesthesia care is a highly kind of dependent, critical care service that demands the immediate availability of our physicians and medical decision-making skills, especially for the veteran patient population. While we greatly value the contribution of CRNAs to the physician-led care team, the level of training required to safely administer care and the quality issues that have been documented in numerous studies makes independent CRNA practice rare with various few States allowing to practice in hospitals and the vast majority of States requiring physician involvement in care provided by CRNAs

in hospitals. Instead of moving forward with this Supremacy project, the VA should pursue a strategy to increase recruitment, training and retention of psychiatrists, anesthesiologists, and other physicians in the VA system. With respect to CRNA practice specifically the VA should maintain the current Directive 1123, which was the product of extensive discussions and multiple rounds of comment over several years. At minimum about NSP development process, designed to get the best results for VA beneficiaries should include relevant position, specialty representatives upon all NSP workgroups that consult with a more diverse group of internal and external stakeholders. Report draft NSPs are published in the Federal Register. The AMA looks forward to working with the VA, as it moves through the NSP development process. Thank you again for the opportunity to comment.

1:02:33

Moderator: Thank you so much. At this time, I will ask if any VHA clinical representatives on the line would like to ask any clarifying questions. Please do so now by raising your hand. Hearing none we will move on. We will now move on to peer specialist.

1:03:11

Moderator: I will now call upon Ann Rea from the American Society of Anesthesiologists. If you could please raise your hand using webinar platform, you can identify you to unmute yourself. Once again, I am now calling upon Ann Rea from the American Society of Anesthesiologists. If you've dialed in by phone, please press star 3 to identify yourself and raise your hand.

1:04:12

Moderator: In the interest of time, we will move forward. We will now move on to registered nurse. I will call upon Terri Roberts from the American Holistic Nurses Association.

1:04:43

Terri Roberts: The AHNA is a professional specialty nursing association dedicated to the promotion of holism and healing. The AHNA believes that nurses enter therapeutic partnerships with clients, their families, and their communities to serve as facilitators in the healing process. AHNA recognizes the list provided in the listening tour today as complimentary and integrative modalities. We have a position statement on the role of nurses in the practice of complementary and integrative health approaches and I will be reading from that. The holistic nursing care process supported by AHNA is one in which nurses abide by the following commitments: acquire maintain current knowledge and competency and holistic nursing practice. This may include integrating complementary and integrative therapies into that nursing practice. Provide care and guidance to persons through nursing interventions and therapies consistent with evidence, based research findings and other sound evidence. Recognize each person as a whole: body, mind, and spirit. Consistent with conventional nursing practice, nurses must be competent in the integrative therapies and practices they employ. The AHNA believes nurses integrate these practices into conventional care as part of their holistic practice. In addition, nurses support and assist clients with their use of integrative health interventions, provided by other practitioners by identifying the need for complementary and alternative interventions, assisting clients, and locating providers of those services, facilitating the use of integrative health care through education, counseling, coaching and other forms of assistance. Coordinating the use of integrated health care in collaboration with various health care providers and evaluating the effectiveness of clients' integrated health care. A nurse practicing as a therapist of a specific conventional therapy or complementary and integrative health approach must have the education skills and credentials ascribed for that therapy. The nurse also must operate within their legal scope of practice, within their licensure and/or the jurisdiction. AHNA views nurses as being in a unique position to implement complementary and integrative health approaches throughout the health care system and that registered nurses represent the greatest number of health care professionals with more than 4.2 million health care professionals and are employed in

more diverse clinical settings than any other health professional. We are also uniquely prepared to differentiate normality from illness; provide interventions for health promotion and illness-related care and the use of a wide range of medical technology and healing arts. Thank you for this listening session and this visionary support of our RNs providing modalities, herein referenced, thank you.

1:07:52

Moderator: Thank you so much. We will be moving back to peer specialist. I will now call upon Yaritza Ilarraza to present their comment.

1:08:11

Yaritza Ilarraza: Thank you. Can I be heard?

Moderator: Yes, ma'am. You may proceed.

1:08:16

Yaritza Ilarraza: Appreciate it. Good afternoon. My name is Yaritza Ilarraza Santos. I am a Veterans Affairs peer specialist serving in the medical center in Richmond, Virginia, and first, I want to express my appreciation for the opportunity to provide input on State variances for peer specialists. Secondly, I need to highlight the information found on the Federal Register dot gov website regarding the authority of Veterans Affairs professionals to practice health care. It reads: We note that the policies and practices confirm in this role only apply to be a health care professionals appointed under 38 U.S. Code 7306; 7401; 7405; 7406; or 7408; or Title 5 of the U.S. Code. VA peer specialists are appointed under 38 U.S. Code 7402. Based on this information, my understanding at this time is that the policies and practices that will be confirmed in this rule for national standards of practice will not apply to the peer specialist profession. Needless to say, I appreciate the opportunity to provide input on matters affecting the peer specialist professions and Veterans, because at a

facility, VISN, nor VACO level as a peer specialist, I have not been surveyed nor have, was extended an invitation to participate in a workbook, work group regarding this topic, other than my due diligence to follow the developments of the VA national standards of practice for peer specialist and registered to attend this session. Nearly 20% of adults in the U.S. experience mental health illness each year. With 5% experiencing a severe mental illness. In addition, over 15% of adults report having substance use disorder with more than 106,000 overdose death that and 1 suicide death that every 11 minutes in 2021 alone. It is imperative that we support the treatment and recovery of individuals with mental illness and substance use disorder. Research shows that peer support specialists, significantly decrease substance use for individuals with substance use disorder and reduce re-hospitalization for individuals with mental health illnesses. Since the listening session grants 3 minutes to present, I welcome questions. I'll wait for additional opportunity to present at the end of the session and send my written comments via email. I yield back.

1:11:07

Moderator: Thank you so much we will move back to registered nurse. I will now call upon Sarah Sanders to present their comment. It seems as though Ms. Sanders is having some technical difficulties; I will move on.

1:12:16

Moderator: I will now call upon Paula Ammar to present their comment.

1:12:49

Paula Ammar: Hello?

Moderator: Good afternoon, we can hear you.

1:12:56

Paula Ammar: I just had a question because I was, and this is for registered nurses, and this was something that I have experienced, and I was listening to lady that spoke regarding registered nurses. And my question is about doing exams. So, I work in primary care, and it used to be a thing where they did foot exams; now they're calling it foot checks. And so, they're saying the LPNs and RNS are to do the foot checks. But those are not being co-signed by a provider. So, in, within that, it is telling nurses that they need to diagnose. And say that there's no infection and that's something that I've never been taught as a nurse, even when I was an LPN to say, and I'm just trying to get some clarification. The National Directive says that the provider is supposed to do the check. But now they're pushing that responsibility to the nurses. And my concern is that the nurses doing the check and no provider looking at diabetic foot should not be something that we should have a responsibility for. So that was my question.

1:14:18

Moderator: Thank you so much for your question. During this session, we're actually taking comments on the national standards of practice. We will take your information back and connect with you offline to get you the information you need. We appreciate it. We will now move on to practical vocational nurse. We did not have a list of preregistered individuals to present on practical vocational nurse. If you would like to comment on this occupation during today's session, please use the Q and A function to indicate your interest to do so. Time will be allotted at the end of the session.

1:15:03

Moderator: We will now move on to rehabilitation counsellor. We do not have a list of preregistered individuals to present on rehabilitation counselor. If you would like to comment on this occupation

during today's session. Please use the Q and A function to indicate your interest to do so. Time will be allotted at the end of the session.

1:15:30

Moderator: We will now move on to mental health counselor. We do not have a list of preregistered individuals to present on mental health counselor. If you would like to comment on this occupation during today's session, please use the Q and A function to indicate your interest to do so. Time will be allotted at the end of the session.

1:15:54

Moderator: We will now move on to marriage and family therapist. I will now call upon Roger Smith from the American Association of Marriage and Family Therapy.

1:16:15

Roger Smith: Name's Roger Smith, again with the American Association from Marriage and Family Therapy, the national professional association representing professional interests of over 70,000 licensed marriage and family therapists in the United States, MFTs, as they are known, are licensed in all 50 States in the District of Columbia to provide necessary behavioral health services, MFTs have been serving as providers in VA health care facilities and clinics under the VA qualification standard for MFTs since 2010. MFTs have to have in terms of education training at least the masters or a doctoral degree. And marriage and family therapy related field supervised clinical experience of two years or more, including such experiences, direct client contact under supervision with patients and passing the clinical exam. These standards are, by the way, also very similar across all States. And then they're also very similar to several of the other mental health professions, in terms of the education training as well as the scope of practice. And, like, the other mental health professions,

MFTs provide individual therapy to Veterans and other clients as well as family and group therapy services. AMFT is supportive of VA's development of national standards of practice for LMFTs and 50 other occupations that allow providers to practice to the full extent of their education and training is very important for these national standards of practice for LMFTs and other occupations to allow providers to practice for the full extent their education training and not unduly restrict the scope of practice of these providers. Having a restrictive scope of practice and other limitations in terms of education or training, or other type limitations, not found in State licensure laws for MFTs and that are not congruent in any way with the education training of MFTs, we believe, would hinder care for Veterans. We believe the national standard for MFTs allows them to practice of the full extent their education and training will increase access to care and lower costs for the VA, allowing the maximum utilization of the skills and MFTs as VA providers. In addition, if VA has already done so, we always encourage again, the VA to reach out to professional health care associations and academic institutions for additional information on education- education, training these providers and they certainly can provide a lot of additional information to the VA, if needed. Again, thank you very much for allowing AMFT to provide VA with these comments. Really appreciate it. Thank you very much.

1:18:57

Moderator: Thank you, I will now call upon Cathy Atkins from the California Association of Marriage and Family Therapists. As a reminder, if you are using your phone, please press star 3 to raise your hand to identify yourself and your name is called. I am now calling upon Cathy Atkins from the California Association of Marriage and Family Therapists.

1:19:45

Moderator: In the interest of time, we will move on. I will now call upon Valene O'Donnell from the

California Association of Marriage and Family Therapist. As a reminder, if you're using, if you are using your phone, please press star 3 to raise your hand to identify yourself when your name is called. I am calling upon Valene O'Donnell from the California Association of Marriage and Family Therapists. In the interest of time, we will move on. We will now move on to addiction therapist.

1:20:42

Moderator: I will now call upon Julie Smith from the National Association for Alcoholism and Drug Abuse Counselors. As a reminder, if you dialed in using your phone, please press star 3 to raise your hand to identify yourself. I am now calling upon Julie Smith from the National Association for Alcoholism and Drug Abuse Counselors.

1:21:34

Moderator: In the interest of time, we will move on. I will now call upon Samuel Collins from the American Acupuncture Council to present their comment. As a reminder, if you are dialing in with your phone, please press star 3 to raise your hand to identify yourself.

1:22:15

Moderator: I am calling upon Samuel Collins from the American Acupuncture Council to present their comment.

1:22:28

Moderator: In the interest of time, we will move on. I will now call upon Grant Miller to present their comment. As a reminder, if you are using your phone, please press star 3 to raise your hand to identify yourself.

1:22:52

Moderator: I am now calling upon Grant Miller to present their comment.

1:23:07

Moderator: In the interest of time, we will move on. I will now call upon Cassandra Williamson from the Transgender and Diverse Veterans of America who will present on all occupations. As a reminder, if you called in using your phone, please press star 3 to raise your hand to identify yourself when your name is called.

1:23:45

Moderator: In the interest of time, we will move on. At this time, I will call upon the individuals who may have experienced technical difficulties earlier in the session when called upon. As a reminder, if you are using your phone, please press star 3 to raise your hand to identify yourself when your name is called. I will now call upon Ian Black from the American Society of Anesthesiologists to comment on certified registered nurse anesthetists.

1:24:33

Moderator: Moving on, I will call upon Ralph Harding from the Association of VA Anesthesiologists. Once again, if you use your phone, please press star 3 to raise your hand to identify yourself.

1:24:57

Moderator: I will now call upon Khurram Ghori from the Association of VA Anesthesiologists. Please press star 3 to identify yourself if you use your phone.

1:25:24

Moderator: In the interest of time, I will move on. I will next call upon Sarah Sanders who will present on registered nurse. As a reminder if you're using your phone, please press star 3.

1:25:42

Sarah Sanders: Hello?

Moderator: Oh, hello Ms. Sanders. We can hear you.

1:25:45

Sarah Sanders: Hello, thank you for the opportunity to speak. I am an RN with a background in critical care, community care, nursing education and holistic care nursing. I'm in favor of a standardized RN scope of practice that includes holistic nursing modalities that are evidence based. In my current role as the whole health supervisor, for a VA health care system that spans three States, I have not been able to determine which holistic modalities the RNs in our health care system can offer due to a lack of standardization, inconsistencies, and the difficulty of getting clear responses from State boards of nursing. Some RNs in the VA are able to perform various types of complementary and integrative health modalities, such as battlefield acupuncture. But it varies from State to State. These inconsistencies make education, training, policy creation, supervision, and veteran access to equitable care difficult. It also makes it difficult to inform all Veterans we serve within my health care system what services are available to them since it varies by State. Additionally, my VA health care system spans a highly rural catchment area. In these rural areas demand for complementary and integrative health modalities is high. The supply of medical providers is low. Standardizing the RN scope of practice for nurses within the VA would increase ease of access for rural Veterans to complementary and integrative modalities. Importantly, as with

other nursing modalities, RNs would be responsible for gaining the appropriate education, training, competency demonstration or certification prior to implementation of holistic modalities. With the required training, RNs may be able to help improve veteran access to the following complementary and integrative health modalities that are approved by the VA. List 1 modalities, such as battlefield acupuncture and acupressure, bio feedback such as heart math, clinical hypnosis, guided imagery, meditation, mindfulness, mantra meditation and other forms of meditation, tai chi, chi gong, yoga, massage. List 2 modalities, such as aromatherapy, healing touch, reiki, therapeutic touch, Alexander technique, emotional freedom technique, reflexology, Ralph Fiennes, somatic experiencing and 0 balancing. Thank you for this listening session and your consideration for a standardized RN scope of practice that includes holistic modalities in line with the recommendations from the American Holistic Nurses Association.

1:28:51

Moderator: Thank you for your comment. I will now move back to psychologist. I will call upon Brooke Trainum with the American Psychiatric Association to provide comment.

1:29:14

Brooke Trainum: Good afternoon, my name is Brooke Trainum, and I'm the director of Practice Policy at the American Psychiatric Association. Thank you for the opportunity to speak today. The American Psychiatric Association represents over 30,000 psychiatric physicians and their patients many of which are part of the VA system. APA appreciates the ongoing efforts of the VA to address persistent challenge our nation's Veterans face and accessing quality mental health care and suicide prevention services. The APA strongly opposes authorizing psychologists prescribing within the VA. Expanding psychologists' scope of practice in this way puts patient safety at risk by allowing clinical psychologists to prescribe and manage medications for Veterans. Despite psychologists' lack of

medical training, authorizing psychologists prescribing does not address the VA's shortage of mental health clinicians. In fact, it has the potential to further silo health care clinicians, instead of encouraging increasing collaboration between providers. In developing any national standard, the entire practice team and their roles must be considered, rather than a siloed approach to care. Psychologists are not allowed to prescribe and manage medication independently without collaborating with medical doctors in any setting, including the VA, because they do not have the requisite training or medical background to do so. To date, no federal program, including Medicare, Medicaid, TRICARE, or the VA, allow psychologists to have independent prescriptive authority. Medicare expressly states that the program does not reimburse for evaluation of management or pharmacologic management by prescribing psychologists, specifically citing psychologists' lack of knowledge and ability. No State allows clinical psychologists to independently prescribe and only five States currently allow any prescribing authority under a collaborative. Collaboration or the supervision of another medical provider or position. Allowing psychologists to prescribe medication, the VA system jeopardizes the safety of our nation's Veterans, one of the most vulnerable populations. This population is frequently diagnosed not only with acute mental health illnesses, but also high rates of comorbid physical health conditions. In fact, more than half the patients living with mental illness, have an underlying physical illness. The complex interactions between mental and physical health conditions, and the medications used to treat them require advanced medical training that psychologists do not possess. While clinical psychologists are highly trained members of the behavioral health team, they are not trained to prescribe for acute and serious mental illness that often requires medication management given the prevailing comorbid physical illnesses, such as diabetes, heart disease or hypertension. Recent patient safety concerns regarding prescribing psychologists have made headlines. A prescribing psychologist living in California was found to be the second highest prescriber of Xanax in New Mexico. Seventeen patients died of toxic effects of drugs within one month of the filling of the prescriptions for controlled substances. Instead of considering an ill-conceived experiment to expand psychologists' scope of practice, putting our

Veterans at risk, we ask that the VA strongly consider supporting other improvements to get real workforce shortages across the mental health care provider continuum, including increasing recruitment, training, and retention of psychiatrists. We thank you for your time today.

1:32:47

Moderator: Thank you so much. I will now call upon Bob Taylor with NAADAC Military and Veterans Affairs Committee.

1:33:12

Bob Taylor: …hear me?

Moderator: Yes, sir.

1:33:18

Bob Taylor: Okay. Bob Taylor. I'm the chair of the Military and Veterans Affairs Committee for NAADAC, which is the program for addiction professionals. My colleague, Julie Smith, was going to talk, but I guess she couldn't make it. NAADAC, the committee, we have concerns with the current focus of the standard of practice. Um, one of them is really how they're going to be used to modify Title 38 and how they're going to work the GS-9/GS-11 positions. And in order to ensure that there are credentialed addiction professionals that are providing addiction care. That's one. The other one that jumps out is, uh, is the VA is saying that it would like to move away from ASAM standards. I would like, committee would like to see the evidence based for that, being as ASAM standards are the standard of care throughout the entire treatment, uh, addiction care field. Um, and those two things seem to be what jumped out and that's probably better information about. Um, again, it's

really off the cuff. I wasn't going to speak, so I apologize for the jumbledness. Um, thank you for your time. I'm a VA client as well and I do appreciate the care that you guys provide. Um, thank you.

1:34:49

Moderator: Thank you so much. We will now open the mic up to any individuals who indicated their interest to present using the Q and A function of the chat. You may raise your hand now, using the Webex platform at the bottom of your screen. If you've dialed in on your phone, you may press star 3 on your phone to raise your hand to indicate your interest to present. Once identified you press star 6 to be unmuted. We ask that individuals please provide comments on occupations that you have not already provide comments, if you did already provide comments. If you would like to add to your comments on something that you've previously spoken about, you may do so by submitting them to us via email at VA.NSP@va.gov.

1:36:29

Moderator: I will now call upon a Ms. Deborah Baker to present their comment.

1:36:40

Deborah Baker: I am the director for Legal and Regulatory Policy at the American Psychological Association. APA is the largest psychology professional organization, representing researchers, academics, and practitioners. I would like to address some previous comments made about psychology. One comment, actually it was made a couple of times, but the comment that there are no federal settings in which qualified psychologists with an additional training in a Master of Science and clinical psychopharmacology aren't practicing and federal settings is actually incorrect. There are prescribing psychologists credentialed in the Department of Defense, Indian Health Service, and U.S. Public Health Service. There are six jurisdictions that now recognize prescriptive authority for those

psychologists who need the additional education and training. We will be planning to submit additional comments in writing. So, I thank you for the opportunity to address those comments and clarify.

1:37:55

Moderator: Thank you so much for your comment. I will now call upon Greg Ropp to present their comment.

1:38:16

Moderator: Apologize, I will now call upon Greg Hopp to present their comment.

1:38:22

Greg Kopp: Uh, K-O-P-P, uh, Kopp, like the police, and good afternoon. My name is Greg Kopp. I'm a registered nurse, Air Force veteran, and uh, I am the national program manager for clinical operations with VA health connect in the office of Integrated Veteran Care. And my comment today about registered nurse national standards. We have seen since the pandemic a tremendous ability for nurses across registered nurses across the enterprise to be able to function and fill in the gaps. One thing that is has really become very glaring is the difference between nursing competencies between inpatient, outpatient, and virtual care, and I urge the committees as they consider these national standards to consider the nursing competencies as well, as the nursing licensure compacts and other things, abilities to practice in these different settings, especially with virtual care across State lines. I believe that is very important for VA to continue to maintain its partnership with the National Coalition of State Licensing Boards to be able to have integrated nursing practice that is consistent across the country but is consistent also with State guidelines. And I believe that we'll be

best served when we are partnered with those State boards. Finally, I would like to encourage our, um, leaders to think about nurse standards as they pertain to virtual care. There is, this is really an untouched for the most part, area of nursing that really needs careful considerations because of the lack of ability to interact with providers for nursing order, or for provider orders. And also, the ability to consider care pathways and care needs of Veterans when they reach out to us and we're able to serve them in the virtual realm. It increases access, it increases equity of care, and we are very much about that. Thank you for your time.

1:41:05

Moderator: Thank you so much. Once again, we are opening up the mic to any individuals who indicated their interest to present using the Q and A function of the chat. You may also raise your hand now to use the Webex platform at the bottom of your screen. If you've dialed in on your phone, you may press star 3 on your phone to raise your hand to indicate your interest to present. Once identified you press star 6 to be unmuted.

1:42:20

Moderator: Once again, we're opening up the mic to any individuals who indicated their interest to present using the Q and A function of the chat, you may raise your hand now, using the webinar Webex platform at the bottom of your screen. If you have dialed in on your phone, you may press star 3 on your phone to raise your hand to indicate your interest to present. Once identified, you press star 6 to be unmuted.

1:43:08

Moderator: I will call upon some of the individuals who may have experienced technical difficulty

earlier when called upon as a reminder. If you're using your phone, please press star 3 to raise your hand to identify yourself.

1:43:19

Moderator: I will call upon Cathy Atkins from the California Association of Marriage and Family Therapists to provide your comment.

1:43:48

Moderator: I will now call upon Valene O'Donnell from the California Association of Marriage and Family Therapists. If you are on the line, please press star 3 to raise your hand if you've dialed in by phone.

1:44:20

Moderator: I will call upon others who may have had technical difficulties earlier in the session. I will now call upon Julie Smith from the National Association for Alcoholism and Drug Abuse Counselors.

1:44:51

Moderator: Moving on, I will call upon Samuel Collins from the American Acupuncture Council to present their comment.

1:45:11

Moderator: Moving on to others who may have experienced technical difficulties. I will call upon Grant Miller to present their comment. Once again, if you use your phone, please press star 3 to raise your hand to identify yourself.

1:45:36

Moderator: I will call upon Cassandra Williamson from the Transgender and Diverse Veterans of America, who will, who will provide comment on all occupations.

1:46:01

Moderator: Once again, I'm opening up our mic to any individuals who indicated their interest to present using the Q and A function of the chat. If you did already present today and have additional comments to make, please do so by submitting your comments via email to VA.NSP@va.gov.

1:46:29

Moderator: I will now call upon Mitzy Drake to provide their comment.

1:46:45

Mitzy Drake: …consider practices, which were not specific nursing competencies, but became necessary during COVID-19. Nursing, for example, has exhibited a competency with rapid sequence intubation and standard medication, such as Etomidate, with physician oversight. Please consider allowing nursing to continue this practice and standardize the allowed medications, such as Propofol and Ketamine. Thank you.

1:47:17

Moderator: Thank you so much, and I would like to call upon Mitzy Drake again. There was a slight delay upon your speaking. Could you please state your affiliation?

1:47:47

Mitzy Drake: Hello again. I'm the clinical nurse expert for critical care at the Malcolm Randall Gainsville VA Florida Medical Center.

Moderator: Thank you so much.

1:48:14

Moderator: Once again, if you would like to provide your comment, please use the hand raising button at the bottom of your webinar platform. Or, if you use your phone, please press star 3 to raise your hand to identify yourself. For those who have already provided comment, if you would like to add any additions to your comments, you may do so by emailing us at VA.NSP@va.gov.

1:49:50

Moderator: We will now conclude the open comments section during this listening session, but the line will remain open until 4:30 p.m. We commend each of you for your steadfast dedication and continued support in enabling VA health care professionals to provide the best care to our Nation's Veterans. As a reminder, all suggestions made through these listening sessions will be used to improve and inform the content included in VA's proposed National Standards of Practice across all 51 occupations. All VA proposals for each occupation's VA national standard of practice will still occur through the Federal Register during the 60-day open comment period. For more information on VA's National Standards of Practice visit the VA National Standards of Practice website and sign up for our newsletter at https://www.va.gov/standardsofpractice/. Thank you again for attending the Veterans Affairs National Standards of Practice listening session number five. A recording and transcript of these listening sessions will be available on the VA's National Standards of Practice website upon conclusion of all scheduled listening sessions. Once again, this listing session has ended. We hope you have a wonderful day. Goodbye.

NOTE: *All listening sessions conducted were 2.5 hours in duration—audio recordings have been edited to remove pauses. Please contact presenters directly to request presented materials referenced in each session.*