ADVANCED PRACTICE NURSES: THE SOLUTION TO THE VA HEALTHCARE CRISIS?

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INTRODUCTION

For decades, the U.S. Department of Veterans Affairs (VA) has had an

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infamous reputation for failing to provide timely healthcare to U.S. Veterans. The solution to this problem has evaded the VA and lawmakers for decades. The issue may be, in part, due to the unique structure of the VA. Unlike most other public benefit programs in the United States, the VA operates its own network of healthcare providers and facilities. This approach has advantages in terms of cost containment, but after decades of underfunding and neglect, the VA network is failing to meet veterans' needs. Additionally, surges in enrollment due to nearly two decades of war have exacerbated the problem. As a result, stories of veterans failing to receive adequate care for serious illnesses, or even dying while waiting for care, are ubiquitous. Finally, in 2015, an internal report confirmed what many had suspected—that hundreds of thousands of veterans were stalled in the VA system waiting to receive care.

1. For instance, in 1921, Congress created the Veterans’ Bureau to help World War I veterans, which Congress abolished nine years later amidst a “cloud of scandal” and corruption. See Michael Pearson, The VA’s Troubled History, CNN, (May 30, 2014, 12:40 PM), http://www.cnn.com/2014/05/23/politics/va-scandals-timeline (highlighting several examples from the past 100 years that illustrate U.S. Department for Veterans Affairs’ (VA’s) failures to provide timely healthcare). In 1945, President Harry Truman accepted the resignation of VA Administrator Frank Hines after several reports of “shoddy care in VA-run hospitals.” Id. In 1947 and 1955, a government reform commission found “widespread instances of waste and poor care in the VA system.” Id. In 1976, a Government Accountability Office (GAO) investigation revealed “numerous shortcomings in patient care” in a Denver VA hospital, “including patients whose surgical dressings [were] rarely changed.” Id. In 1991, the Chicago Tribune reported that the VA “failed to treat patients in a timely manner.” Id. Finally, in 2001, despite a 1995 goal to reduce wait times to less than thirty days, the GAO found that veterans “still often wait more than two months for appointments.” Id.


3. See infra Part II.

4. See Johnathan Cohn, The Veterans Affairs Scandal was Decades in the Making, NEW REPUBLIC (May 21, 2014), https://newrepublic.com/article/117855/veterans-affairs-scandal-was-decades-making (explaining that when “federal lawmakers changed eligibility guidelines, so that all veterans—not just those with service-related disabilities or low incomes—were eligible to get medical services at government-run veterans’ clinics. That flooded the system and caused delays.”).

5. See DEP’T OF VETERANS AFFAIRS OFFICE OF INSPECTOR GEN., 14-01792-510, VETERANS HEALTH ADMINISTRATION: REVIEW OF ALLEGED MISMANAGEMENT AT THE HEALTH ELIGIBILITY CENTER i–ii (2015), (finding that of about 867,000 records stalled in the VA’s enrollment system, there were more than 307,000 records that belonged to veterans who had died months or years in the past); see also Curt Devine, 307,000 Veterans May Have Died Awaiting Veterans Affairs Healthcare, Report Says, CNN (Sept. 3, 2015, 11:38 AM), http://www.cnn.com/2015/09/02/politics/va-inspector-general-report (showing “due to
Responding to these developments, Congress enacted the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act). The Choice Act gives veterans the option to see a non-VA doctor if they live more than forty miles away from a VA-operated healthcare provider or if the wait to see a VA doctor is longer than thirty days.

The Choice Act, however, has largely failed to solve the problems that have plagued the VA for years. Faced with ongoing issues, especially surrounding wait times and the accessibility of medical care, the VA promulgated a new rule—the Advanced Practice Registered Nurses Rule (APRN Rule)—that will allow advanced practice nurses to provide care without the supervision of a doctor. The APRN Rule does not change or eliminate the Choice Act; instead, the VA promulgated it as another tool to use in its efforts to reduce veteran wait times. The VA believes this new measure will shorten wait times and reduce veteran healthcare expenses without additional costs to taxpayers.

The APRN Rule will allow the VA’s advanced practice registered nurses, except for nurse anesthesiologists, to practice without the direct supervision of a physician. In its proposal stage, the rule received a lot of support. Several organizations, including veterans’ groups, professional nursing organizations, and eighty Democratic and Republican members of Congress voiced support for the proposed rule. The proposal also high-

7. See id. § 101(b)(2)(A)–(B).
9. See VA Grants Full Practice Authority to Advanced Practice Registered Nurses, U.S. DEP’T OF VETERANS AFFAIRS, (Dec. 14, 2016, 2:05 PM), https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2847 (stating that the Advanced Practice Registered Nurses (APRN) regulation is designed to “increase [the VA’s] capacity to provide timely, efficient, effective, and safe primary care . . .”) (quoting Dr. David J. Shulkin).
10. See U.S. DEP’T OF VETERANS AFFAIRS, ECONOMIC IMPACT ANALYSIS FOR RIN 2900-AP44, ADVANCED PRACTICE REGISTERED NURSES (Nov. 9, 2016) (anticipating savings based on several statewide studies).
lighted several studies that showed that granting nurses greater authority would have significant benefits for the VA system. However, the proposal was not without dissenters. Notably, the American Medical Association (AMA) issued a statement opposing the proposal arguing that “physician-led, patient-centered, team-based patient care” is the best approach to improving the quality of care for our country’s veterans.

This Comment argues that the APRN Rule is a step in the right direction. Part I will discuss the VA and how its healthcare system works. Part II will examine several of the notable issues that have compelled the VA to reform its practices, including several instances of scandal and cover-up. Part III will analyze the measures Congress took to help remedy some of the VA’s issues by enacting the Choice Act, and why it was unsuccessful. Part IV will examine the new rule and the studies and commentary surrounding it. Finally, Part V concludes that while the new rule is a step in the right direction, it is missing the mark in several vital areas.

I. THE VETERANS ADMINISTRATION

The VA was established in 1930, and, at the time, consisted of forty-five hospitals with an operating budget of $786 million. Now, it is the nation’s largest integrated healthcare system with $186.5 billion in the President’s 2018 budget. The Veterans’ Health Administration (VHA) oversees the VA’s healthcare system, and it currently provides medical care to “9.3 million veterans at more than 1,700 sites of care, including 151 medical cen-


16. Veterans Health Administration, supra note 2.

The VHA has its basis in law. The U.S. Code provides that VHA’s primary function is to “provide a complete medical and hospital service for the medical care and treatment of veterans.” The U.S. Code also establishes an all-inclusive personnel system for VHA medical employees, which allows the VA to carry out its medical care mandate. Additionally, Congress outlined the basic qualifications for VA healthcare employees “To ensure that the VA would have highly qualified medical personnel available...”

Congress also granted the VA the authority to regulate the professional activities of VA medical personnel. An individual seeking employment in a VA healthcare position must, among other requirements, “be licensed, registered, or certified to practice their profession in a State.” However, the standards Congress prescribed are simply the minimum qualifications that VHA must abide by.

In addition to rules that govern its employees, the VA also has provisions that dictate who qualifies for VA healthcare. The VA determines veterans’ eligibility status by their military service. A veteran, to qualify, must have been honorably discharged after completing at least twenty-four continuous months of service—unless the veteran was discharged for an injury incurred while in service. If a veteran received any other than honorable discharge, the VA would determine eligibility on a case-by-case basis.

20. See generally 38 U.S.C. chs. 73–74 (2012) (outlining The Veterans’ Health Administration’s (VHA’s) personnel system); see also Advanced Practice Registered Nurses, 81 Fed. Reg. at 90,199 (Dec. 14, 2016) (codified at 38 C.F.R. §§ 17.410, 17.415) (explaining that these chapters grant VHA the authority to regulate its medical personnel outside of the civil service rules). This provision in the statute means that VHA can preempt local and state employment rules for employees working within the VA system. Advanced Practice Registered Nurses, 81 Fed. Reg. 90,198, 90,199.
21. Id.
24. Id.
26. Id.
27. U.S. DEP’T OF VETERANS AFFAIRS, CLAIMS FOR VA BENEFITS AND CHARACTER OF DISCHARGE (2014); see also U.S. DEP’T OF VETERANS AFFAIRS, IB 10-448, OTHER THAN HONORABLE DISCHARGES, IMPACT ON ELIGIBILITY FOR VA HEALTH CARE BENEFITS (2017).
honorable discharge makes one ineligible for VA services.\textsuperscript{28} If a veteran qualifies for VA services, the VA categorizes them into one of eight “priority groups.”\textsuperscript{29} The priority groups are a budgetary measure designed to highlight which veterans are most in need of care.\textsuperscript{30}

Once discharged from service, veterans enroll in the VA healthcare system by calling a toll-free number, going to a clinic, or applying online.\textsuperscript{31} The veterans need to have their discharge forms to start the process.\textsuperscript{32} As part of the application, the VA requires that veterans go through a “means test” each year where the VA reviews the veteran’s financial information to determine their priority group and whether they can afford a co-pay.\textsuperscript{33} After the VA accepts the veterans’ paperwork, representatives schedule appointments for the veterans to see doctors within fourteen days.\textsuperscript{34}

\textsuperscript{28} VA Benefits for Other Than Honorable Discharge, \textsc{Fight4Vets}, http://www.fight4vets.com/va-benefits-for-other-than-honorable-discharge (last visited Oct. 25, 2017); see also Ryan Guina, Types of Military Discharges, \textsc{Military Wallet} (Jan. 19, 2011), http://themilitarywallet.com/types-of-military-discharges (explaining the different types of military discharges). The military lists the type of discharge a service member received on his or her DD-214 discharge paperwork. Guina, supra. There are several discharge options. An “honorable discharge” is for a service member who exceeded standards for performance and personal conduct. \textit{Id}. A “general discharge” is for service members who gave a satisfactory performance but “failed to meet all expectations of conduct for military members.” \textit{Id}. An “other than honorable discharge” comes when a veteran participates in certain acts like use of violence, criminal conduct, or adultery. \textit{Id}. Finally, a dishonorable discharge is for instances when the military finds a service member’s actions to be “reprehensible.” \textit{Id}.

\textsuperscript{29} Carter Moore, How Does the VA Healthcare System Work?, \textsc{Quora} (May 11, 2015), http://www.quora.com/How-does-the-VA-Healthcare-system-work (dividing the priority groups into eight categories). The highest priority goes to veterans with VA-related service-connected disabilities fifty percent or more disabling or determined to be unemployable due to service-connected conditions. \textit{Id}. The lowest priority is for veterans with a gross household income above the VA and the geographically-adjusted income limits for their resident location and who agree to pay copays. \textit{Id}.

\textsuperscript{30} \textit{Id}.


\textsuperscript{32} \textit{Id}. (indicating that the discharge form is known as a DD-214).

\textsuperscript{33} \textit{Id}.

\textsuperscript{34} \textit{Id}. (noting that doctors are also supposed to see existing patients between fourteen and thirty days after requesting an appointment).
II. A LONG HISTORY OF PROBLEMS

Survey data reveals that when veterans can access the VA healthcare system, they are highly satisfied with the quality of care that they receive. Veterans' dissatisfaction with the VA is due to the delay they experience when they need to see a doctor. Medical care delay has been the crux of the VA's issues for quite some time. The VA Office of the Inspector General (IG) has released many reports since 2005 that highlight continual problems with "manipulating lengthy wait times and potentially worsening patient outcomes." In fact, the 2005 report concluded that (1) VA employees were not following scheduling procedures, (2) VA medical facilities did not have effective electronic waiting list procedures, (3) VHA did not have an adequate training program for schedulers, and (4) that outpatient scheduling procedures needed improvement nationwide.

After the 2005 report, the problem only worsened, and in 2010, the VA released an internal memorandum that noted several "gaming strategies"—ways VA employees were getting around the four issues highlighted in the 2005 report—auditors should watch for, admitting that it was not an exhaustive list. In the 2010 memorandum, the VA's Deputy Under Secretary for Health Administrative Operation, William Schoenhard, revealed that "to improve scores on assorted access measures, certain facilities have adopted use of inappropriate scheduling practices," adding that "This is not patient centered care." The memorandum also highlighted "scheduling practices to avoid," which uncovered some of the tactics that VA centers were using to manipulate the official times that patients were waiting for care.

35. See Podolsky, supra note 15.
36. Id.
37. Id.
38. OFFICE OF INSPECTOR GEN., DEP'T OF VETERANS AFFAIRS, 04-02887-169, AUDIT OF THE VETERANS HEALTH ADMINISTRATION'S OUTPATIENT SCHEDULING PROCEDURES (2005). Survey officials "visited eight medical facilities, interviewed 247 schedulers whom medical facility managers identified as being responsible for scheduling appointments, and reviewed 1,104 medical care appointments scheduled for the week of June 21-27, 2004." Id. Survey officials also asked "29,818 VHA employees responsible for scheduling appointments to complete a web-based survey designed to capture their training experiences, adequacy of supervision, and scheduling practices." Id. 15,750 employees responded to all or part of the survey. Id.
40. Memorandum from William Schoenhard, Deputy Under Sec'y for Health for Operations and Mgmt., Dep't of Veterans Affairs, to Network Dir. 1 (Apr. 26, 2010).
41. Id. at 2-3 (describing some of the inappropriate scheduling tactics the VA centers were using).
The 2010 memorandum also described how VA employees altered a veteran's preferred appointment time when it was not conducive to doctor availability.\textsuperscript{42} To manipulate the data, VA employees would conceal the difference between what the patient requested and what the VA scheduled by either entering an incorrect date, not entering any date, or indicating that the earliest available date was the patient's desired date.\textsuperscript{43} Then, in 2013, after a Government Accountability Office (GAO) report highlighted ongoing problems with patient wait times, Schoenhard sent a subsequent memorandum to VA facilities revealing additional "tweaks" to the scheduling process.\textsuperscript{44} Despite these repeated incidents, VA clinics continued with these faulty practices, and veterans continued to struggle with receiving the care that they needed.

\textbf{A. Time to Blow the Whistle}

The deception scheme erupted in 2014 when whistleblowers from the Phoenix, Arizona VA Hospital reported several tactics that the hospital was using to hide or alter statistics that revealed how long veterans were waiting to receive care.\textsuperscript{45} Among the more serious allegations was a report that hospital staffers had changed or physically altered hospital records to hide how many people died while waiting for care at the Phoenix VA hospital.\textsuperscript{46}

\begin{itemize}
\item appointments requested beyond the thirty-day guideline would be denied or held until it was within the guideline. \textit{Id.} Auto-rebooking removed critical scheduling data from the system and prevented verification that the clinic scheduled the patient within thirty days. \textit{Id.} An additional tactic was to use a slot for a "Test Patient so that the slot could not be used," and then to later cancel the test patient and to then schedule a patient in the appointment slot. \textit{Id.} at 4. Sometimes numerous patients were scheduled at one block of time. \textit{Id.} On other occasions a VA center would pretend that a patient had cancelled an appointment when in fact the clinic had cancelled it. \textit{Id.} at 4–5.
\item 43. \textit{Id.}
\item 44. \textit{Id.} (describing how new patient wait times were measured using the creation date of an appointment as the first reference point and the completed appointment as the second).
\item 46. \textit{See, e.g.}, Hegseth, \textit{supra} note 45.
\end{itemize}
The whistleblowers revealed that staffers did this by removing “deceased” notes on files to make statistics seem better, so the VA did not have to admit that the veteran “died while waiting for care.”

A timeline surrounding the Phoenix VA hospital whistleblower scandal highlights the problems seen in many VA clinics across the country. In early 2012, Dr. Katherine Mitchell, a VA emergency room physician, warned Sharon Helman, the incoming director of the Phoenix VA Health Care System, that the “Phoenix ER was overwhelmed and dangerous.” Following that allegation, GAO reporters told the VHA that “its reporting of outpatient medical-appointment wait times was unreliable,” and that long wait times and inadequate scheduling processes at VA medical centers have been persistent problems. In 2013, Dr. Mitchell filed a confidential complaint, but the VA failed to address her most serious concerns, and VA officials placed her on administrative leave shortly after that.

The same year Dr. Sam Foote, a doctor of internal medicine at the Phoenix VA hospital, also filed a complaint with the VA Office of IG alleging that the VA’s “purported successes in reducing wait times” were actually due to staffers manipulating data, “not improved service.” In his complaint, Dr. Foote also alleged that veterans were dying while waiting for care. In December 2013, Dr. Foote retired and became a whistleblower by meeting with the press. That same month, investigators from the VA’s Office of the IG visited the Phoenix VA hospital to explore the allegations, and the scheme erupted from there.

B. VA Report Confirms Whistleblowers’ Allegations

In May 2014, the VA’s Office of IG released an interim report that “[confirmed] whistleblower allegations of mismanagement and manipula-

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47. Bronstein et al., supra note 45.
49. Timeline: The Road to VA Wait-Time Scandal, supra note 45.
50. Id.
51. See Timeline: The Story Behind the VA Scandal, supra note 48.
52. Timeline: The Road to VA Wait-Time Scandal, supra note 45.
53. Id.
54. Id.
55. Id.
tion of data related to patient wait times.\textsuperscript{56} As part of the findings, the IG found that the Phoenix VA Hospital "was reporting wait times of just [twenty-four] days while the actual delay in appointments averaged nearly four months."\textsuperscript{57} Further, "1,700 veterans had signed up for initial appointments in Phoenix but did not appear on any wait lists."\textsuperscript{58} Finally, in August 2014, the VA IG issued a final report acknowledging that forty-five patients experienced "unacceptable and troubling lapses in follow-up, coordination, quality, and continuity of care" at the Phoenix VA Hospital.\textsuperscript{59} The IG conceded that patients "experienced access barriers that adversely affected the quality of primary and specialty care."\textsuperscript{60} However, the report did not explicitly conclude that veterans died because of waitlist manipulation.\textsuperscript{61} As the manipulations of data surfaced at the Phoenix VA Hospital, employees at other VA hospitals began making similar allegations. A Texas VA employee claimed he was "'coached' on how to 'cook the books' to conceal long wait times for patients," and an e-mail from a VA employee in Cheyenne, Wyoming echoed the allegations.\textsuperscript{62} VA employee allegations combined with VA IG reports called attention to similar problems in VA hospitals in Colorado, Florida, South Carolina, and Pennsylvania.\textsuperscript{63}

C. Veterans' Stories

Amidst such reports from whistleblowers, media outlets, and government officials, stories of veterans who had been personally affected by these prob-

\textsuperscript{56} OFFICE OF INSPECTOR GEN., DEPT OF VETERANS AFFAIRS, 14-02603-178, VETERANS HEALTH ADMINISTRATION, INTERIM REPORT: REVIEW OF PATIENT WAIT TIMES, SCHEDULING PRACTICES, AND ALLEGED PATIENT DEATHS AT THE PHOENIX HEALTH CARE SYSTEM i–ii (2014); see also Timeline: The Road to VA Wait-Time Scandal, supra note 45.

\textsuperscript{57} Timeline: The Road to VA Wait-Time Scandal, supra note 45 (noting that most of the wait-time discrepancies "occurred because of delays between the veteran's requested appointment date and the date the [Phoenix VA hospital created the appointment]").

\textsuperscript{58} Id.

\textsuperscript{59} DEPT OF VETERANS AFFAIRS, OFFICE OF INSPECTOR GEN., AUGUST 2014 HIGHLIGHTS (2014).

\textsuperscript{60} Id.

\textsuperscript{61} Id.; see also Timeline: The Road to VA Wait-Time Scandal, supra note 45.

\textsuperscript{62} Rich Gardella et al., VA Whistleblowers Describe Alleged 'Cooking' of the Books, NBC NEWS (May 9, 2014, 4:09 PM), http://www.nbcsnews.com/storyline/va-hospital-scandal/va-whistleblowers-describe-alleged-cooking-books-n101781 (describing the same tactic in Wyoming, where a VA staffer advised scheduling clerks to present a doctor's first available appointment date to a patient and then to book that date as the patient's desired date to eliminate wait time).

\textsuperscript{63} Zezima, supra note 31 (explaining that such practices were systematic nationwide).
lems began to surface. The story of Barry Coates illustrates how dire these delays were for some veterans. In 2011, Mr. Coates was suffering from “excruciating pain and rectal bleeding.”64 He went to several VA clinics and hospitals in South Carolina looking for an answer, but all he received was a hemorrhoids diagnosis and some pain medication.65 As the pain worsened, Mr. Coates begged VA officials for a colonoscopy but found himself on a waiting list.66 Finally, about a year after his initial appointment, Mr. Coates received a colonoscopy that revealed a “cancerous tumor about the size of a baseball.”67 By the time Mr. Coates received chemotherapy, his cancer had progressed, and he passed away in January 2016.68

Problems surrounding wait times have plagued the VA for decades. Many VA hospitals, succumbing to the pressure of cutting down wait times, began using faulty—and in many instances, corrupt—practices to make it appear that veterans’ wait times were getting better. In 2014, these practices came to a head when whistleblowers from several VA hospitals across the nation spoke out about what was happening in VA facilities. With that exposure came a demand from society that the VA improve these problematic outcomes and abandon these corrupt practices.

III. THE CHOICE ACT

Responding to these scandals, Congress created a solution—the Choice Act—a measure that passed with overwhelming bipartisan support.69 The Choice Act was a $10 billion program that was supposed to give veterans some reprieve.70


65. Id. (adding that the VA doctor also mentioned that Mr. Coates “may need a colonoscopy,” however, the doctor did not arrange anything).

66. Id.

67. Id.


A. The Choice Act Provisions

Under the Choice Act, the VA gives veterans a card that allows them to see a non-VA doctor if they are more than forty miles away from a VA facility, or if they are “unable to schedule an appointment within the wait-time goals of the [VHA]” (i.e., thirty days). Upon signing the Choice Act into law, President Barack Obama outlined three important areas that the Choice Act was to address: (1) giving the VA the resources it needed, (2) ensuring timely care, and (3) holding senior executives accountable. While the Choice Act does expand survivor benefits, improve care for victims of sexual assault, and help veterans struggling with traumatic brain injuries, its main focus is to facilitate better access to healthcare. However, reports show that since its inception, the Choice Act has largely failed for several reasons.

B. Problems with the Choice Act

The Choice Act has been problematic since it became a law in 2014. Wait times have worsened, and patient access data shows that when comparing the May 2015 statistics to the May 2016 numbers, 70,000 more veterans had to wait at least a month before the VA could accommodate them. The VA contended that the increase in wait times was due to an

72. Id. § 101(b)(2)(A); see also The Veterans Access, Choice and Accountability Act of 2014, HOUSE COMM. ON VETERANS’ AFFAIRS, https://veterans.house.gov/legislation/the-veterans-access-choice-and-accountability-act-of-2014.htm (last visited Oct. 25, 2017) (explaining that the Choice Act was to provide “$10 billion for the newly-established Veterans’ Choice Fund” to cover the costs of this increased access to non-VA care). Choice program authority would end when the VA’s “funds are exhausted or three years after enactment, whichever occurs first." The Veterans Access, Choice and Accountability Act of 2014, supra.
73. Brenchley, supra note 69 (explaining how the Choice Act would help the VA). First, the Choice Act would give the VA the resources it needed by hiring more doctors and nurses to ensure that the VA could keep up with the demand that would result from a new generation of veterans returning home from war. Id. Second, the Choice Act would help the VA ensure timely care by allowing veterans to get the care that they need someplace else when VA services were inaccessible for them. Id. Finally, the Choice Act would help hold people accountable by giving the VA Secretary more authority to remove senior executives who “fail to meet the standards of conduct and competence that the American people demand.” Id.
74. Id.
75. See VETERANS HEALTH ADMIN., PENDING APPOINTMENT AND ELECTRONIC WAIT LIST SUMMARY-NATIONAL, FACILITY, AND DIVISION LEVEL SUMMARIES WAIT TIME
influx in enrollment after soldiers returned home from the Iraq and Afghanistan wars, but the problems with the Choice Act go deeper than that. For example, a March 2016 GAO report highlighted several systematic errors that "continue to affect the reliability of wait-time data used for oversight." Additionally, the GAO report revealed that the Choice Act "had little impact on getting veterans to see a primary care physician in thirty days." Further, thousands of veterans that the VA had referred to private physicians ended up returning to the VA for care. In some instances, this was because the VA could not find a suitable doctor, but for 28,287 veterans, this was because the private doctor was too far away.

1. Failure to Pay Non-VA Hospitals

Other issues have plagued the Choice Act. First, there are many reports of the VA failing to pay non-VA hospitals for their services. As a result, healthcare providers are frustrated with the program, "which makes it hard to keep them in the network." In March 2015, the VA reported a backlog of more than $878 million in delayed payments intended for non-VA providers that were providing emergency medical services to veterans. Then in June 2015, Vince Leist, President and CEO of North Arkansas Regional Medical Center (NARMC), testified before the Subcommittee on Health of the Committee on Veterans' Affairs of the U.S. House of Repre-
sentatives that since 2011, NARMC had 215 claims totaling more than $750,000 that the VA did not pay. According to Leist, “lack of prompt payment from the VA combined with continued reductions to Medicare and Medicaid payments for hospitals, are jeopardizing access to care for patients.”

2. Accelerated Implementation of the Choice Act

A second issue that has plagued the Choice Act is the accelerated pace which Congress required the VA to implement it, giving the VA ninety days from the time the President signed the Choice Act. Typically, a program of comparable size and magnitude would take at least a year to implement. As a result, VA officials immediately decided that they could not run the program themselves. According to Baligh Yehia, Assistant Deputy Under Secretary for Community Care, the VA “didn’t have the resources,” to implement the Choice Act. However, VA Secretary Bob McDonald said that turning to outside healthcare administrators for help was a “primary flaw.” According to McDonald, the VA “would literally just give the veteran a number to call.” This made the process difficult because the VA took an average of nineteen days to submit appointments to contractors. Thus, instead of easing access to healthcare, these new provisions were creating massive problems for veterans who needed help.

83. Id. (testifying that North Arkansas Regional Medical Center has tried to resolve these claims, but the attempts have only led to “long periods on hold to speak to VA service personnel, limitations on the number of cases to be discussed per phone call, and lost medical records.”).

84. Id.

85. See Walsh et al., supra note 78; see also Martin Matishak & Ramsey Cox, Senate Passes Overhaul of VA in 93-3 Vote, THE HILL (June 11, 2014, 5:50 PM), http://thehill.com/blogs/floor-action/senate/209046-senate-passes-va-overhaul (quoting Senator John McCain saying, “This is an emergency.”). Because the situation was so dire, Congress required the VA to implement the bill within ninety days of it being signed into law. Id.

86. See Walsh et al., supra note 78.

87. See id.

88. Id.


90. Id.

91. See Walsh et al., supra note 78.
3. Confusion Surrounding the Choice Act

A third complaint with the Choice Act is that the program is "confusing and complicated."\(^92\) Neither veterans nor their doctors understand it, and many physicians who want to provide care for veterans are unable to because the certification process is so complex.\(^93\)

Unfortunately, what was supposed to finally provide a reprieve for veterans accessing care through the VA system has proved to be anything but that. With issues still surrounding wait times and accessibility, confusion regarding the law on the part of both patients and doctors, and payments and complaints being backlogged for months, the Choice Act has done little to improve the outlook for veterans trying to access medical care through the VA.

IV. "FULL PRACTICE AUTHORITY" FOR ADVANCED PRACTICE REGISTERED NURSES

Responding once again to ongoing concerns surrounding the VA system, particularly surrounding wait times and accessibility, the VA proposed a new rule on May 25, 2016.\(^94\) In this proposed rule, the VA announced its intentions to grant full practice authority\(^95\) to its APRNs.\(^96\) The APRN Rule subdivided APRNs into four separate categories: Certified Nurse practitioners (CNPs), Certified Registered Nurse Anesthetists (CRNAs), Clinical Nurse Specialists (CNSs), or Certified Nurse-Midwives (CNMs).\(^97\) Each advanced practice area has its own specializations.\(^98\)

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92. See Lawrence et al., supra note 75.
93. See Lawrence & Murphy, supra note 81.
95. See infra Part IV.A.
97. Advanced Practice Registered Nurses, 81 Fed. Reg. at 33,156. See id. at 33,160 (explaining the different advanced practice nursing degrees). A Certified Nurse Practitioner (CNP) provides basic care focused on a specific population or health need with the ability to write prescriptions. Id. A Certified Registered Nurse Anesthesiologist (CRNA) administers anesthesia for all types of surgery. Id. A Certified Nurse Specialist (CNS) provides specialist care in several areas: cardiology, oncology, neonatology, OB/GYN, pediatrics, neurology, and mental health. Id. A Certified Nurse-Midwife (CNM) provides prenatal care, delivers babies, and provides postpartum care to normal, healthy
With its proposal, the VA intended to expand the pool of qualified healthcare professionals who are authorized to provide primary healthcare and other services. The VA asserted that allowing APRNs to provide these services—pursuant to their education and training—would alleviate long waitlists by creating a larger pool of qualified medical professionals to attend to veterans' healthcare needs. The VA also highlighted that the APRN Rule would promote efficiency by allowing it to use its healthcare and personnel resources "more effectively." Finally, the VA averred that the services under the APRN Rule would be "consistent with the nursing profession's standards of practice for such roles."

A. Comments Surrounding the APRN Rule

The APRN Rule went through the notice-and-comment process until July 25, 2016. The VA received 223,296 comments in response to the proposal. While the APRN Rule garnered a great deal of support from commenters, especially professional nursing organizations, it also received some dissent, notably from the AMA.

In support of the APRN Rule, the American Nurses Association (ANA) wrote a letter to the VA's Secretary Robert McDonald saying that the rule "is based on careful study and stakeholder engagement, and is consistent with recommendations from the Institute of Medicine and the VA Commission on Care." The ANA further stated, "the proposed rule recog-
nizes that supervision requirements are unnecessary and costly." In contrast, the AMA also wrote a letter as part of the comment process in which it stated that it was “disappointed” by the VA’s “unprecedented” proposal to allow APRNs’ full practice authority regardless of state law. The AMA argued that “providing physician-led, patient-centered, team-based patient care” is the best approach to improving the quality of care for our country’s veterans, and that the APRN Rule “will significantly undermine the delivery of care within the VA.”

On December 14, 2016, the VA adopted most of its proposed rule by announcing that it would amend its provider regulations to permit full practice authority to three of the four proposed APRN groups. The final rule is very similar to the proposed rule with one notable difference—the final rule excluded CRNAs from the group of APRNs that now have full-practice authority in the VHA system. This is in large part because there were 104,256 comments against granting full practice authority to VA CRNAs.

The main argument against granting VA CRNAs full practice authority was that it would “eliminat[e] the team-based concept of care in anesthesia.” A secondary argument against including CRNAs in the new rule was that there is “no shortage of physician anesthesiologists in VA.” Dissent for including CRNAs in the final rule was not unanimous, however. The VA received 9,613 comments in support of full practice authority for CRNAs. Supportive commenters noted that “CRNAs currently exercise their full scope of practice in seventeen states and in the Army, Navy, Air Force, Combat Support Hospitals, Forward Surgical Teams, and the Indi-

108. Id.
110. Id.
112. Id.
114. Id.
115. Id. The American Society of Anesthesiologists (ASA) and the American Medical Association (AMA) praised the VA’s decision to exclude CRNAs from the final rule. See Joyce Frieden, Nurse Anesthetists Left Out of New VA Policy, MEDPAGETODAY (Dec. 13, 2016), https://www.medpagetoday.com/publichealthpolicy/militarymedicine/62054. The AMA commended the VA for recognizing the “critical need for collaboration among physicians and nurse anesthetists,” and the ASA praised the VA for acknowledging that the “operating room is a unique care setting . . . requiring physician leadership.” Id.
The VA was still deciding whether the new rule would cover CRNAs, and it accepted comments regarding this proposition until mid-January 2017. The VA specified that its decision not to include CRNAs in the final rule did not reflect CRNAs' abilities, rather that the VA did not have an anesthesiology access problem.

Exactly how the APRN Rule will work, and whether it will be effective requires an in-depth examination of it. Additional considerations include how similar practices work in the non-VA healthcare sector and the commentary surrounding this new change.

B. Provisions of the New Rule

Understanding exactly what the APRN Rule entails is necessary to determine its potential ramifications. The rule will allow APRNs to practice "to the full extent of their education, training, and certification... regardless of individual state restrictions that limit such full practice authority." The rule uses the term "full practice authority" to refer to

117. Id. Unsurprisingly, one of the most vocal critics of the VA's decision to exclude CRNAs is the American Association of Nurse Anesthetists (AANA). See generally VA Final Rule News, AM. ASS'N NURSE ANESTHETISTS, http://webcache.googleusercontent.com/search?q=cache:IEHMyMPdqSj:www.aana.com/newsandjournal/News/Pages/052516-VA-Proposed-Rule-News.aspx+&cd=1&hl=en&ct=clnk&gl=us (last visited Oct. 25, 2017) (providing several articles highlighting their position on granting CRNAs full practice authority). Following the VA's decision not to include CRNAs in the final rule, Cheryl Nimmo, a U.S. Army Reserves Veterans and President of the AANA, wrote an opinion piece for Forbes that chided the VA for "illogically excluding [CRNAs] from the rule while at the same time confirming their qualifications and expertise." Cheryl Nimmo, VA Ignores CRNA Evidence as Veterans Wait for Timely Anesthesia Care, FORBES (Jan. 12, 2017, 11:00 AM), https://www.forbes.com/sites/realspin/2017/01/12/va-ignores-crna-evidence-as-veterans-wait-for-timely-anesthesia-care/#6f291f4122c7. Ms. Nimmo added that the VA's decision will continue to harm veterans who "endure dangerously long wait times for anesthesia and other healthcare services." Nimmo supra.


119. Id. Nurses' organizations, such as the American Association of Nurse Practitioners and the American Nurses Association joined the AANA in criticizing the VA's decision not to include CRNAs in the final rule. See Joyce Frieden, Nurse Anesthetists Planning to Oppose VA Rule, MEDPAGE TODAY (Dec. 16, 2016), http://www.medpagetoday.com/publichealthpolicy/militarymedicine/62145. However, they released statements declaring intent to continue to "advocate for CRNAs to have full practice authority" while voicing optimism that the VA will eventually include them in the new rule. Frieden supra.

120. Advanced Practice Registered Nurses, 81 Fed. Reg. at 90,198. In enacting this rule, the VA did carve out an exception for "applicable State restrictions on the authority to
the APRNs’ authority to provide basic healthcare services “without the clinical supervision” of a physician when the APRN is working “within the scope of their VA employment.”

The VA would grant an APRN “full practice authority” if the APRN could demonstrate that he or she meets the specified criteria. The VA believes that standardizing APRN full practice authority throughout the VA, regardless of individual state practice regulations, will help “ensure a consistent continuum of healthcare across VHA by decreasing the variability in APRN practice that currently exists across VHA as a result of disparate state practice regulations.” Thus, the VA’s rule preempts state nursing licensure laws, and its justification for doing so is to promote a consistent and efficient system throughout the VHA.

1. Defining “Full Practice Authority”

Understanding specifically what “full practice authority” without “physician oversight” entails is helpful in examining the ramifications of this new measure. The rule grants specific authority to APRNs depending on their specialization. Under 38 C.F.R. § 17.415(d)(1)(i)(A)-(E), a CNP has full practice authority to:

(A) Take comprehensive histories, provide physical examinations and other health assessment and screening activities, diagnose, treat, and manage patients with acute

Prescribe and administer controlled substances.”

Id. Currently, twenty-three states and the District of Columbia allow CNPs to prescribe medication without the supervision of a physician. See Nurse Practitioner Scope of Practice Laws, HENRY J. KAISER FAMILY FOUND. (July 24, 2015), https://www.kff.org/other/state-indicator/total-nurse-practitioners/?currentTimeframe=0&sortModel=%7B%22colId%22:%22%22Location%22,%22sort%22:%22asc%22%7D.


122. Id.; see also infra Part IV.A (outlining the VA’s criteria for APRNs under the new rule).

123. See infra Part IV.A. The VA did this in consideration of Executive Order 13,132, which outlines the procedure an agency must follow if its rule will preempt state law. See Advanced Practice Registered Nurses, 81 Fed. Reg. at 90,205; see also Exec. Order No. 13,132, 64 Fed. Reg. 43,255 (Aug. 4, 1999).


125. Though the specific role of an APRN varies depending on their specialization, full practice authority generally means that an advanced nurse can provide primary healthcare pursuant to their education and training without the oversight of a physician. See AM. ASS’N OF NURSE PRACTITIONERS, ISSUES AT-A-GLANCE: FULL PRACTICE AUTHORITY (2013). This includes services such as evaluating patients, diagnosing, initiating and managing treatments, and prescribing medications. Id.
and chronic illnesses and diseases; (B) order laboratory and imaging studies and integrate the results into clinical decision making; (C) prescribe medication and durable medical equipment; (D) make appropriate referrals for patients and families, and request consultations; [and] (E) aid in health promotion, disease prevention, health education, and counseling as well as the diagnosis and management of acute and chronic diseases.\footnote{126}

Under § 17.415(d)(1)(ii), a CNS has “full practice authority to provide diagnosis and treatment of health or illness states, disease management, health promotion, and prevention of illness and risk behaviors among individuals, families, groups, and communities within their scope of practice.”\footnote{127} Finally, under § 17.415(d)(1)(iii), a CNM would have full practice authority to provide services to women, “including gynecological care, family planning services, preconception care, prenatal and postpartum care, childbirth, care of a newborn, and treating the partner of their female patients for sexually transmitted disease and reproductive health.”\footnote{128}

The APRN Rule also includes provisions that clarify its scope and the standards that the VA requires advanced practice nurses to adhere to. Section 7402 of U.S.C. Title 38 establishes the requirements for the VA to impose when hiring healthcare professionals.\footnote{129} To be eligible for appointment as a VA employee in a nursing position covered by § 7402(b), a person must have “successfully completed” an approved nursing course, and “be registered as a graduate nurse in a state.”\footnote{130} However, § 7402(b) only establishes the “basic qualifications necessary to be eligible for ap-
pointment” within the VA. Thus, Congress has granted the VA the ability to establish additional requirements for healthcare employees as it sees fit. Under the APRN Rule, the VA opted to exercise that option. Now, pursuant to § 17.415(a)(1), an APRN opting to exercise full practice authority would need to have “successfully completed a nationally-accredited, graduate-level educational program” that prepares them to practice in one of the four APRN roles. Additionally, § 17.415(a)(2) will require an APRN to have passed a national certification examination that measures the APRNs’ skills, and § 17.415(a)(3) will require an APRN to “possess a license from a state licensing board in one of the four recognized APRN roles.”

With the APRN Rule, the VA has expanded the pool of qualified medical professionals that can provide much needed services to our nation’s veterans. Through this new rule, advanced nurses will now be able to provide core medical services to veterans such as diagnosing illnesses and diseases, prescribing medications, providing gynecological care, and managing diseases. Although the VA has yet to expand the scope of CRNAs, the APRN Rule will allow greater access to medical services that treat issues that arise every day in VA hospitals.

V. ANALYSIS AND RECOMMENDATIONS

The VA is optimistic that these new measures will help to resolve some of the issues that have plagued the VA for years. The VA believes that utilizing its APRNs to the full extent of their education and training will allow VHA to more effectively discharge its statutory mandate. This new rule would not affect the Choice Act, which remains intact; rather, it would be another tool for veterans seeking healthcare through the VA system.

Analyzing whether this new rule will be effective requires breaking down the VA’s major issues—namely, the lack of timely access to healthcare for our nation’s veterans, the inefficiency of the VA system, and the corruption and cover-ups that whistleblowers have brought to light. When Congress enacted the Choice Act in 2014, it attempted to address these issues. Reports have shown, unfortunately, that the Choice Act has been mostly

131. 38 U.S.C. § 7402 (indicating that the statute allows the Secretary for Health to establish other discretionary rules or qualifications).
133. Id.
134. Id. (asserting that the VA believes the additional requirements promote a safe healthcare environment for veterans); see also SHORES, supra note 10 (asserting that effectively utilizing its APRNs will allow the VA physicians to focus on the “most complex” cases).
135. See supra Part III.
unsuccessful at combating these problems. Among the reasons for this are the haste with which the VA had to implement the Choice Act once President Obama signed it into law; the VA neglecting to pay non-VA practitioners for their services; the confusion surrounding the program—on the part of both veterans and healthcare professionals; and the overall inefficiency of the program.

A. Improving the APRN Rule

Will the APRN Rule be a better “fix” than the Choice Act? Will it help fill in the holes that are still gaping because of the Choice Act’s deficiencies? One of the most pressing issues for the VA to address is patient wait-time. All other problems surrounding VHA seem to continually come back to this major issue. The VA seems cognizant of that, and the APRN Rule seems to adequately respond to this perpetual problem. Upon announcing the adoption of the rule, VA Under Secretary for Health, Dr. David J. Shulkin said: “[a]mending this regulation increases our capacity to provide timely, efficient, effective, and safe primary care; aids VA in making the most efficient use of APRN staff capabilities; and provides a degree of much needed experience to alleviate the current access challenges that are affecting the VA.”

VA officials have stated that a primary purpose for enacting this measure is to increase veteran access to VA healthcare, “particularly in medically-underserved areas.” According to VA officials, “This preemptive rule increases access to care and reduces the wait-time for VA appointments utilizing the current workforce already in place.” The APRN Rule appears to be a logical, cost-effective way to increase access to the basic services that many veterans spend months (or longer) waiting to receive.

Several concerns surround the APRN Rule, however, some of which the VA should address. Among the most concerning, is the argument that the APRN Rule will negatively affect the quality of patient care. Though

136. See supra Part III.B.2.
137. Press Release, U.S. Dep’t of Veterans Affairs, supra note 111.
139. Id. (explaining that utilizing VA APRNs to the full extent of their training “increases [the] VA’s capacity to provide timely, efficient, and effective primary care services”).
141. See, e.g., Press Release, Andrew W. Gurman, President, Am. Med. Ass’n, AMA
studies show that APRN-delivered care does not negatively affect patient safety, these concerns warrant attention and discussion. Several commentators questioned an APRNs’ years of training versus those of a physician, citing an AMA statement that “physicians typically receive a combined total of over 10,000 hours of training and patient experience prior to beginning practice, whereas the typical APRN receives less than 1,000 hours of training and patient experience.” The VA responded by stating that “APRN education is competency based and APRNs must demonstrate that they have integrated the knowledge and skill to provide safe patient care.”

Still, the commenters make a valid point about the large discrepancy between physician training hours compared to that of an APRN. While better efficiency and access should be primary goals for the VA to achieve, it should never compromise patient care and safety to achieve them. There is a middle ground, however. Perhaps a new APRN is still too inexperienced to be granted “full practice authority,” but that does not mean that they do not have the training to eventually be able to do so. In line with other professional positions, a modification of this rule could be to require a new APRN to work 4,000 hours—approximately two years of full-time work—under the supervision of an APRN who has already met the hours requirement, or under a physician. The VA could modify the APRN Rule to include a provision that new APRNs must work under the supervision of a more experienced APRN or a medical doctor for a certain number of hours before being granted the full practice authority that the rule provides.

Statement on VA rule on Advanced Practice Nurses (Dec. 13, 2016) (arguing that physician-led care is the “best approach to improving quality care for our country’s veterans”).

142. See DEPT VETERAN AFFAIRS, EVIDENCE-BASED SYNTHESIS PROGRAM (ESP), EVIDENCE BRIEF: THE QUALITY OF CARE PROVIDED BY ADVANCED PRACTICE NURSES, 3 (2014) (highlighting one study that estimates that “nurse practitioners... are capable of providing 70% or more of the care required for adults and 90% in pediatrics”); see also INST. OF MED. OF THE NAT’L ACAD., THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH 27 (2011) (advancing the idea that evidence supports the notion that utilizing APRNs can greatly expand “access to quality care”).

143. Advanced Practice Registered Nurses, 81 Fed. Reg. at 90,203; see also Press Release, Am. Med. Ass’n, supra note 141 (emphasizing the value that physician training and expertise brings to a healthcare team).

144. Advanced Practice Registered Nurses, 81 Fed. Reg. at 90,203; see also APRNs & Veterans, supra note 102 (highlighting the well-documented history of APRNs providing safe and effective care).

145. See, e.g., CHRISTIE LUM, LICENSURE REQUIREMENTS FOR PROFESSIONAL COUNSELORS – 2010, (Am. Counseling Ass’n, 2010) (highlighting that many states require post-degree supervision to obtain a counseling license).
With this approach, a new APRN could gain valuable experience under the tutelage of a more experienced provider while still allowing the VA to utilize APRNs to help alleviate patient wait times.

Other commenters stated that they were concerned that granting full practice authority to APRNs would undermine the value of team-based care. The concern is that "physicians and other members of a healthcare team bring unique value to patient care that is based on the individual member's education, skill, and training." The commenters were concerned that eliminating the physician-led, team-based care model would put patients at risk. The VA addressed the dissenters' argument by stating that "team based [sic] care was not addressed in the proposed rule because...establishing full practice authority to VA APRNs, including CRNAs, would not eliminate any well-established team based [sic] care." Thus, the VA did not make any edits based on these comments.

While the VA did acknowledge these concerns in the APRN Rule, it could do more to substantively address them. It is possible to still provide safe, team-based care while allowing APRNs to have full practice authority. This rule does not undermine the authority of VA physicians; it simply expands the pool of available, trained individuals who can provide services that the VA seems to struggle to efficiently provide. A recommendation would be to continue to ensure that physicians are available as part of every care team, while still allowing APRNs to provide many of the services that veterans traditionally had to wait for an available physician to provide.

To address commenters’ concerns, the VA could modify the rule with

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146. Physician groups that oppose expansion of APRN authority “envision a system in which physicians delegate the care of less complex patients to (supervised) nurse practitioners.” DEP’T VETERAN AFFAIRS, EVIDENCE-BASED SYNTHESIS PROGRAM (ESP), supra note 142.


148. Id.; see also AAFP Joins Push Against Greater Authority for APRNs in VA Facilities, AM. ACAD. FAMILY PHYSICIANS (July 26, 2016, 12:10 PM), http://www.aafp.org/news/government-medicine/20160726vasign-on.html (stating that advanced nurses “should not be considered substitutes for physicians as leaders of the care team”).


150. Id.

151. See Eileen T. O’Grady, Chapter 43: Advanced Practice Registered Nurses: The Impact on Patient Safety and Quality, in PATIENT SAFETY AND QUALITY: AN EVIDENCE-BASED HANDBOOK FOR NURSES (NCBI, 2008) (highlighting research that demonstrates that APRN-delivered care is “at least equivalent to that of physician-delivered care as regards to safety and quality”).
language that makes it clear that team-based care will remain an integral part of VA care. Language detailing that the VA is committed to team-based care and that each VA facility will continue to provide APRNs and medical doctors as part of the treatment team could assuage the concerns of the commenters. Further, the VA could generate internal memoranda or a press release that explain how the VA will “continue to provide team-based care,” while implementing these new measures that use professionals already employed by VA and trained to provide these services to alleviate the access problems that have plagued the VA for decades. That could alleviate the concerns of the commenters while also addressing the pressing reasons that this rule is needed in the first place.

B. Expanding the APRN Rule to Address Other Concerns

Overall, the APRN Rule seems to be a cost-effective, safe, and logical way to address the issues surrounding veterans’ access to healthcare through the VA. With some modifications, the APRN Rule could help the VA with patient wait times. But is the APRN Rule missing the mark in some of the other problem areas? The rule does little to remedy the problems surrounding the Choice Act, other than to potentially solve access problems—which are a huge part of the overall problem. Additionally, will it address the efficiency problems that seem to plague the VA health system? According to VA officials, the APRN Rule standardizes “APRN practice authority enabl[ing] veterans, their families, and caregivers to understand more readily the healthcare services that VA APRNs are authorized to provide.”

This could be a helpful step, but the rule fails to address problems related to inefficient practices—for instance, the problem of non-VA healthcare providers not receiving payments for their services. The VA could either modify the Choice Act or include provisions in the APRN Rule that make for a standardized, efficient system that all VA officials across the country will follow.

According to the VA, a benefit to the rule is that the care of APRNs will be standardized throughout the entire VA system, eliminating the confusion caused by different practice rules in different states. The VA should also standardize paperwork, waitlist procedures, enrollment, and payment processes so that veterans and providers know exactly what to expect, and how to proceed when the need for healthcare arises. Further, having liaisons throughout the country to reach out to and train non-VA providers could significantly improve some of the problems that veterans and providers have had with that aspect of the Choice Act.

Finally, the Choice Act, and the APRN Rule continue to do very little to remedy the cover-up problems that have created multiple scandals throughout the VA system over the years. These kinds of corrupt practices are unacceptable, and the VA should take measures to deal with such problems swiftly and decisively when they arise. Perhaps if wait times go down because of the APRN Rule, and if the VA introduces a more efficient process, the scandals and the cover-ups will decrease. However, there still needs to be a culture shift within the VA that recognizes that cover-ups are not an appropriate way to combat the problems faced by the VA. As the largest single healthcare provider in the nation, the VA is bound to experience problems. However, a system that promotes finding solutions—such as the APRN Rule—rather than perpetuating cover-ups, is essential to the integrity and reputation of the VA.

**CONCLUSION**

Search the Internet for problems surrounding the VA, and pre-Choice Act stories highlighting scandal, corruption, and inefficiency readily appear. A search for post-Choice Act results, unfortunately, tells a similar tale. Several years from now, when the VA has had the opportunity to fully implement the APRN Rule, will the stories and headlines improve? They must; our nation’s veterans deserve more. The VA seems to be taking steps in the right direction with a rule that grants full practice authority to APRNs; however, there are still glaring issues that VA officials need to address, and there are possible modifications to the Choice Act and the APRN Rule that could help the VA resolve these issues that have plagued it for years. Understanding that a healthcare system this large and this complex is bound to have problems, the VA would benefit from continuing to listen to the complaints of veterans and healthcare providers, and immediately quashing cover-ups when they first arise.
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