January 13, 2017

The Honorable Robert A. McDonald  
Secretary  
U.S. Department of Veterans Affairs  
810 Vermont Avenue NW  
Washington, DC 20420

Director, Regulations Management (02REG)  
U.S. Department of Veterans Affairs  
810 Vermont Avenue NW  
Room 1068  
Washington, DC 20420


Dear Secretary McDonald,

On behalf of the American Association of Colleges of Nursing (AACN), I am writing to commend the Department of Veterans Affairs (VA) for granting three of the four Advanced Practice Registered Nurse (APRN) roles (nurse practitioner, certified nurse-midwife, and clinical nurse specialist) within the Veterans Health Administration (VHA) to practice “without the clinical supervision of physicians”1 (pg. 90199), as this policy change will undoubtedly improve delivery of high-quality services in a timely manner, as noted in the Federal Register final rule “Advanced Practice Registered Nurses” published on December 14, 2016.1 Of vital importance, I write to strongly urge the Department to extend this same policy to certified registered nurse anesthetists (CRNAs), so that Veterans will have direct access to their care.

As the national voice for academic nursing, AACN represents 800 schools of nursing across the country that educate more than 457,000 students (Registered Nurses and APRNs) and employ over 19,000 full-time faculty members. In academic year 2015-2016, AACN member institutions educated over 88,000 APRN students, and among them, 4,430 CRNA students who are in the pipeline to provide high-quality anesthesia and pain management services.2 Through our membership, AACN is committed to preparing these highly-qualified clinicians to be full partners in the healthcare delivery system to improve anesthesia care across the nation, including within the Veteran community.

The Department states that it "has chosen not to include CNRAs in the final rule due to VA's lack of access problems in the area of anesthesiology”1 (pg. 90199) and seeks public comment on “whether there are access issues or other unconsidered circumstances that might warrant their [CRNAs] inclusion in a future rulemaking”1 (pg. 90199).
I would like to offer the association’s perspectives in response to the Department’s justification to exclude CRNAs from practicing to the full extent of their education and training on the basis of “lack of access problems in the area of anesthesiology.” As the “largest integrated health care system in the United States” serving over 8.9 million Veterans annually at 1,233 healthcare facilities, the VA is well aware of the growing demand for healthcare services at both the intradepartmental and national levels. According to the VA:

- The number of VHA enrollees rose from 6.8 million in 2002 to 9.1 million in 2014, with the total U.S. Veteran population projected at 21.681 million as of September 2015.
- The number of outpatient visits nearly doubled between 2002 and 2014 (46.5 million to 92.4 million) and inpatient admissions rose by more than 25% (564.7 thousand to 707.4 thousand).

Clearly, these statistics demonstrate a growing Veteran population utilizing VHA services and indicate that creating a policy that is static could be detrimental to access to care, including anesthesia services.

**Ensuring Anesthesia Services to Veterans in Rural Areas**
According to the VA, nearly one-quarter of Veterans live in rural areas. Veterans in rural areas are often faced with the challenge of commuting far distances to receive care, often at the expense of receiving that care in a timely fashion. Veterans living in rural areas also have a higher rate of poverty (25.7%) compared to Veterans in urban areas (19.7%). The strain on finances and time that traveling to a VA care site can place on a Veteran living in a rural area may deter him or her from seeking care if they do not believe that their needs will be met in a reasonable fashion.

When CRNAs are not able to practice to the full extent of their education and training, regardless of whether they practice in a rural or urban VA setting, it is these rural-located Veterans who stand to lose out on timely, comprehensive care. When CRNAs are limited by physician oversight, the VA facility, whether located in a rural or urban environment, cannot offer maximum efficiency to Veterans seeking anesthesia care. Therefore, Veterans who either access VA facilities within rural areas, or who must travel to urban areas, face compounded barriers to accessing anesthesia services. However, should CRNAs be granted full practice authority, CRNAs and anesthesiologists alike would be able to staff procedures requiring anesthesia or pain management without being hindered by burdensome regulations that currently impact both professions. This would, in turn, free up both types of anesthesia providers to turn their full attention to patient care.

**Ensuring Anesthesia Services are Available for Seriously Disabled Veterans**
Also striking to note are the increases in the number of Veteran patients enrolled within Priority Group 1 and Priority Group 2— VA healthcare coverage groups where eligibility is heavily determined by “service-connected disabilities” (i.e., disability sustained by “an injury or illness that was incurred or aggravated during active military service.”) Out of the eight existing Priority Groups, Group 1, which represents the most disabled Veterans, experienced a jump in enrollment from 441,491 Veterans in 2000 to 1,599,196 in 2014. This again demonstrates growth in Veterans requiring services, and therefore imperative the full healthcare team, including CRNAs, can be utilized to their full extent.
Demand for Anesthesia Providers in the VHA

The final rule acknowledges there are “difficulties in hiring and retaining anesthesia providers but generally believes this situation is improving”\textsuperscript{1} (pg. 90200). Given the data and points of consideration raised with respect to Veterans in rural areas and those with disabilities, the logical solution to increase access to care would be to grant CRNAs full practice authority. As of August 2016, there are 940 anesthesiologists and 937 CRNAs within the VHA\textsuperscript{1} (pg. 90200). By implementing this policy, the VHA would allot itself the ability to more fully maximize essentially half of its current anesthesia workforce.

Again, I thank you for the opportunity to comment on this final rule and respectfully urge the VA to grant CRNAs full practice authority in the implementation of this rule. CRNAs are a necessary component of the VA healthcare team, and the parameters of their practice should align with not only their APRN counterparts, but also with national standards that the Department dually notes in the final rule to improve Veterans’ health care. If you have any questions, or if AACN can be of assistance, please contact AACN’s Chief Policy Officer, Suzanne Miyamoto, at Smiyamoto@aacn.nche.edu or 202-463-6930, ext. 247.

Sincerely,

Deborah Trautman, PhD, RN, FAAN
President and Chief Executive Officer
American Association of Colleges of Nursing

CC: The Honorable David J. Shulkin, MD
Under Secretary for Health


On page 90199, the Department states “This rulemaking increases veterans’ access to VA health care by expanding the pool of qualified health care professionals who are authorized to provide primary health care and other related health care services to the full extent of their education, training, and certification, without the clinical supervision of physicians, and it permits VA to use its health care resources more effectively and in a manner that is consistent with the role of APRNs in the non-VA health care sector, while maintaining the patient-centered, safe, high-quality health care that veterans receive from VA.”

\textsuperscript{2} American Association of Colleges of Nursing (AACN). (2016). Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing. Washington, D.C.


