July 19, 2016

Secretary Robert A. McDonald
Department of Veterans Affairs
810 Vermont Avenue NW
Room 1068
Washington, DC 20420
Attn: Director, Regulations Management (02REG)

Submitted electronically to www.regulations.gov

Re: Advanced Practice Registered Nurses (RIN 2900–AP44)

Dear Secretary McDonald:

On behalf of the American Nurses Association (ANA), we are pleased to comment on the Department of Veterans Affairs' (VA) proposed regulation on Advanced Practice Registered Nurses (APRNs). As the only full-service professional organization representing the interests of the nation's 3.6 million registered nurses (RNs), ANA is privileged to speak on behalf of its state and constituent member associations, organizational affiliates, and individual members. RNs serve in multiple direct care, care coordination, and administrative leadership roles, across the full spectrum of health care settings. ANA members also include the four advanced practice registered nurse (APRN) roles: nurse practitioners, clinical nurse specialists, certified nurse-midwives and certified registered nurse anesthetists.[1]

The proposed regulation would amend VA's medical regulations to permit full practice authority (FPA) for all four APRN roles when they are acting within the scope of their VA employment and would authorize the use of APRNs 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 or mandatory collaboration of physicians. The rule defines FPA as "the authority of an APRN to provide services . . . without the clinical oversight of a physician, regardless of State or local law restrictions, when that APRN is working within the scope of their VA employment." It would preempt conflicting state law with the exception of certain limitations imposed by the Controlled Substances Act (CSA), 21 U.S.C. 801 et seq. The rule describes some services that can be provided by an APRN with FPA, as defined by VA, and the qualifications for the four APRN roles.

[1]The Consensus Model for APRN Regulation defines four APRN roles: certified nurse practitioner, clinical nurse specialist, certified nurse-midwife and certified registered nurse anesthetist. In addition to defining the four roles, the Consensus Model describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.

We are aware of the unprecedented attention given to the proposed rule, with extensive news coverage and over 80,000 comments submitted as of today. Our comments echo the sound science and reasoning the VA presented in the supplementary information and the section-by-section analysis, and addresses some of the opposing views.

The proposed 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.

ANA appreciates the careful study and stakeholder engagement described in the section-by-section analysis. In particular, the proposed rule is an important step toward implementing the recommendations of the Institute of Medicine (IOM) of the National Academy of Sciences to remove scope of-practice barriers. Specifically, the 2010 IOM report, "The Future of Nursing: Leading Change, Advancing Health," recommended that APRNs "should be able to practice to the full extent of their education and training."

The proposal is also consistent with the recently released report from the Commission on Care. The report's second overall recommendation is to "Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management." The report notes that the Veterans Health Administration (VHA) is "currently failing to optimize use of advanced practice registered nurses (APRNs)," and recommends that "VHA increase the efficiency and effectiveness of providers and other health professionals and support staff by adopting policies to allow them to make full use of their skills." This proposed rule does exactly that.

The proposed rule is consistent with other efforts to improve access to high-value patient-centered care.

Although the American Medical Association (AMA), calls the rule "unprecedented," ANA agrees with the VA that the proposed changes in this rulemaking would not be "completely novel or unexpected to the general public or other Federal entities that provide health care services to beneficiaries." While the nurse practitioner and clinical nurse specialist roles are somewhat newer, nurses first gave anesthesia while caring for wounded Civil War soldiers, and the first published outcomes of nurse-midwifery care came from the Frontier Nursing Service when nurse-midwives began riding horseback in Appalachia in 1925. The more recent, rapid growth in the utilization of APRNs is a result of quality outcomes and acceptance of these roles by consumers and policymakers.

APRNs have been leaders in the development of innovative models of care delivery and are fully prepared to serve as primary care providers in patient-centered primary care teams. Costly and unnecessary legislative and regulatory requirements for physician supervision are at odds with efforts to build interdisciplinary teams and create a more effective health care system.

The proposed rule does nothing that would displace physicians.

Comments opposing the rule – particularly those from heavily utilized form letters - suggest that it would "substitute nurses for physicians," and "force physicians out of the operating room." Other commenters call it a "mandate that would substitute nurses for physicians."

The rule, of course, does nothing of the sort. The supplementary information in the proposed rule recognizes this by stating that "APRNs would not be authorized to replace or act as physicians or to provide any health care services that are beyond their clinical education, training, and national certification."

The proposed rule would not limit efforts to further team-based care.

In the VA, as in many health care settings from rural health clinics to specialty intensive care units, APRNs work side-by-side with their physician colleagues. As the Institute of Medicine roundtable on team-based care notes, these issues "seem much less problematic in the field than they are in the political arena."[2] And, as the VA notes, with APRNs playing a more prominent role in providing ongoing patient care in a team model, physicians should be available to perform the tasks that only physicians have been trained to perform.[3]

And while there is, unfortunately, a continued opposition from some in organized medicine, physician groups are beginning to acknowledge that team-based care need not always be "physician-led." There is a growing understanding of team leadership as situational and dynamic. In the words of the American College of Cardiology, "The leader should be the team member with the greatest knowledge and experience and the best qualifications for the leadership task at hand,"[4] Likewise, the American Congress of Obstetricians and Gynecologists suggest that "...the team member who can best address the priority needs of the patient assumes the lead health care provider role."[5]

The proposed rule recognizes that supervision requirements are unnecessary and costly.

Despite comments suggesting otherwise, the proposed rule does little, if anything to change the services APRNs provide in VA facilities. Currently, NPs serve as primary care providers in the Patient Aligned Care Teams (PACT), CRNAs skills are used in the operating room as well as during conscious sedation and pain management procedures, and CNSs bring their expertise to special services from oncology to pain management.

Indeed, full practice authority for APRNs is the *current practice* in 21 States and the District of Columbia,[6] federal IHS and DOD facilities, and most VA Medical Centers. What the proposed rule does is address the "crazy quilt" of state regulations in the remaining states, decrease the variability

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[2] Mitchell, P., Wynia, M., Golden, R., McNeellis, B., Okun, S., Webb, C. E., Kohorn, I. V. (2012). Core principles & values of effective team-based health care. Discussion Paper, Institute of Medicine, Washington, DC. Accessed at www.iom.edu/tbc

[3] Economic Impact Analysis for RIN 2900-AP44/WP2013-036, Advanced Practice Registered Nurses. Accessed at https://www.regulations.gov/document?D=VA-2016-VHA-0011-0003

[4] American College of Cardiology. 2015 ACC Health Policy Statement on Cardiovascular Team-Based Care and the Role of Advanced Practice Providers. *J Am Coll Cardiol*. 2015;65(19):2118-2136. doi:10.1016/j.jacc.2015.03.550

[5] The American College of Obstetricians and Gynecologists. Collaboration in Practice: Implementing Team-Based Care. Obstetrics & Gynecology. 2016;127(3). Accessed at http://www.acog.org/Resources-And-Publications/Task-Force-and-Work-Group-Reports/Executive-Summary-for-Collaboration-in-Practice-Implementing-Team-Based-Care

[6] The National Council of State Boards of Nursing tracks implementation of the Consensus Model for APRN Regulation and updates that information as needed on their website.

in care provided by APRNs throughout the VA system and remove requirements in the VHA for "clinical oversight" for APRNs.

APRNs, and many of their "supervising physicians," have long been frustrated by the delays in care and duplication of services that often result from scheduling "confirming" visits with physicians and seeking co-signatures. More recently, policymakers are making the *business case* for lifting these unnecessary requirements and utilizing clinicians effectively, realizing that "an inefficient delivery system that unnecessarily restricts health professionals from practicing to the full extent of their training is bad for the economy."[7] A 2012 analysis of the economic benefits of more fully utilizing APRNs in Texas concluded that the "total current impact of enhanced efficiency includes $16.1 billion in total expenditures and $8.0 billion in output (gross product) each year as well as 97,205 permanent jobs in Texas."

So why do these requirements exist? In the words of law professor Barbara Safriet, who has written on this subject for decades, "the restrictions faced by advanced practice nurses in some states are the product of politics rather than sound policy."[8] From the early days of legislative recognition and regulation of health care providers, medical practice acts "essentially claimed the entire human condition as the exclusive province of medicine." While there have been many changes in health care regulation, the authority to supervise persists in many states. As Safriet notes, "Countless thousands of individual physicians (including two who helped create the new roles of nurse practitioner and nurse anesthetist) have long recognized and supported the full practice capabilities of advanced practice nurses. It is the official policy of several national medical organizations, however, to actively oppose legal recognition of any other providers' expanded authority to practice without physician supervision and be paid directly for their services." ANA fully supports the VA proposal to exercise Federal preemption of State nursing licensure laws to the extent such State laws conflict with the FPA granted to VA APRNs while acting within the scope of their VA employment.

It has been suggested that professional protectionism is at work. The Federal Trade Commission has addressed in its advocacy comments various physician supervision requirements imposed on APRNs, the sort of requirements that this rule would preempt. It notes in Policy Perspectives: Competition Advocacy and the Regulation of Advanced Practice Nurse Practitioners that "Physician supervision requirements may raise competition concerns because they effectively give one group of health care professionals the ability to restrict access to the market by another, competing group of health care professionals, thereby denying health care consumers the benefits of greater competition."[9]

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[7] Bay Area Council Economic Institute (2014) Full Practice Authority for Nurse Practitioners Increases Access and Controls Cost. Accessed at http://www.bayareaeconomy.org/files/pdf/BACEI%20NP%20Report%209.8.14.pdf

[8] Safriet, BJ. (2011) Federal Options for Maximizing the Value of Advanced Practice Nurses in Providing Quality, Cost-Effective Health Care. Chapter H in The Future of Nursing: Leading Change, Advancing Health.

[9] Federal Trade Commission (2014). Policy Perspectives: Competition Advocacy and the Regulation of Advanced Practice Nurse Practitioners. Accessed at: https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf

Each APRN is personally accountable for his or her practice, and to patients, the respective licensing board, the nursing profession, and society. It is outdated and unnecessary that physicians should supervise care provided by APRNs or that written collaborative agreements should be required.

Moreover, individual accountability extends to legal liability. It is inappropriate to expect physicians, or any other providers, to accept responsibility or liability for care in which they have not been directly involved, as often is the case in "supervising physician" arrangements.

The proposed rule includes separate descriptions of full practice authority for each of the four APRN roles

The 2008 publication of the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education, after years of substantial work by many organizations, provided a clear definition of an APRN, described requirements for broad based APRN education, and described the four APRN roles. In promulgating this rule, the VA has recognized the importance of the Consensus Model and the work that has been done by the National Council of State Boards of Nursing and all the stakeholders to implement the Consensus Model.

The proposed rule (in section 38 CFR 17.415(d)(i)-(iv)) describes FPA for each of the four APRN roles, noting that the authority includes *but is not limited to* specific tasks. Separate descriptions are included for each of the four roles. ANA urges the VA to carefully consider the recommendations and comments from the experts in each APRN organization and to work closely with these experts to ensure that FPA for each APRN role is appropriately described in this regulation and subsequent VHA guidance issuances.

For example, the National Association of Clinical Nurse Specialists (NACNS) has urged the VHA to utilize an internal mechanism to recognize CNSs who do not have a national certification exam available. The American College of Nurse-Midwives (ACNM) has been advocating for inclusion of CNMs and CMs in the VA for many years and urged the VA to include CNMs and CMs in the VA Handbook. ANA appreciates the foresight of the VA in planning for the increased women's health needs of veterans and urges the VA to move forward with plans to hire CNMs "to improve access to health care for the increasing number of female veterans."

Collaboration is an inherent part of APRN practice; *mandatory* collaboration is problematic.

It is within an APRN's professional judgment and responsibility to assess and treat patients within the bounds of his or her scope of practice. As is true with our physician colleagues, APRNs regularly consult, collaborate and refer as necessary to ensure that the patient receives appropriate diagnosis and treatment. As the FTC noted in their Policy Perspectives, "Effective collaboration between APRNs and physicians does not necessarily require any physician supervision, much less any particular model of physician supervision."

In the supplementary information, the VA notes that the proposed change would "permit APRNs to practice to the full extent of their education, training and certification, without the clinical supervision **or mandatory collaboration** of physicians [emphasis added]." The proposed rule,

however, in defining FPA (17.415(b)) states that an APRN has authority to provide certain services "without clinical oversight of a physician."

ANA and our state nurses associations are well aware of how efforts to lift requirements for physician supervision of APRN practice have sometimes led to requirements for "collaboration" that are *even more restrictive* than the language we sought to modernize.

We recommend that the final rule add "mandatory collaboration" to section 17.415(b) so that "FPA means the authority of an APRN to provide services described in paragraph (d) of this section without clinical oversight of a physician **or mandatory collaboration**, regardless of State or local law restrictions…"

This proposed rule preempts costly and time-consuming processes in the states.

The VA notes that it would be impractical, costly and time-consuming to lobby each State that does not allow FPA to APRNs to change their laws. Sadly, ANA and our state nurses associations spend significant resources each year to do just that. By exercising Federal preemption of State laws to the extent such laws conflict with the full practice authority granted to VA APRNs, thousands of APRNs acting within the scope of their VA employment will be able to provide care more efficiently, and more Veterans will be served without delay.

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ANA applauds the VA for taking this important step to standardize the practice of APRNs in the VA system and allow APRNs to practice to the full extent of education, training and certification. Costly and unnecessary legislative and regulatory requirements for physician supervision are at odds with efforts to build interdisciplinary teams and create a more effective health care system. Implementation of this proposal would enable the VA to increase veteran access to needed health care and provide additional health care services in medically underserved areas where APRNs are already practicing, but not to the full extent of their practice authority. It is an important step in ensuring that our nation's veterans receive the high quality health care that they have earned, and it is long overdue.

We appreciate the opportunity to share our views on this matter. If you have questions, please contact Mary Beth Bresch White, Director, Health Policy (marybreschwhite@ana.org).

Sincerely,

Debbie Hatmaker

Debbie D. Hatmaker, PhD, RN, FAAN
Executive Director

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