



AMERICAN OSTEOPATHIC ASSOCIATION

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July 25, 2016

The Honorable Robert McDonald
Secretary
Department of Veterans Affairs
810 Vermont Avenue, NW, Room 1068
Washington, D.C. 20420

RE: RIN 2900-AP44, Advanced Practice Registered Nurses

Dear Secretary McDonald:

The American Osteopathic Association and the 35 undersigned osteopathic professional organizations, representing 123,000 osteopathic physicians and osteopathic medical students nationwide, appreciate the opportunity to provide comments on the Department of Veterans Affairs (VA) proposed rule concerning Advanced Practice Registered Nurses (APRNs).

The osteopathic profession values the contributions of APRNs to the health care delivery system. As part of a physician-led care team, APRNs provide indispensable care to patients at the top of their education, training and license. The undersigned organizations are concerned, however, that the VA's proposal to expand the authority of APRNs to treat patients without physician involvement will undermine this patient-centered, team-based approach to providing care to our veterans within the VA system, as well as disregard the states' important role in regulating the delivery of health care services to ensure the quality of care for their residents. While the expertise of physicians and APRNs are complementary, they are not equivalent, and our nation's veterans deserve the best care that can be provided to them, especially given their often complex and unique health care needs.

We therefore strongly oppose this proposed rule, and urge the VA to instead focus on ways to improve access to care provided to veterans in community settings through the Choice Program. This would reduce wait times for appointments for all veterans, and free up VA clinicians to care for sicker and more complex patients in VA facilities prepared to address their unique needs.

Education and Training

Veterans often have multiple complex medical conditions that make them more vulnerable to complications or emergencies. It is critically important that they have access to the more extensive expertise and care that can only be provided by a physician. For example, osteopathic (DOs) and allopathic (MDs) physicians complete four years of medical school, which includes two years of didactic study and two years of clinical rotations. Clinical rotations in the third and fourth year are done in community hospitals, major medical centers, and physicians' offices. This is followed by

three to seven years of postgraduate medical education, i.e. residencies, where DOs and MDs develop advanced knowledge and clinical skills relating to a wide variety of patient conditions.

DOs receive significant additional training in musculoskeletal conditions, and have particular expertise in pain management, a condition that affects many VA patients. As well, all DOs receive an average of 200 hours of education and hands-on experience in Osteopathic Manipulative Medicine (OMM), which continues in osteopathic residencies and provides osteopathic physicians with extensive training in the care of patients suffering from musculoskeletal pain. This is particularly valuable to veterans, who can often have difficult to diagnose or manage chronic pain as a result of combat injuries, polytrauma, or joint injuries sustained during training. A 2010 report by the U.S. Army Surgeon General's Pain Management Task Force specifically highlights the value of OMM for active and retired service members, and provides a strong endorsement of it and a number of recommendations for both the VA and the Department of Defense to increase its use.¹

We therefore disagree with the Notice of Proposed Rulemaking's (NPRM) contention that the care provided by APRNs is equal to the care of their physician counterparts. As a result of the above-referenced extensive medical education and training, physicians have a more comprehensive and nuanced understanding of medical treatment of disease, complex case management, and safe prescribing practices. Nurses are not as extensively trained, which could limit their differential diagnoses on complex medical conditions and lead to misdiagnoses without appropriate physician involvement.

Given the complexities of our veterans' medical conditions, providing less than a physician-led, team-based model of care that is veteran-centered exacerbates a fragmented two-tier health care system that will not meet the health care needs of those who have served our country. A 2012 study by the University of Washington and the research arm of nonprofit health care provider Group Health showed that when physician-supervised nurse care managers were added to the care team for patients with depression combined with diabetes and/or heart disease, patient outcomes improved and costs were reduced.² At the end of the two-year study, patients overseen by these teams were less depressed and had improved levels of blood sugar, cholesterol and blood pressure. Patients who were seen under a traditional model failed to realize the same health benefits.

State Preemption

Currently, 21 states and the District of Columbia provide full practice authority to certified nurse practitioners (CNPs), and 17 states provide it to Certified Registered Nurse Anesthetists (CRNAs). The remaining states require physician involvement for APRN practice including direct supervision, team-management, or collaborative practice agreements. These state requirements should not be undermined – even within the VA system.

Congressional Intent

The NPRM cites statute to make the argument that the VA has the authority to institute this dramatic shift away from a physician-led, team-based model of care. Yet it is unclear how the cited sections support the VA's position. Section 7401 of Title 38, U.S.C. lists registered nurses, and Section 7402 lists the qualifications for these positions in the VA that Congress set. The only

¹ [Office of The Army Surgeon General: Pain Management Task Force Final Report: May 2010.](#)

² Katon W, Russo J, Lin EB, et al. Cost-effectiveness of a Multicondition Collaborative Care Intervention: A Randomized Controlled Trial. *Arch Gen Psychiatry.* 2012; 69(5):506-514. doi:10.1001/archgenpsychiatry.2011.1548.

qualifications listed under “Nurse” are that to be eligible to “be appointed to a nurse position, a person must (A) have successfully completed a full course of nursing in a recognized school of nursing, approved by the Secretary, and; (B) be registered as a graduate nurse in a State.” This demonstrates clearly that Congress recognizes state authority over VA personnel licensure and scope by requiring licensure by the state as a condition of appointment to a nursing position.

Executive Order 13132, Federalism

As the NPRM notes, Section 4 of Executive Order 13132 requires that when an agency proposes to act through rulemaking to preempt state law, “the agency shall consult, to the extent practicable, with appropriate State and local officials in an effort to avoid such conflict,” and “the agency shall provide all affected State and local officials notice and an opportunity for appropriate participation in the proceedings.” Yet the VA did not provide affected state and local officials with such notice; instead, the NPRM states the VA reached out to state nursing boards to solicit comments and input from them, and then received calls and correspondence of support from state and local officials who had heard about the VA’s intent from the National Council of State Boards of Nursing. Furthermore, no state medical boards (whether osteopathic or allopathic) were consulted. By the very nature of the NPRM, these state medical boards, who are charged with overseeing independent medical practice and assuring patient safety, are “affected State officials.”

Proposed 17.415(e)

The NPRM notes this section would expressly state the intended preemptive effect of proposed 17.415 to ensure it is clear that conflicting state and local laws related to the practice of APRNs would have no force or effect when such APRNs are working within the scope of their VA employment. It then states that accordingly, “State disciplinary actions that would penalize, or otherwise interfere with, an APRN’s full practice authority in the performance of their official VA duties, would likewise be effectively preempted. However, where there is no conflict between this regulation and state law, the state would retain authority to impose state regulations on its APRN licensees and take disciplinary actions for any violations.”

We seek clarification on these statements, and are concerned about the unintended consequence this could have. The NPRM creates two standards to which employed APRNs would be subject, and creates a disconnect within the VA’s proposed policy, which would preempt state law for some APRNs and apply state law for the same function for other APRNs. State nursing boards establish their own licensing and practice standards based on the unique needs and characteristics of the individuals receiving care within that state’s borders. While a local VA facility is federally regulated, a veteran seeking care there resides in that state and will therefore have different needs and considerations for care than a veteran at a VA facility in another state across the country. As well, the statement that prevents state disciplinary actions “that would penalize, or otherwise interfere with, an APRN’s full practice authority in the performance of their official VA duties” is vague and ambiguous. Furthermore, under proposed 17.415(a) of this very rule, APRNs must maintain *state* licensure in that APRN role. To preempt a state’s licensing and disciplinary authority from enforcing its regulations will put veterans at significant risk.

Hiring and Workforce Improvements

While we appreciate the VA’s efforts to address unacceptable wait times and lack of access to VA health care services, we would argue that simply expanding practice authority of APRNs is not a solution, and only attempts to address access to care by potentially lowering the quality of care being delivered to VA patients. For example, there is no shortage of physician anesthesiologists in the VA

system, and therefore expanding the scope of CRNAs will not have an impact on wait times. We believe other measures would be more effective in dealing with the VA's backlog. For example, we agree with the VA Commission on Care's final report that the Veterans Health Administration (VHA) lacks competitive pay, is forced to use inflexible hiring processes, and continues to use an outdated talent management approach from the last century.³

Currently, in order to apply for a position within the VA health system, a physician must apply through the usajobs.gov job portal. Serious delays in the application process have often led to physicians removing themselves from job contention. The undersigned organizations encourage the VA to create a more streamlined employee application system by creating a separate job portal aimed at physician recruitment that is detached from the usajobs.gov system and located directly on the Department of Veterans Affairs homepage. We also encourage the VA to continue its outreach to medical associations and societies regarding physician recruitment and best practices.

VA Improvements

We also agree with the Commission's assessment that the design and implementation of the Veterans Choice Program has proven to be flawed. The Commission recommends: "Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community-based health care networks, to be known as the VHA Care System, from which veterans will access high-quality health care services."⁴ As the VA considers the goals of the Commission's recommendations, in the short term we believe the VA should expand its collaborative efforts with the medical community in the private sector so that veterans can continue to access care outside of the VA system. This could especially increase veteran access to needed health care in medically-underserved areas, as well as decrease the amount of time veterans spend waiting for patient appointments, as this proposed rule argues maximizing APRN capabilities could do.

Part of fulfilling our promise to the men and women who have served our country is ensuring access to a high-quality, accountable, and transparent health care system that is responsive to their particular health care needs. The AOA believes that a physician-led, team-based model offers the best possible care, and looks forward to working together with the VA to ensure that our veterans are able to receive the care they deserve.

Sincerely,

American Osteopathic Association

Alaska Osteopathic Medical Association

American Academy of Osteopathy

American College of Osteopathic Emergency Physicians

American College of Osteopathic Family Physicians

American College of Osteopathic Obstetricians and Gynecologists

American College of Osteopathic Pediatricians

American Osteopathic Academy of Orthopedics

American Osteopathic Association of Medical Informatics

American Osteopathic College of Dermatology

³ VA Commission on Care final report, June 30, 2016, pg. 15

⁴ VA Commission on Care final report, June 30, 2016, pg. 23.

American Osteopathic College of Radiology
Arkansas Osteopathic Medical Association
Arkansas Society of the American College of Osteopathic Family Physicians
Connecticut Osteopathic Medical Society
Florida Osteopathic Medical Association
Illinois Osteopathic Medical Society
Kansas Association of Osteopathic Medicine
Kentucky Osteopathic Medical Association
Louisiana Osteopathic Medical Association
Maine Osteopathic Association
Massachusetts Osteopathic Society
Michigan Osteopathic Association
Mississippi Osteopathic Medical Association
Missouri Association of Osteopathic Physicians and Surgeons
Nevada Osteopathic Medical Association
New Jersey Association of Osteopathic Physicians and Surgeons
New Mexico Osteopathic Medicine Association
Ohio Osteopathic Association
Oklahoma Osteopathic Association
Osteopathic Physicians & Surgeons of California
Pennsylvania Osteopathic Medical Association
Rhode Island Society of Osteopathic Physicians and Surgeons
Tennessee Osteopathic Medical Association
Utah Osteopathic Medical Association
Washington Osteopathic Medical Association
Wisconsin Association of Osteopathic Physicians & Surgeons