American College of Physicians
Leading Internal Medicine, Improving Lives

July 25, 2016

David J. Shulkin
Under Secretary for Health
Department of Veterans Affairs
810 Vermont Ave. NW, Room 1068
Washington, DC 20420

Dear Under Secretary Shulkin,

The American College of Physicians (ACP) appreciates this opportunity to provide comments on the Department of Veterans Affairs (VA) proposed rule Advanced Practice Registered Nurses (RIN 2900– AP44). The American College of Physicians is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 148,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

The proposed rule would:

- Establish additional professional qualifications an individual must possess to be appointed as an APRN within the VA.
- Permit full practice authority for APRNs except for applicable State restrictions on the authority to prescribe and administer controlled substances.
- Exercise Federal preemption of State nursing licensure laws to the extent such State laws conflict with the full practice authority granted to VA APRNs while acting within the scope of their VHA employment.

The ACP supports the VA's intent to improve access to high-quality care for our nation's veterans and believes that health care access can be broadened not only by increasing the number of VA-based physicians and health care professionals but also by enhancing collaboration and cooperation through dynamic clinical care teams. In a 2013 ACP position paper *Principles Supporting Dynamic Clinical Care Teams*, published in the Annals of Internal Medicine, http://annals.org/article.aspx?articleid=1737233, ACP offered policy principles that

envisioned a team-based health care approach where physicians, nurses, physician assistants, and other health care professionals would establish new lines of communication, collaboration and cooperation to better serve patient needs and remove barriers that impede real teamwork (1). It is through this lens that ACP has considered the VA proposal to grant full practice authority for all VA advanced practice registered nurses (APRNs) who meet the proposed education, certification, licensure requirements.

The College urges the VA to fundamentally revamp the proposed to rule to:

1. **Eliminate the proposal to amend the medical regulations within the VA to permit full practice authority for all VA APRNs (which include Certified Nurse Practitioners, Certified Registered Nurse Anesthetists, Clinical Nurse Specialists, and Certified Nurse-Midwives) when they are acting within the scope of their VA employment, thereby broadly preempting applicable state laws that do not grant such authority**.
2. **Implement alternative approaches that support dynamic clinical care teams, consistent with the 2013 ACP position paper, *Principles Supporting Dynamic Clinical Care Teams,* rather than by granting full independent practice authority to APRNs**. In that paper, we offered the following definition: "*A clinical care team for a given patient consists of the health professionals—physicians, advanced practice registered nurses, other registered nurses, physician assistants, clinical pharmacists, and other health care professionals—with the training and skills needed to provide high-quality, coordinated care specific to the patient's clinical needs and circumstances."*
    a. We believe that APRNs can and should play an essential role in providing high quality care to patients to the full extent of their training and skills within a dynamic clinical care team that meets the principles in ACP's 2013 paper. This can best be achieved by the VA adopting best practices to promote dynamic clinical care teams that assign "*specific clinical and coordination responsibilities for a patient's care within a collaborative and multidisciplinary clinical care team . . . based on what is in that patient's best interest* (1), *matching the patient with the member or members of the team most qualified and available at that time to personally deliver particular aspects of care and maintain overall responsibility to ensure that the patient's clinical needs and preferences are met."*
    b. We reaffirm the importance of "patients having access to a personal physician who is trained in the care of the 'whole person' and has leadership responsibilities for a team of health professionals, consistent with the Joint Principles of the Patient-Centered Medical Home."
    c. We believe that "*Although physicians have extensive education, skills, and training that make them uniquely qualified to exercise advanced clinical responsibilities within teams, well-functioning teams will assign responsibilities to advanced practice registered nurses, other registered nurses, physician*

assistants, clinical pharmacists, and other health care professionals for specific dimensions of care commensurate with their training and skills to most effectively serve the needs of the patient."

The following comments expand on our rationale for the above positions, and our suggested alternative approaches to achieve the VA's goal of "fully maximizing VA APRN staff capabilities, which would increase the VA's capacity to provide timely, efficient, and effective primary care services, as well as other services" *within the context of dynamic clinical care teams rather than granting full independent practice authority to APRNs.* We believe our alternative would "increase veteran access to needed VA health care, particularly in medically-underserved areas, as well as decrease the amount of time veterans spend waiting for patient appointments."

Overarching Comments

The clinical care team paradigm "requires a new way of thinking about clinical responsibilities and leadership, one that recognizes that different clinicians will assume principal responsibility for specific elements of a patient's care as the patient's needs dictate, while the team as a whole must ensure that all elements of care are coordinated for the patient's benefit (1)." The College believes that this approach is the recognized standard of care for most high-functioning integrated systems, that it should be the standard of care provided within the VA and that this standard should be reflected within its policies. Rather than emphasizing independence and disconnection among health care professionals, the VA should strengthen its commitment to integrated, collaborative team-based care. Doing so will not only address health care clinician shortages, but also create an environment of cooperation and respect, where the needs of the patient are paramount.

Clinical Leadership within a Dynamic Clinical Care Team

In the context of a dynamic clinical care team, concerns about hierarchy recede to the background and a more collaborative, nuanced leadership approach is applied to ensure that professional relationships are based on trust and effective communication, and patient needs and concerns are considered at all points of care. Although physicians may be most qualified to provide team leadership, clinical responsibilities may be assigned to other health care professionals, including APRNs, in situations where the needs of the patient dictate and the competencies, skills, and expertise of the clinician permit. In essence, no one clinician is "independent" but must work collaboratively with his or her colleagues to deliver high-quality care based on the patient's needs at that time.

Primary Care Within Dynamic Clinical Care Teams

In ACP's *Principles on Dynamic Clinical Care Teams,* we adopted the Institute of Medicine (IOM) definition of primary care: "The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community" (2). Our paper notes that "Primary care encompasses various activities and responsibilities. It is simplistic to view primary care as a single type of care that is uniformly best provided by a particular health care professional." ACP provided the following scenario to illustrate how a clinical care team would operate:

> An advanced practice registered nurse providing primary care commensurate with his or her training may consult with or make a referral to an internal medicine physician, a family physician, or another physician specialist when presented with a patient with significantly complex medical conditions. To illustrate, the advanced practice registered nurse sees a patient who scheduled an appointment for the symptoms of "nausea and fatigue." On initial evaluation in the office, the nurse practitioner determines that the patient is acutely ill and may have hepatitis on the basis of icteric sclera and jaundice. Because of the complexity of the patient's underlying problems of diabetes and hypertension and his current acute presentation, the nurse practitioner consults with an internist and subsequently transfers the patient to the internist's care. The internist immediately assumes primary responsibility for the patient's care (1).

Specific Recommendations

1. **The VA should take action to facilitate and encourage collaboration among all physicians, APRNs and other health care professionals working at the top of their license as part of a dynamic clinical care team. ACP recommends that the VA develop and establish best practices and protocols on dynamic clinical care teams.**

As an integrated Federal health care system with a responsibility to provide comprehensive care to our nation's veterans, the VA is well-positioned to embrace and implement the technological and cultural shift that is necessary for dynamic clinical care teams to thrive. To achieve this we recommend that the VA develop best practices for team-based care that includes physicians, APRNs, and other health care professionals. Therefore, rather than emphasizing independent practice we urge the VA to continue to develop team-based care by instilling shared values in all VA staff associated with patient care, in addition to protocols for establishing and maintaining effective referral and consultation relationships.

A 2012 Institute of Medicine (IOM) discussion paper, *Core Principles & Values of Effective Team-Based Health Care* (3), illustrates how members of a well-functioning clinical care team foster a respectful, collaborative environment while acknowledging unique skills and competencies:

> Members of health care teams often come from different backgrounds, with specific knowledge, skills and behaviors established by standards of practice within their respective disciplines. Additionally, the team and its members may be influenced by traditional, cultural, and organizational norms present in health care environments. For these reasons it is essential that team members develop a deep understanding of and respect for how discipline-specific roles and responsibilities can be maximized to support achievement of the team's shared goals. Attaining this level of understanding and respect depends upon successful cultivation of the personal values necessary for participating in team-based care.

The product of the IOM collaboration is a list of shared values and principles of high-functioning health care teams. Shared values among team members include honesty, discipline, creativity, humility, and curiosity. Principles to guide team-based care include establishing clear roles for team members, mutual trust, effective communication, shared goals, and measurable processes and outcomes (4). The VA must also disseminate best practices on appropriate referrals and work to define clear roles so that non-physician health care professionals know when to refer patients to primary care physicians and specialists.

The VA's Patient Aligned Care Team (PACT) model, a VA-customized approach to the patient-centered medical home, could provide a valuable framework for promoting team-based care principles (5). PACT team members, typically the veteran/patient, a primary care provider such as a physician, a registered nurse, a licensed practical nurse, and a clerical assistant, "go through formalized training to learn best practices for team function, and some teams undergo further training to become trainers themselves. Teams work with a panel of patients and meet regularly to debrief. The team is led by a team member, often the RN care manager (3)." The PACT model provides a useful example of how a team-based care model incorporates veterans into the decision-making process and demonstrates how physicians and non-physician health professionals (such as a registered nurse care manager) can perform leadership roles while providing seamless coordinated care through open communication and information sharing.

2. **The VA's proposed rule should be revised *in a way that affirms the importance of VA patients—our nation's veterans—having access to a personal physician who is trained in the care of the "whole person" and has leadership responsibilities for a team of health professionals.***

Proposed 17.415(b) would grant authority to APRNs to provide services without the clinical oversight of a physician, regardless of State or local law restrictions, when the APRN is working within the scope of their VA employment. Under proposed 17.415(d)(i) certified nurse practitioners would have full practice authority to provide the following services: Comprehensive histories, physical examinations and other health assessment and screening activities; diagnose, treat, and manage patients with acute and chronic illnesses and diseases;

order, perform, supervise, and interpret laboratory and imaging studies; prescribe medication and durable medical equipment; make appropriate referrals for patients and families; and aid in health promotion, disease prevention, health education, and counseling as well as the diagnosis and management of acute and chronic diseases.

The Joint Principles of the Patient-Centered Medical Home, adopted in 2007 by ACP and others, underscores the importance of patients "having an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care ... [T]he personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients" (6). Physicians have extensive education, skills, and training that make them uniquely qualified to exercise advanced clinical responsibilities within clinical care teams. Physicians, advanced practice registered nurses, other registered nurses, physician assistants, clinical pharmacists, and other health care professionals have different training, skills, knowledge bases, competencies, and experience in patient care. Although some training and competencies overlap, physicians have more years of training, and the range of care appropriately provided by each discipline is not equal (7).

It is simplistic to view primary care as a single type of care that is uniformly best provided by a particular health care professional. The diverse activities that are often considered under the rubric of primary care often extend into what may be better considered "secondary" or even "tertiary" (1). An APRN or physician assistant, for example, may appropriately deliver wellness and preventative care, diagnose and treat a self-limited minor illness, or provide care of a well-defined single problem with standardized treatment algorithms. It may be most appropriate for a physician to perform more clinically complex services such as diagnosis of a more complicated undifferentiated clinical presentation; acute or chronic management of patients with complex and often multiple clinical conditions (such as multiple, serious, or rare illnesses or clinical problems); or comprehensive, longitudinal care of the "whole person" not limited to a specific disease condition or medical intervention over a patient's lifetime and across all care settings (1).

Again, we emphasize that in a team-based model, the health care professional who possesses the appropriate skills and competencies to address the patient's care needs should assume responsibility for the patient. Regardless of which team member has overall clinical leadership responsibilities for the team, it is incumbent that each health care professional consults with or transfers the patient to the appropriate team member with the skills and competencies to provide the highest level of care to the patient.

3. **ACP recommends that the VA *not* grant full practice authority for APRNs beyond that which is permitted by applicable state licensing laws. At the same time, the College strongly believes that state legislatures should conduct an evidence-based review of**

their licensure laws to ensure that they are consistent with the following licensure principles offered in our *Principles on Dynamic Clinical Care Teams*:

a. **The purpose of licensure must be to ensure public health and safety.**
b. **Licensure should be evidence-based. It should protect the public from receiving care from clinicians that is beyond their training, skills, clinical experience, and demonstrated competence; licensure should not restrict qualified clinicians from providing care that is commensurate with, but does not extend beyond, their training, skills, clinical experience, and demonstrated competence. Licensure should ensure that each member of the health care team practices within ethical standards as a condition of obtaining and maintaining their license.**
c. **Licensure should ensure a level of consistency (minimum standards) in the credentialing of clinicians who provide health care services.**
d. **Licensing bodies should recognize that the skills, training, clinical experience, and demonstrated competencies of physicians, nurses, physician assistants, and other health professionals are not equal and not interchangeable.**
e. **Licensing laws should ensure that clinicians who are qualified to provide a level of care commensurate with their training, skills, clinical experience, ethical standards, and demonstrated competency are not restricted from doing so. Changes in licensure laws must not harm patients by allowing health professionals to deliver services for which they are not qualified.**

Rather than pre-empting state laws that do not allow for full independent practice authority by APRNs, the College recommends that the VA work to ensure that APRNs, as well as other non-physician clinicians who are in the VA system, be allowed to practice to "the top of their license" *when practicing as part of a clinical care team that meets the principles in ACP's position paper, consistent with applicable state laws.* ACP's *Principles on Dynamic Clinical Care Teams* states that:

> Clinicians within a clinical care team should be permitted to practice to the full extent of their training, skills, and experience and within the limitations of their professional licenses as determined by state licensure and demonstrated competencies. All clinicians should consult with or make a referral to other clinicians in disciplines with more advanced, specific, or specialized training and skills when a patient's clinical needs would benefit from such consultation and referral (8). This principle is best satisfied when each member of the team has appropriate confidence in his or her own training and skills, combined with professional ethics in recognizing the limits of his or her training and skills (9,10). In a well-functioning team that is providing primary care, collaboration among all team members, using the full range of skills and abilities among primary care clinicians, may help to reduce unnecessary referrals and escalation of care

to non–primary care specialists, thereby enhancing access to these specialties for patients who need such services (11).

We believe that state licensure laws should seek to promote and support true team-based and collaborative care. To illustrate, state licensure requirements that mandate ongoing communication between and among physicians and advanced practice registered nurses (sometimes called "supervision" or "collaboration" requirements), should be directed solely to ensuring ongoing, team-based communication and exchange of information, consultation, and appropriate referrals between and among the clinical disciplines involved in a patient's care. They should not restrict clinicians from providing a level of care that is commensurate with, but does not extend beyond, their training and competencies.

ACP believes that regulation of each clinician's respective role within a team must be approached cautiously, recognizing that teams should have the flexibility to organize themselves consistent with the principles of professionalism described previously. While we believe that states must retain their ability to ensure public health and safety through evidence-based licensure regulation, and we strongly oppose preemption by the VA of such laws, we support giving the VA the flexibility to organize its clinical care teams in a way that allows all members of the team to practice to the full extent of their training, skills, and to the maximum extent allowed under applicable state laws.

4. **The VA should promote dynamic clinical care teams to address workforce shortages, especially in primary care, supported by telemedicine and "virtual" teams.**

ACP's *Principles on Dynamic Clinical Care Teams* states that a "cooperative approach including physicians, advanced practice registered nurses, other registered nurses, physician assistants, clinical pharmacists, and other health care professionals in collaborative team models will be needed to address physician shortages." We recognize that in many communities, severe and growing shortages of physicians (particularly of internal medicine physician specialists and other physician specialties trained in primary and comprehensive care) create a barrier to achieving the vision of every patient being able to have "an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care," as requested by the Joint Principles of the Patient-Centered Medical Home (6). Public policy needs to be directed toward increasing the number of primary care physicians (as well as other disciplines in shortage) and reducing barriers to physicians practicing in currently underserved communities.

ACP policy on the role of nurse practitioners in primary care, adopted by the Board of Regents in 2009, acknowledges that "NPs [nurse practitioners] are critical to improving access to health care in underserved communities. Most state laws do not include physical proximity requirements for supervising and collaborating physicians, allowing NPs to provide much-

needed primary care in rural and other underserved communities. The success of health care delivery will require collaborative teams of physicians and nonphysicians to provide quality care for individuals and populations with both common and complex health care needs using evidence-based guidelines and effective models of collaboration" (7).

The College recognizes that especially in physician shortage areas, it may be infeasible for patients to have "an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care" (7). They may also be unable to have immediate on-site access to other team members who may be located some distance from where the patient lives and accesses medical care. In such cases, collaboration, consultation, and communication between the primary care clinician or clinicians who are available on site and other out-of-area team members who may have additional and distinct training and skills needed to meet the patient's health care needs are imperative. Even if a physician and APRN are not physically co-located, the patient should have access to a "virtual" clinical care team through use of telemedicine, electronic health records, regular telephone consultations, and other technology to enable the on-site primary care clinician and all members of the health care team to effectively collaborate and share patient information. Telemedicine and telehealth technologies can help virtual clinical care teams provide clinical consultation and decision support as well as patient education, remote monitoring, and other services" (1).

In states that allow APRNs full practice authority, the VA should ensure that APRNs are able to connect with a clinical care team that includes primary care physicians and other physician specialists so that patients can receive the highest level of quality care and consultation from the appropriate clinician.

The proposed rule states 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." ACP's *Principles on Dynamic Clinical Care Teams* states that "*Patients* have the right to be informed of the discipline, educational background, and competencies of the members of the clinical care team (7). To minimize patient confusion and ensure informed choice, the clinical care team should be able and prepared to provide patients and families with information about the training of all health professionals within the team and the meaning of all professional designations (such as MD, DO, NP, DNP, PA, PhD, PharmD, and LCSW-C), including information on the differences in the years of training and clinical experiences associated with their professional designations. Such information should always be available for each clinician providing care. Because patients view the term 'doctor' as being synonymous with 'physician' when used in a health care setting, it is incumbent on all health care professionals with a doctoral degree other than MD or DO to clarify that they are not physicians when using the term 'doctor' in the patient care setting" (7).

Conclusion

Nurses are an essential part of the clinical care team and are able to deliver high-quality care. The College especially recognizes and supports the role of APRNs in providing high quality, accessible and patient-centered care within a dynamic clinical care team that is organized around the principles in *ACP's Principles on Dynamic Clinical Care Teams*. We reaffirm our support for VA patients having access to a personal physician who accepts clinical responsibilities for care of the "whole person" consistent with the Patient-Centered Medical Home model. We assert that physicians have unique training and skills to exercise clinical leadership for dynamic clinical care teams. We observe that physicians and nurses receive different levels of education and are not interchangeable in the team setting.

Rather than implementing its proposal to allow for full practice authority by APRNs by preempting more limiting state laws, we strongly urge the VA to shift its focus away from defining levels of hierarchy and supervisory roles to creating an environment where the shared values and necessary principles of team-based, patient-centered care are promoted at every level, and where physicians and other health care professionals are provided the tools and resources to improve quality and develop a collegial environment where the needs of our veterans are fully served. The specific recommendations in this comment letter offer an alternative to the VA's well-intended but ultimately fundamentally flawed "full practice authority" pre-emption of state laws that would promote highly functioning, patient-centered dynamic clinical teams that use the talents, skills, training and professionalism of all members of the team to provide the best possible care to VA patients. Our nation's veterans deserve nothing less.

Sincerely,

Nitin S. Damle MD MS FACP

Nitin S. Damle, MD, MS, FACP
President

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