Public Interest Comment on

VA NP [RIN: 2900-AP44 - Proposed Rule - Advanced Practice Registered Nurses (81 Fed. Reg. 33155, May 25, 2016)][1]

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Docket No. VA-2016-VHA-0011

The Arkansas Center for Research in Economics (ACRE) is an Arkansas-focused research center housed at the University of Central Arkansas. ACRE uses its research to find solutions for the issues Arkansans face in their daily lives and to train the next generation of researchers, teachers, voters, and business leaders. We provide our research to policymakers in Arkansas's government, news outlets, and the citizens of Arkansas. Much of our work focuses on regulations that restrict the right of people to practice their professions. This includes licensing and scope of practice rules. Thus, this comment on the US Department of Veterans Affairs' (VA's) notice of proposed rulemaking[2] does not represent the views of any particular affected party or special interest group, but it is designed to assist the commission as it develops scope of practice rules for advanced practice registered nurses (APRNs) working at VA facilities.

I. Introduction

In the notice of proposed rulemaking, the VA seeks specific information on the impact of granting APRNs full practice authority. Full practice authority would allow advanced practice registered nurses to provide health care without the presence of a physician. I focus on the impact of expanding the the practice authority of certified nurse practitioners (CNPs), which are commonly referred to as nurse practitioners (NPs).

[1] Prepared by David T. Mitchell, PhD, director, Arkansas Center for Research in Economics at the University of Central Arkansas. This comment does not represent an official position of the University of Central Arkansas.

[2] US Department of Veterans Affairs. RIN: 2900-AP44 - Proposed Rule - Advanced Practice Registered Nurses (81 Fed. Reg. 33155, May 25, 2016).

Expanded authority will increase the availability of nurse practitioners for primary care, which will induce both high levels of patient satisfaction and high-quality care. This is important to Arkansas's 249,274 veterans.[3] Peer-reviewed literature that focuses on outcomes, not inputs, shows the following:

- **Nurse practitioners provide excellent primary care.**
- **Nurse practitioners are less expensive than physicians, and it would be easier to increase their numbers.**
- **Nurse practitioners are more likely to move to rural areas than physicians.**
- **Nurse practitioners provide excellent care for diabetes and other chronic conditions.**
- **The increased use of nurse practitioners is likely to spur innovation in health care delivery.**
- **The use of nurse practitioners allows primary care physicians to focus on more complex services.**

II. Nurse Practitioners Provide Excellent Primary Care

There is a considerable body of research indicating that nurse practitioners provide comparable quality to physicians for primary care patients,[4,5,6,7,8,9,10,11] culminating with an Institute of Medicine (IOM) report recommending that advanced nurse practitioners be free

[3] http://www.va.gov/vetdata/Veteran_Population.asp

[4] Swann M, Ferguson S, Chang A, Larson E, Smaldone A. (2015). Quality of primary care by advanced practice nurses: a systemic review. *International Journal for Quality in Health Care*. 27(5): 396-404.

[5] Newhouse RP, Stanik-Hutt J, White KM, *et al*. (2011). Advanced practice nurse outcomes 1990-2008: a systematic review. *Nursing Economics*. 29(5): 230–50.

[6] Laurant M, Reeves D, Hermens R, Braspenning J, Grol R, Sibbald B. (2005). Substitution of doctors by nurses in primary care. *Cochrane Database Systematic Reviews*. 2:CD001271.

[7] Roblin DW, Howard DH, Becker ER, Kathleen Adams E, Roberts MH. (2004). Use of midlevel practitioners to achieve labor cost savings in the primary care practice of an MCO. *Health Services Research*. 39(3): 607–26.

[8] Lenz ER, Mundinger MO, Kane RL, Hopkins SC, Lin SX. (2004). Primary care outcomes in patients treated by nurse practitioners or physicians: two-year follow-up. *Medical Care Research and Review*. 61(3): 332–51.

[9] Mundinger MO, Kane RL, Lenz ER, et al. (2000). Primary care outcomes in patients treated by nurse practitioners or physicians: a randomized trial. *Journal of the American Medical Association*. 283(1): 59–68.

[10] Venning P, Durie A, Roland M, Roberts C, Leese B. (2000). Randomised controlled trial comparing cost effectiveness of general practitioners and nurse practitioners in primary care. *British Medical Journal*. 320(7241): 1048–53.

[11] Mafi, J. N., Wee, C. C., Davis, R. B., & Landon, B. E. (2016). Comparing use of low-value health care services among US advanced practice clinicians and physicians. *Annals of Internal Medicine*.

to practice to the full extent of their training.[12] The research includes both observational studies and randomized studies.[13] Based on this research and the experience of nurse practitioners in states that allow full practice, the National Governors Association has recommended that states provide full practice to nurse practitioners to help alleviate the growing primary care shortage.[14]

III. Nurse Practitioners Are Cheaper Than Physicians, and It Would Be Easier to Increase Their Numbers

Using NPs is an excellent way to reduce wait times for veterans. Nationwide, there are concerns over the looming shortage of primary care physicians.[15,16] This shortage is attributed to many factors, including shifting demographics toward an older population[17] and fewer medical students choosing primary care in favor of more lucrative specialties.[18] My own work is focused on state-level analysis instead of VA labor supply, but it suggests that as nurse practitioners gain autonomy it is possible to increase their supply by 3.69 NPs per 100,000 patients in each state.[19] Additional autonomy encourages more providers to earn their advanced degree in nursing. This increase is possible because of both internal and external motivations.

When NPs do not have to work under physician supervision, the cost savings can be large. A RAND Corporation study suggested that using more APRNs and physician assistants (PAs) could save the Commonwealth of Massachusetts between $1.4 and $1.8 billion over a ten-year period.[20]

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[12] Institute of Medicine. (2011). *The Future of Nursing: Leading Change, Advancing Health*. Washington, DC: National Academies Press.

[13] Horrocks, S., Anderson, E., & Salisbury, C. (2002). Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors. *British Medical Journal*. 324(7341), 819–823.

[14] National Governors Association. (2012). *The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care*. Accessed May 26, 2016, from http://www.nga.org/cms/home/nga-center-for-best-practices/center-publications/page-health-publications/col2-content/main-content-list/the-role-of-nurse-practitioners.html.

[15] Grover, A., & Niecko-Najjum, L. M. (2013). Building a health care workforce for the future: more physicians, professional reforms, and technological advances. *Health Affairs*. 32(11): 1922–1927.

[16] Colwill, J. M., Cultice, J. M., & Kruse, R. L. (2008). Will generalist physician supply meet demands of an increasing and aging population?. *Health Affairs*. 27(3): w232–w241.

[17] Phillips Jr, R. L., Bazemore, A. M., & Peterson, L. E. (2014). Effectiveness over efficiency: underestimating the primary care physician shortage. *Medical Care*. 52(2), 97–98.

[18] Jolly, P., Erikson, C., & Garrison, G. (2013). US graduate medical education and physician specialty choice. *Academic Medicine*. 88(4), 468–74.

[19] Mitchell, D.T., Helms, Z. & Pfaff, J. (2016) Primary Care and Nurse Practitioners in Arkansas. ACRE Policy Review 16-01. Conway, AR: Arkansas Center for Research in Economics. Available at: http://uca.edu/acre/files/2016/06/APRN-Policy-Brief.pdf

[20] Eibner, C., Hussey, P. S., Ridgely, M. S., & McGlynn, E. A. (2009). Controlling health care spending in Massachusetts: an analysis of options. Santa Monica, CA: RAND Corporation.

In the case of nurse practitioners, these barriers restrict the services that nurse practitioners may provide.[21,22,23]

The barriers lead to:

- Difficulty scheduling appointments for primary care and routine visits.
- Longer in-office waiting times to see a provider.
- Higher patient and payer health care costs.
- Less transparency in billing.
- Higher administrative costs for physician practices that employ nurse practitioners.

IV. Nurse Practitioners Are More Likely to Move to Rural Areas Than Physicians

In Arkansas 101,788 veterans live in rural areas. That's almost half of the veterans in the state.[24] Counties with the least access to primary care—including counties such as those along the Mississippi Delta—often face difficult population health issues, including obesity and diabetes, that have been shown to be improved by greater access to primary care.[25,26,27,28] Nationwide over 40 percent of VA-enrolled veterans live in rural areas.[29] Problems caused by the shortage of primary care physicians are exacerbated by their

[21] Kleiner MM, Marier A, Park KW, Wing C. (2014). *Relaxing Occupational Licensing Requirements: Analyzing Wages and Prices for a Medical Service*. Working paper: w19906. National Bureau of Economic Research.
[22] Pittman P, Williams B. (2012). Physician wages in states with expanded APRN scope of practice. *Nursing Research and Practice.* v2012.
[23] Fairman JA, Rowe JW, Hassmiller S, Shalala DE. (2011). Broadening the scope of nursing practice. *New England Journal of Medicine.* 365: 193–6.
[24] Rural Veterans by State. National Center for Veterans Analysis and Statistics. http://www.va.gov/vetdata/docs/SpecialReports/Rural_Veterans_by_State.xlsx.
[25] Gaglioti AH, Petterson S, Bazemore A, Phillips R. (2016). Access to primary care in US counties is associated with lower obesity rates. *Journal of the American Board of Family Medicine*. 29(2): 182–90.
[26] Ferguson S, Swan M, Smaldone A. (2015). Does diabetes self-management education in conjunction with primary care improve glycemic control in Hispanic patients? A systemic review and meta-analysis. *The Diabetes Educator*. 41(4): 472–84.
[27] Gaglioti AH, Petterson S, Bazemore A, Phillips R. (2016). Access to primary care in US counties is associated with lower obesity rates. *Journal of the American Board of Family Medicine*. 29(2): 182–90.
[28] Lenz ER, Mundinger MO, Hopkins SC, Lin SX, Smolowitz JL. (2002). Diabetes care processes and outcomes in patients treated by nurse practitioners or physicians. *The Diabetes Educator.* 28(4): 590–8.
[29] Skupien, Mary Beth. (2012). "Increasing Access to Care: Reaching Out to Rural Veterans." *Vantage Point*. http://www.blogs.va.gov/VAntage/7637/increasing-access-to-care-reaching-out-to-rural-veterans/.

unequal distribution—especially in relatively poor and rural communities.[30] Nurse practitioners can help redress this imbalance.

V. Nurse Practitioners Provide Excellent Care for Diabetes and Other Chronic Conditions

Between 2000 and 2008 the number of VA patients with diabetes increased by 34 percent.[31] Utilization of practitioners increased even faster than the number of patients.[32] Many chronic conditions, such as diabetes, are best treated by improving primary care.

The VA has done an excellent job of reducing costs per patient with diabetes, but demographic trends suggest that the VA will have increasing numbers of patients with chronic diseases.[33,34] There is extensive evidence that primary care interventions have substantial effects on the risk factors, incidence, and control of diabetes.[35,36,37,38] Thus, anything alleviating the primary care shortage could have dramatic effects in diabetes care and outcomes. However, the gains appear to be magnified when primary care diabetes interventions are managed by advanced practice nurses.[39,40,41] There is no consensus as to why this occurs, though possible explanations include:

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[30] Petterson, S. M., Phillips Jr, R. L., Bazemore, A. W., & Koinis, G. T. (2013). Unequal distribution of the US primary care workforce. *American family physician*, 87(11), Online-Online.

[31] Yoon, J., Scott, J. Y., Phibbs, C. S., & Wagner, T. H. (2011). Recent trends in Veterans Affairs chronic condition spending. *Population health management*, 14(6), 293–298.

[32] US Department of Health and Human Services. (2013). Projecting the supply and demand for primary care practitioners through 2020.

[33] Asch, S. M., McGlynn, E. A., Hogan, M. M., Hayward, R. A., Shekelle, P., Rubenstein, L., & Kerr, E. A. (2004). Comparison of quality of care for patients in the Veterans Health Administration and patients in a national sample. *Annals of Internal Medicine*. 141(12), 938–945.

[34] Jha AK, Perlin JB, Kizer KW, Dudley RA. (2003) Effect of the transformation of the Veterans Affairs Health Care System on the quality of care. *New England Journal of Medicine.* 348:2218-27.

[35] Gaglioti AH, Petterson S, Bazemore A, Phillips R. (2016). Access to primary care in US counties is associated with lower obesity rates. *Journal of the American Board of Family Medicine*. 29(2): 182–90.

[36] Ferguson S, Swan M, Smaldone A. (2015). Does diabetes self-management education in conjunction with primary care improve glycemic control in Hispanic patients? A systemic review and meta-analysis. *The Diabetes Educator.* 41(4): 472–84.

[37] Ma J, Yank V, Xiao L, Lavori P, Wilson SR, Rosas LG, Stafford RS. (2013). Translating the diabetes prevention program lifestyle intervention for weight loss into primary care: a randomized trial. *JAMA Internal Medicine.* 173(2): 113–21.

[38] Stellefson M, Dipnarine K, Stopka C. (2013). The chronic care model and diabetes management in US primary care settings: a systemic review. *Preventing Chronic Disease.* 10: E26.

[39] Ohman-Strickland PA, Orzano AJ, Hudson SV, Solberg LI, DiCiccio-Bloom B, O'Malley D, *et al.* (2008). Quality of diabetes care in family medicine practices: influence of nurse-practitioners and physician's assistants. *The Annals of Family Medicine.* 6(1): 14–22.

[40] Denver EA, Barnard M, Woolfson RG, Earle KA. (2003). Management of uncontrolled hypertension in a nurse-led clinic compared with conventional care for patients with type 2 diabetes. *Diabetes Care*. 26(8): 2256–60.

[41] Lenz ER, Mundinger MO, Hopkins SC, Lin SX, Smolowitz JL. (2002). Diabetes care processes and outcomes in patients treated by nurse practitioners or physicians. *The Diabetes Educator.* 28(4): 590–98.

- Spending more time with patients. APRNs spend an average of 12 minutes face-to-face with patients, while primary care physicians spend only an average of 7 minutes with patients.[42]

- Increased patient communication and follow-up care.[43] APRNs are more likely to document diabetes education in patient encounters.[44]

It is important to note that even if nurse practitioners perform no better than physicians in managing diabetes patients, simply increasing access to primary care services to these patients by using unrestricted nurse practitioners would generate substantial cost savings in diabetes care.

VI. The Increased Use of Nurse Practitioners Is Likely to Spur Innovation in Health Care Delivery

Increasing competition between providers and between different types of providers, leads to higher incentives for innovation. Increased competition may provide all sorts of improvements to access to care issues. For example, advanced practice nurse staffed clinics generally offer weekend and evening hours. This not only provides greater flexibility for patients, but provides competitive incentives for other types of clinics to offer extended hours as well.[45]

VII. Greater Use of Nurse Practitioners Allows Primary Care Physicians to Focus on More Complex Services

According to the Institute of Medicine, the expansion of nursing scopes of practice has neither diminished the critical role of physicians in patient care nor reduced physician

[42] Venning P, Durie A, Roland M, Roberts C, Leese B. (2000). Randomised controlled trial comparing cost effectiveness of general practitioners and nurse practitioners in primary care. *British Medical Journal*. 320(7241): 1048–53.

[43] Richardson GC, Derouin AL, Vorderstrasse AA, Hipkens J, Thompson JA. (2014). Nurse Practitioner management of type 2 diabetes. *The Permanente Journal*. 18(2): e134-e140.

[44] Lenz ER, Mundinger MO, Hopkins SC, Lin SX, Smolowitz JL. (2002). Diabetes care processes and outcomes in patients treated by nurse practitioners or physicians. *The Diabetes Educator*. 28(4): 590–98.

[45] Massachusetts Department of Public Health. (2007). Commonwealth to propose regulations for limited service clinics: rules may promote convenience, greater access to care. Accessed November 12, 2015, from http://www.mass.gov/?pageID=pressreleases&agId=Eeohhs2&prModName=dphpressrelease&prFile=070717_clinics.xml.

incomes.[46] This is because physicians are able to task switch to more complex cases involving additional training.[47,48]

VII. Existing Use of Nurse Practitioners

Expanding the use of nurse practitioners would not be a radical change from current practice. Twenty-one states and the District of Columbia already allow APRNs to practice to the full extent of their training.[49] Those states make consumer sovereignty and choice an important part of health care. In states with full practice authority, consumers have greater choice of providers.

Other states continue to restrict the ability of APRNs to practice without physician collaboration. These regulations are well meaning, but they overreach. Excessive regulation may fail to generate meaningful protections while creating practice barriers that curb competition. More generally, reduced competition leads to less innovation and greater consolidation, which increase costs and reduce access to care.

Thus, even well-meaning regulations may not be effective when considering their overall effect. The trick is to balance protection with competition—which often starts with a focus on the overall outcomes of a regulation rather than the inputs. The amount or expense of a practitioner's training is not important to our veterans, the quality of care is. In light of these concerns, the Federal Trade Commission examined state regulations of advanced practice nurses and concluded that these regulations frequently exceed what is necessary to protect consumers.[50] The FTC found that the regulations impede competition. Yet, "competition among health care providers yields important consumer benefits, as it tends to reduce costs, improve quality, and promote innovation and access to care."[51]

VIII. Limitations

I have purposefully constrained my analysis to APRNs practicing primary care. I have focused on certified nurse practitioners. I have not discussed certified registered nurse anesthetists, clinical nurse specialists, or certified nurse-midwifes. I believe that these

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[46] Institute of Medicine. (2011). *The Future of Nursing: Leading Change, Advancing Health*. Washington, DC: The National Academies Press.
[47] Katz MH. (2015). The right care by the right clinician. *JAMA Internal Medicine*. 175(1): 108.
[48] Hughes DR, Jiang M, Duszak R. (2015). A comparison of diagnostic imaging ordering patterns between advanced practice clinicians and primary care physicians following office-based evaluation and management visits. *JAMA Internal Medicine*. 175(1): 101–7.
[49] American Association of Nurse Practitioners. (2016). *State Practice Environment.* Accessed May 26, 2016, from https://www.aanp.org/legislation-regulation/state-legislation/state-practice-environment.
[50] Federal Trade Commission (2014). *Competition and the Regulation of Advanced Practice Nurses*. Washington, DC.
[51] Federal Trade Commission (2014). *Competition and the Regulation of Advanced Practice Nurses*. Washington, DC. pg. 4.

professions are excellent providers, but my research has focused on APRNs practicing primary care.

I also have not discussed section 17.415 of the proposed rule, which states "a CNP has full practice authority to . . . order, perform, supervise, and interpret laboratory and imaging studies."

While it is vital that CNPs be able to order laboratory and imaging tests, I know of no peer-reviewed work comparing the outcomes of CNPs to general practitioners or radiologists when analyzing advanced imaging including CT and MRI scans. Many practitioners read X-rays with great results.[52,53] Perhaps advanced imaging is better left to a clinical trial.

IV. Conclusion

The US Department of Veterans Affairs could make a serious improvement to the lives of veterans by expanding the scope of practice rules for APRNs. Using APRNS to the full extent of their training would lead to better health outcomes and higher patient satisfaction. A wide range of groups from the National Academy of Medicine, the AARP, the Robert Wood Johnson Foundation, the National Governors Association, and the Federal Trade Commission have encouraged the greater use of nurse practitioners. Changing this rule would save money, reduce wait time, and improve access to care. In states like Arkansas that would make a large improvement in the lives of veterans.

[52] Mann, C. J., Grant, I., Guly, H., & Hughes, P. (1998). Use of the Ottawa ankle rules by nurse practitioners. *Journal of Accident & Emergency Medicine*, 15(5), 315–16.

[53] Meek, S., Kendall, J., Porter, J., & Freij, R. (1998). Can accident and emergency nurse practitioners interpret radiographs? A multicentre study. *Journal of Accident & Emergency Medicine*, 15(2), 105–07.