The above Advanced Practice Registered Nurse (APRN) organizations representing over 340,000 APRNs and over 77,000 APRN students fully support the efforts of the Veterans Health Administration (VHA) to improve access to quality healthcare for our nation’s Veterans. This includes the VHA’s proposal to recognize all APRNs as Full Practice Providers. To this end, our community applauds recommendation 6.4.2.1 outlined in the Assessment B (Health Care Capabilities) of the Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs. Conducted by the RAND Corporation pursuant to the Veterans Access, Choice, and Accountability Act (P.L. 113-146), this assessment recommends the VHA “formally grant Full Practice Authority for all advanced practice nurses (APNs) (that is, nurse practitioners, clinical nurse specialists, nurse anesthetists, and nurse midwives) across VA....”

There are roughly 6,000 APRNs currently serving in VHA care sites. APRNs, which include nurse practitioners, certified registered nurse anesthetists, certified nurse-midwives, and clinical nurse specialists, receive extensive education and clinical training in their specific healthcare fields. They are required to pass rigorous national certification board exams to demonstrate their expertise, knowledge, and competency. APRNs bring a unique, comprehensive perspective of patient care and are highly skilled collaborators in the delivery of team-based care. Recognizing APRNs as Full Practice Authority providers would bolster the Department’s efforts to increase access to care by utilizing the full skill set and expertise of VHA APRNs, many of whom are Veterans themselves. At a time when safety, timeliness, and provider availability are of utmost concern, this recommendation is a critical step toward improving Veterans access to the high quality healthcare they have earned.

Captured in the “Policy Options to Increase Productivity of Existing Resources,” section of the assessment, recommendation 6.4.2.1 is aligned with the Institute of Medicine’s The Future of Nursing: Leading Change, Advancing Health recommendation to remove practice barriers to allow APRNs to practice to the full scope of their education and training, current policy in the Department of Defense and is consistent with decades of empirical evidence showing that APRNs directly contribute to increasing access to care, improving care coordination, and lowering costs.1

Furthermore, our organizations remain steadfast supporters of the Improving Veterans Access to Quality Care Act of 2015 (H.R. 1247), which would recognize all four APRN roles as FPA providers in the VHA.

We respectfully urge members of the Committee and stakeholders of Veterans health to support Full Practice Authority for APRNs and request that the VHA move forward with publishing this proposal for public comment.

Prepared by:
RAND Corporation

A Product of the CMS Alliance to Modernize Healthcare
Federally Funded Research and Development Center
Centers for Medicare & Medicaid Services (CMS)

Prepared For:
U.S. Department of Veterans Affairs

At the Request of:
Veterans Access, Choice, and Accountability Act of 2014
Section 201: Independent Assessment of the Health Care Delivery
Systems and Management Processes of the Department of Veterans
Affairs

Assessment B (Health Care Capabilities)

September 1, 2015

Prepared for CAMH under:
Prime Contract No. HHS-M500-2012-00008I
Prime Task Order No. VA118A14F0373

This document was prepared for authorized distribution only. It has not been approved for
public release.
©2015 RAND Corporation. All rights reserved.
Assessment B (Health Care Capabilities)

respondents as critically important to reducing delays in care) to provide direct care. The impact of this policy option on access is highly dependent on (1) the extent to which support staff time is maximized for facilitating clinic workflow and (2) the availability of independent practitioners whose productivity might be improved through increases in support staffing.

**Increase physical space for health care delivery.** This option would entail purchasing or leasing new physical infrastructure, or repurposing existing physical spaces to be used for providing health care (for example, exam rooms, office space, medical equipment space). This option would face significant constraints in its implementation as well as its expected impact on access. First, the purchase or leasing of new space (assuming it is available in areas where it was needed) would require significant additional funding and would entail burdensome and lengthy procurement or contracting processes; the process would consume enough time that the initial need would likely far surpass actual capacity by the time the space is secured. Second, the impact on access would be wholly dependent on both the availability of physical space for purchase or lease in areas where it is needed as well as the availability of health care providers and support staff to utilize the additional space. The latter requirement underscores the need to ensure adequate health care workforce within VA as an antecedent to any consideration of acquiring new space for health care delivery. The likely fiscal impact and administrative complexity of this option, together with an impact on access that is highly dependent on other major variables, makes this option a less feasible approach to improving timely and accessible care in VA than others.

**Integrate with DoD military health system.** This option, in its most fully realized form, would entail integrating VA and DoD workforce and physical infrastructure to provide joint health care to Veterans and active-duty personnel and their families. It would likely require both a single governance structure to oversee joint operations as well as a single electronic health record system. Improvements in access to care under this option are highly dependent on the capacity that is created through such a merger. It is possible that additional capacity constraints might be created, particularly given the administrative hurdles and related “growing pains” of a newly created organization of this size. The financial and administrative complexity of integrating the two systems will be significant, likely detracting from any long-term potential cost savings, efficiency gains, or access improvements. Moreover, this option may not have strong stakeholder support as it could result in lost jobs, culture clashes, and the loss of a “Veteran-only” health care system. In a less ambitious form, this option might involve developing an interoperable electronic health record system so Veterans could access care at military treatment facilities if needed; however, VA’s history of unsuccessful attempts to build an interoperable electronic health record system point to a low likelihood of success in the near term.

6.4.2 Policy Options to Increase Productivity of Existing Resources

There are numerous options for improving the use of existing resources and making them more productive. Below, we describe and evaluate three options that were frequently raised in our interviews and in the published literature: (1) formalize full nursing practice authority throughout VA, (2) formalize task assignment in outpatient clinics, and (3) standardize return visit intervals for common conditions. Other options that we considered but did not select for

---

The views, opinions, and/or findings contained in this report are those of RAND Corporation and should not be construed as an official government position, policy, or decision.

266
evaluation include eliminating inappropriate care, expanding care management programs for complex chronic conditions, and expanding working hours.

6.4.2.1 Formalize Full Nursing Practice Authority throughout VA

6.4.2.1.1 Overview

This option would formally grant full practice authority for all advanced practice nurses (APNs) (that is, nurse practitioners, clinical nurse specialists, nurse anesthetists, and nurse midwives) across VA, superseding individual state laws governing scope of practice where applicable. This would include authority to, for example, evaluate and diagnose conditions, order and interpret tests, and admit patients without physician oversight. VA is currently considering changes to a VA Nursing Handbook that would expand the breadth of VA nurses’ authority. In addition, H.R. 1247, the “Improving Veterans Access to Care Act of 2015,” currently under consideration in the House Committee on Veterans Affairs, would give APNs in VA full practice authority.

6.4.2.1.2 Rationale

Allowing full nursing practice authority is often raised as a key approach to addressing physician workforce shortages and access problems in non-VA contexts, particularly in primary care (Carrier, Yee, & Stark, 2011; Wilson, 2008). A 2011 Institute of Medicine report, “The Future of Nursing: Leading Change, Advancing Health,” suggests that removing scope of practice barriers and allowing APNs to practice independently could increase clinical productivity; substituting APNs for physicians across a wider range of health care services frees up physician time to handle more complex cases (Institute of Medicine, 2011). Results from the Chief of Staff module of our 2015 Survey of VA Resources and Capabilities show that 68 percent of respondents (76 out of 111 sites) identified providers performing clinical activities that could be performed by individuals with less training as a key issue negatively impacting provider and system efficiency.

VA is the largest employer of APNs in the nation (VA, 2010a; Domine et al., 1998; Faris et al., 2010). Data from our workforce analyses show that in FY 2014, VA utilized 3,626 nurse practitioners, 396 clinical nurse specialists, and 598 certified registered nurse anesthetists. Currently, the ability of APNs to practice independently varies widely across VA, with nursing scope of practice established at the facility level (VA Directive 2008-049: Establishing medication prescribing authority for APNs). To our knowledge, there is no systematic analysis of VA compared with non-VA use of APNs and scope of practice.

Interviewees noted that although some VA facilities formally grant full practice authority to APNs, many facilities implicitly defer to state laws (despite VA federal supremacy) that require nurses to collaborate with physicians or may even require formal physician supervision (Cassidy, 2012; Institute of Medicine, 2011; Pearson, 2012). Interviewees also revealed that full nursing practice authority can vary within facilities even at the department or team level, whereby APNs with more experience or established relationships with their physician partners are granted more leeway. Although some observers have described VA as being at the vanguard in the use of APNs with respect to both numbers employed and relative autonomy in

The views, opinions, and/or findings contained in this report are those of RAND Corporation and should not be construed as an official government position, policy, or decision.
clinical care (Huang et al., 2004; Robinson & Petzel, 2010), the variation in how they are utilized and the extent to which they are allowed to practice independently has been highlighted as a critical barrier to achieving optimal use of VA resources and capabilities (Kizer & Norby, 1998).

6.4.2.1.3 Implementing Steps

The cornerstone of this option is standardizing full practice authority for APNs across the VA system. A first step to implementing this option could be to endorse and implement proposed changes to VA’s nursing handbook that would recognize APNs as independent practitioners authorized to provide patient care without physician supervision. The revised handbook would standardize processes and formally recognize the expanded scope of practice throughout the system (VA, 2011b). Subsequently, new scope of practice protocols would be required to clearly specify the expanded scope of nursing practice (Mohler et al., 1998), similar to the national templates previously proposed by former Undersecretary of Health Kenneth Kizer (Kizer & Norby, 1998). This might require forming an expert consensus panel to determine relevant qualifications and minimum standards for allowing expanded scope of practice. For example, recent legislation in New York State enacted in January 2015 allows nurse practitioners with over 3,600 hours (approximately two years) of clinical practice to practice independently (that is, without a written collaborative agreement with a physician) but does not change scope of practice rules for nurse practitioners with under 3,600 hours of practice (New York State Assembly, 2013). Nurse providers would have to engage in additional training and certification to meet standards for full practice authority, and undergo routine performance evaluations according to a prespecified schedule. Continuing medical education programs would have to be developed to sustain nursing skills relevant to full practice authority. Existing nursing oversight bodies may need to be restructured to address new regulations under an expanded scope of practice; Dr. Kizer had previously recommended funding an Advanced Practice Nursing Council to be responsible for licensure, role, and scope of practice protocols, as well as education and training opportunities (VHA, 1997). In addition, the establishment of professional standards boards for APNs at the local or network level to provide consistency in the development and interpretation of relevant rules and regulations will be needed.

6.4.2.1.4 Evaluation

Impact on access. An option to formalize full practice authority might impact access in two ways: (1) It could allow APNs to spend less time on tasks such as reviewing clinical decisions with a supervising physician and more time providing direct patient care, and (2) it could allow physicians to spend less time supervising APNs and more time caring for patients. Quantitative data on the effect of full practice authority on access as a result of additional time for patient care are limited and mixed. Although it is clear that following scope of practice regulations is time-consuming for both the nurse and the physician, it is unclear how much of that time could and would be redirected to patient care. One study found that APNs in states allowing full practice authority worked 11 percent more hours per year than APNs in states with scope of practice restrictions—but that physicians worked 6 percent fewer hours, presumably because independently practicing APNs were picking up the patient care duties (Kleiner et al., 2014). In contrast, another study found that physicians increased their direct patient care hours by 8

The views, opinions, and/or findings contained in this report are those of RAND Corporation and should not be construed as an official government position, policy, or decision.

268
percent, given that they spent less time supervising APNs (Traczynski & Udalova, 2013). There are some data to suggest that granting full nursing practice authority could increase the supply of APNs due to either more entrants to nursing programs or nurses relocating to states with expanded scope of practice laws (Kalist & Spurr, 2004). Under an expanded scope of nursing practice, VA may be able to attract more APNs from the private sector in states that have scope of practice restrictions, which is particularly salient for states with large rural areas where VA might be struggling to ensure an adequate provider workforce.

Finally, some data suggest that the total amount of care provided to patients might increase with full nursing practice authority. One study found a 2-percent increase in number of office visits when state scope of practice was expanded, and the percentage of patients receiving preventive care and reporting timely and accessible care increased by as much as 10 percent on some measures (Traczynski & Udalova, 2013).

Indirect evidence also supports the positive potential impact on access that formalizing independent nursing might have, particularly through better use of APNs in clinical practice. For example, APNs in the private sector see twice as many patients per day as a VA APN, suggesting considerable room for improvement in VA’s use of APNs as clinical providers (Mohler et al., 1998), which might be achieved via relaxed scope of practice regulations. Data also suggest that APNs can function effectively as physician substitutes in VA primary care given similarities in the patterns of patient encounter characteristics across provider types (Morgan et al., 2012). In addition, a substantial body of literature shows that important health outcomes—including disease-specific physiologic measures, reduction of symptomatology, mortality, hospitalization and other utilization measures, and patient satisfaction—are comparable between patients served by APNs and those served by physicians (Grumbach et al., 2003; Horrocks, Anderson, & Salisbury, 2002; Laurant et al., 2009; Laurant et al., 2005; Mundinger et al., 2000; Naylor & Kurtzman, 2010; Wilson et al., 2005).

This option could impact access in both primary and specialty care settings. Nurse practitioners are a core member of VA’s primary care Patient Aligned Care Team model and are widely used in chronic conditions management, which can involve specialty services (for example, endocrinology for diabetes management, cardiology for heart failure management) (Newhouse et al., 2011). APNs have also been increasingly used in geriatrics, with the launching of an adult-gerontology clinical nurse specialist board certification in 2013. Finally, under this option clinical nurse anesthetists might be more widely used in inpatient and surgical settings.

**Fiscal impact.** Evidence regarding the possible fiscal impact of this option is also mixed but suggests the potential for cost savings. APNs are a less expensive alternative to physicians for providing direct patient care. Prior research in non-VA settings demonstrates that substituting some APNs for physicians (for example, five APNs and three physicians versus eight physicians) in a collaborative practice model results in significant cost savings over time (Bosque, 2015) given salary differences. More efficient use of APN time in clinical practice might also decrease costs; one study found that when APNs in retail clinics were allowed to practice independently, the clinics’ cost savings were greater than when they could not practice independently because of state scope of practice regulations (Spetz et al., 2013). Although cost calculations may be
different between VA and non-VA—particularly in fee-for-service settings—these findings point to the potential savings that might be realized through more efficient use of APNs in practice.

On the other hand, if granting full practice authority increases access to care, the total amount of services provided might escalate, increasing overall costs. One study found that total spending on office visits (that is, all office-based settings for physician and APN care) was 4.3 percent higher in states with full practice authority than in states with scope of practice restrictions (Stange, 2014). However, increases in spending related to greater access to primary and preventive care could be offset by savings from reduced utilization in more intensive settings; for example, one study found reductions in ambulatory-sensitive emergency department visits (Traczynski & Udalova, 2013). Some have argued that APNs might contribute to costs because they tend to order more diagnostic tests than physicians do (Jauhar, 2014; Medical Society of the State of New York, 2015), presumably to compensate for differences in training and knowledge; however, this assertion is often based on a study published in 1999 that did not directly estimate the effect of expanding nursing practice authority on costs but simply compared nursing to physician practices.

The estimated implementation costs of this option are relatively low, and the option may reduce costs over time. There will likely be costs associated with developing new and expanded scopes of practice and standardizing them across VA, communicating and educating providers and staff about the expanded nursing authorities, and training and credentialing to appropriately reflect the expanded scope. These costs may be at the individual facility level or structured through VA Nursing Academy Partnership, which provides training at 18 academic nursing partnership sites across VA.

**Stakeholder acceptability.** This option could face strong political opposition from physician advocates within and outside VA. Allowing full nursing practice authority has historically been a controversial topic, and physician reluctance to accept the expanding role of nonphysician practitioners remains a persistent cultural barrier that will require sustained and intensive attention by VA leadership and beyond to overcome (Kizer & Norby, 1998). Physician organizations including the American Medical Association have been vocal in their ongoing opposition to allowing full nursing practice authority particularly in response to the recently proposed scope of practice changes to VA’s nursing handbook (Beck, 2014). A recent JAMA commentary by three VA physicians (Bakaeen, Blaustein, & Kibbe, 2014) recommended that VA hire more physicians, nurses, and support staff to care for the increased number of VA enrollees, but warned against hiring nurse practitioners and physician assistants to replace primary care physicians, stating that “This is not the time to test unproven and controversial solutions” (p. 481). Physician organizations often state that substituting APNs for physicians may put patients at risk for poorer outcomes despite a lack of evidence to support this claim. Stakeholder acceptability might be fostered by emphasizing evidence supporting the ability of APNs to provide care that is as safe as the care provided by physicians (Fairman, 2008; Groth, Norsen, & Kitzman, 2010; Hatem et al., 2008; Hogan, 2010; Horrocks et al., 2002; Hughes, 2010; Laurant et al., 2004; Dullisse & Cromwell, 2010; Newhouse et al., 2011; Laurant et al., 2009; Jackson et al., 2011; Ohman-Strickland et al., 2008; Lenz et al., 2004). Establishing a consensus-based minimum standard for clinical experience before an APN is granted full practice

The views, opinions, and/or findings contained in this report are those of RAND Corporation and should not be construed as an official government position, policy, or decision.
authority, as New York State has done, will likely be critical to facilitating stakeholder acceptability.

Strong physician opposition may also stoke patient and Veteran reluctance to support this policy option, although evidence regarding patient preferences for physicians versus APNs remains mixed. As an example, one survey commissioned by the American Academy of Family Physicians found that patients preferred and trusted physicians over nurse practitioners (Porter, 2013), while another study using survey data from the AHRQ found that patients reported better experiences with care from APNs compared with physicians (Creech, 2011).

Due to persistent physician workforce shortages and concerns related to health insurance expansion, state legislatures are increasingly receptive to expanding scopes of practice for nurses, which could contribute to this option’s successful implementation in VA. To date, 20 states and the District of Columbia have given APNs practice autonomy, and several other states are considering it (Phillips, 2014). The Institute of Medicine’s first recommendation in its Future of Nursing report was to “remove scope of practice barriers.” This growing political support for full nursing practice authority in the broader context of access delays, increasing demand for primary care, and workforce shortages may soon offset the political challenges historically raised by physician advocacy groups.

**Operational feasibility.** Once endorsed, this option would likely require time to fully implement as new scopes of practice are drafted and care protocols developed. It would require coordination and partnership among several different VA offices, including but not limited to the Office of Nursing Service, Office of Patient Care Services, several Clinical Operations offices (for example, Primary Care Operations, Mental Health Operations, Geriatrics and Extended Care Operations), and network and facility directorship, to ensure that APNs begin to practice independently in a consistent and guideline-concordant manner. The Central Office-level policy change would have to be appropriately communicated through the regions down to the facility level, and monitored and evaluated for an initial implementation period, with feedback processes built in. Nursing leadership—both at VA Central Office and the facility level—may need to provide additional oversight and develop evaluation processes to incorporate expanded scopes. Additionally, new training and continuing education protocols would have to be developed and implemented to support expanded nursing scope of practice.

**Summary statement.** Formalizing full practice authority for APNs would likely be a cost-effective approach to increasing the productivity of VA’s existing workforce. However, entrenched political barriers to enactment may limit uptake and challenge full implementation in practice, making this a longer-term solution rather than an immediate fix.

### 6.4.2.2 Formalize Task Assignment in Outpatient Clinics

#### 6.4.2.2.1 Overview

This option would formally assign clinic tasks according to job function, with a focus on maximizing the use of clerical and clinical support staff to make physicians more productive and optimize clinic workflow. Our interviews revealed a prevailing perception that staff performs clinic tasks on an “as available” basis rather than being assigned tasks that match their skills and

---

The views, opinions, and/or findings contained in this report are those of RAND Corporation and should not be construed as an official government position, policy, or decision.