by executive departments and agencies should be undertaken only with full consideration of the legitimate prerogatives of the states and with sufficient legal basis for preemption."[9]

Moreover, Executive Order 13132 of August 4, 1999 requires that "any regulatory preemption of state law shall be restricted to the *minimum level necessary* to achieve the objectives of the statute pursuant to which the regulations are promulgated."[10] We do not support the VHA's assertion in the preamble of the Proposed Rule that it complied with this requirement. Executive Order 13132 requires the VHA to "consult with state and local officials early in the process of developing the proposed regulation." While the VHA solicited input from state boards of nursing, there is no mention of any outreach to the state boards of medicine. We urge the VHA to consult with state boards of medicine and other physician stakeholders that do not support the Proposed Rule for legitimate patient safety reasons before adopting a policy that would subvert states' rights.

Comparison to DoD policy

The VHA tries to make the case that the Proposed Rule is neither "novel [n]or unexpected" by referring to other agencies, such as the Military Health Service, that "employ APRNs in independent practice without oversight from physicians." However, the VHA does not cite specific policies to support this claim and the Proposed Rule, which would permit all APRNs to practice "*without the clinical supervision or mandatory collaboration of physicians,*" is significantly and qualitatively different from employment policies that allow some APRNs to practice independently.

For example, the Air Force Medical Service (AFMS) states that privileged CRNAs "may act independently in areas of demonstrated competency within their designated scope of practice." However, the AFMS also explicitly states that (1) "CRNAs *will consult* with an anesthesiologist or any other medical specialty for patients who require such medical consultation based on acuity of the health condition or complexity of the surgical procedure;" (2) "a *collaborative relationship* is a key component for safe, quality healthcare;" (3) "CRNAs granted MTF [military treatment facility] privileges *must have physician consultation* (privileged to the same scope of practice) available either in person or by phone when they are performing direct patient care activities;" and (4) all privileged APRNs "*must have a physician supervisor available for consultation and collaboration.*" Nowhere does the AFMS use language antithetical to team-based care like that employed in the Proposed Rule (e.g., "without the clinical supervision or mandatory collaboration of physicians"). In fact, the AFMS expressly requires the opportunity and availability for physician collaboration.[11]

The VA Under Secretary for Health was correct when he stated that "part of what any good health care professional does is know when it is time to seek help from more experienced professionals."[12] However, these best practices need to be built into policies and structures so that the framework for support is available when health care professionals need it. In its current iteration, the Proposed Rule stands in stark contrast to the team-based model by explicitly eschewing supervision and collaboration.

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[9] 74 Fed. Reg. 24693-24694 (May 22, 2009).
[10] 64 Fed. Reg. 43255-43259 (August 10, 1999).
[11] Air Force Instruction 44-119, Medical Quality Operations (August 16, 2011).
[12] Lisa Rein, Top VA doc: if there aren't enough doctors, have nurses treat our vets, The Washington Post (June 2, 2016).