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March 20, 2023

The Honorable Denis McDonough
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Re: RIN 2900-AR50–Emergency Suicide Care Interim Final Rule

Dear Secretary McDonough:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide comments on the Department of Veterans Affairs (VA) Interim Final Rule (IFR), "RIN 2900-AR50–Emergent Suicide Care."[1] The AMA applauds the VA in establishing a new benefit that will furnish, reimburse, and pay for emergent suicide care for certain individuals, to include the provision of emergency transportation necessary for such care. We offer the following comments to ensure that veterans in acute suicidal crisis receive high quality and timely care while reducing the potential for waste, fraud, and abuse.

Provision of Emergent Suicide Care

The VA has established suicide prevention as its highest clinical priority. Unfortunately, "in September 2019, VA reported that veterans accounted for 13.5 percent of all deaths by suicide among U.S. adults in 2017, despite constituting only 7.9 percent of the adult population."[2] The VA also reported that an average of 16.8 veterans died by suicide each day in 2020 and that "the age and sex-adjusted suicide rate of Recent Veterans Health Administration (VHA) Users was 43.4% higher than for other Veterans."[3] Due to the increased suicide prevention care needed by the veteran population the AMA believes that a board-certified physician should be the head of a veteran's health care team.

However, the IFR states that a determination to deliver emergent suicide care must be made by a health care provider, which the VA defines as anyone who is licensed to practice health care by a State and who is performing care within the scope of their practice as defined by a State or VA practice standard. **The AMA strongly believes that board-certified physicians should be the head of the care team, especially when there is concern that a patient could harm themselves or others, as is the case with a veteran in acute suicidal crisis.**

While all health care professionals play a critical role in providing care to patients, non-physician practitioners' skillsets are not interchangeable with that of fully educated and trained physicians. This is

[1] https://www.federalregister.gov/documents/2023/01/17/2023-00298/emergent-suicide-care.
[2] https://www.gao.gov/assets/gao-20-664.pdf.
[3] https://www.mentalhealth.va.gov/docs/data-sheets/2022/2022-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-508.pdf.

fundamentally evident based on the difference in education and training between the distinct professions. Physicians complete four years of medical school plus a three-to-seven-year residency program, including 10,000-16,000 hours of clinical training. By contrast, nurse practitioners complete only two to three years of education, have no residency requirement, and only 500-720 hours of clinical training. The current physician assistant education model is two years in length with only 2,000 hours of clinical care and no residency requirement. Patients expect the most qualified person—physician experts with unmatched training, education, and experience—to be diagnosing and treating veterans in the midst of a suicidal emergency.

But it is more than just the vast difference in hours of education and training; it is also the difference in rigor and standardization between medical school/residency and non-physician practitioner programs that matter and must be assessed. During medical school, students receive a comprehensive education in the classroom and in laboratories, where they study the biological, chemical, pharmacological, and behavioral aspects of the human condition. This period of intense study is supplemented by two years of patient care rotations through different specialties, during which medical students assist licensed physicians in the care of patients. During clinical rotations, medical students continue to develop their clinical judgment and medical decision-making skills through direct experience managing patients in all aspects of medicine. Following graduation, students must then pass a series of examinations to assess a physician's readiness for licensure. At this point, medical students "match" into a three-to-seven-year residency program during which they provide care in a select surgical or medical specialty under the supervision of experienced physician faculty. As resident physicians gain experience and demonstrate growth in their ability to care for patients, they are given greater responsibility and independence.

Nurse practitioner programs do not have similar time-tested standardizations. For example, between 2010-2017, the number of nurse practitioner programs grew by more than 30 percent with well over half of these programs offered mostly or completely online, meaning less in-person instruction and hands-on clinical experience. In addition, many programs require students to find their own preceptor to meet their practice hours requirement, resulting in much variation among students' clinical experiences. Furthermore, the physician assistant education model assumes that in practice, physician assistants will engage in supervision by, or in collaboration with, a physician. Our veterans in an emergency deserve the best possible care—they deserve and have a right to have physicians leading their health care team.

Moreover, there is strong evidence that increasing the scope of practice of nurse practitioners and physician assistants has resulted in increased health care costs and decreased quality of care. For example, a high-quality study published by the *National Bureau of Economic Research* in 2022 compared the productivity of nurse practitioners and physicians (MDs/DOs) practicing in the emergency department using VHA data. The study found that nurse practitioners use more resources and achieve worse health outcomes than physicians. Nurse practitioners ordered more tests and formal consults than physicians and were more likely than physicians to seek information from external sources such as X-rays and CT scans.[4] They also saw worse health outcomes, raising 30-day preventable hospitalizations by 20 percent, and increasing length of stay in the emergency department. Altogether, nurse practitioners practicing independently increased health care costs by $66 per emergency department visit.[5] The study found that these productivity differences make nurse practitioners more costly than physicians to employ, even accounting for differences in salary.[6] Not only does the increased resource use by nurse practitioners

[4] *Productivity of Professions: Lessons from the Emergency Department*, Chan, David C. and Chen, Yiqun, NBER, Oct. 2022.
[5] *Id.*
[6] *Id.*

result in increased costs and longer lengths of stay, but it also means patients undergo unnecessary tests, procedures, and hospital admissions.

Furthermore, according to multiple Government Accountability Office audits, the VA is doing an inadequate job of supervising and disciplining its non-physician providers. Over the past few years, the VA Office of Inspector General has reported multiple cases of quality and safety concerns regarding VA providers.[7] The issues reported range from providers lacking appropriate qualifications to poor performance, and provider misconduct.[8] Unfortunately, the VA has been deficient in putting an end to this subpar care, in part due to poor VA reporting and oversight.[9,10] This lack of oversight means that patients' safety could easily be jeopardized if non-physician providers are allowed to make determinations to deliver emergent suicide care.

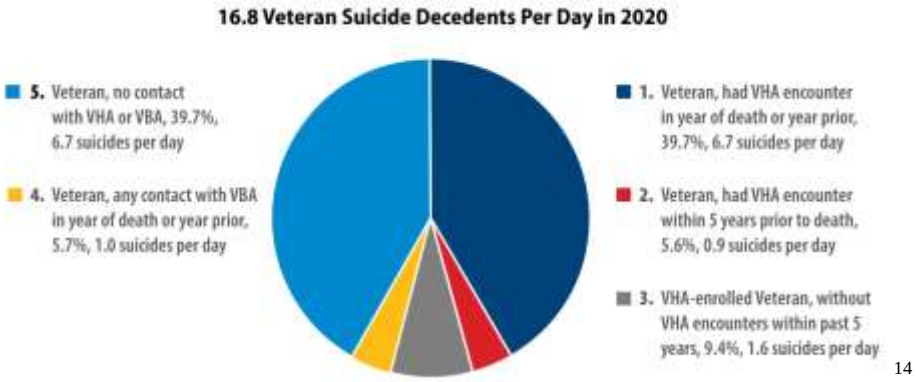
As such, to ensure that veterans who are in the midst of an acute crisis receive the best care possible, there should be a requirement that these veterans receive care from a physician-led team and that any care received from private physicians is reimbursed at a minimum of 100 percent of Medicare rates.

Payment or Reimbursement for Emergent Suicide Care

The AMA wants veterans in acute suicidal crisis to get the care they need when they need it. Moreover, the AMA applauds the VA for beginning to enhance and develop alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide adequate or timely care. However, the VA has had trouble with accurately counting and reporting veteran suicides. For example, the VHA counted a veteran who attempted to die by suicide but lived as deceased in their records.[11] A large cause of the inaccuracy is due to the fact that the "VHA does not obtain complete information or corroborate the information it obtains with other sources."[12] The VHA has even acknowledged this problem and has "identified the need for quality veteran suicide-related data to better understand the scope of the problem. The inaccurate information is also inconsistent with federal internal control standards, which state that management should use quality information that is complete and accurate to achieve the entity's objectives…"[13] This lack of accurate data surrounding veteran suicide care could be particularly problematic when combined with this IFR since more veterans will be eligible for, and receive care, within and outside of the VHA for acute suicidal crisis.

As shown in the chart below, about half of veterans who died due to suicide did not have contact with the VHA prior to death. This likely indicates that with the changes that this IFR will bring about, veterans will increasingly receive suicide care outside of the VA.

[7] https://www.gao.gov/assets/710/702090.pdf
[8] https://www.gao.gov/assets/710/702090.pdf.
[9] https://www.gao.gov/assets/710/702090.pdf.
[10] https://www.gao.gov/assets/710/702090.pdf.
[11] https://www.gao.gov/assets/gao-20-664.pdf.
[12] https://www.gao.gov/assets/gao-20-664.pdf.
[13] https://www.gao.gov/assets/gao-20-664.pdf.



[14]

The VA has had some success at increasing the accuracy of their data concerning veterans who are at risk of suicide through the Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment (REACH VET) program. "Fully implemented across the VA in 2017, the REACH VET program includes a predictive model to analyze data from VHA health records to identify veterans at increased risk for suicide. According to VHA, the REACH VET program was created to complement, and not replace, its other suicide prevention intervention strategies."[15] However, this program only analyzes information collected within the VHA, meaning care received outside of the VHA will likely not be included in this information and screening system. Accordingly, as the VA works to expand the ability for veterans to receive care from a multitude of facilities, we encourage the VA to work to ensure that the information they are using to determine who qualifies for, and utilizes, these expanded services is accurate and up to date regardless of where the care is received. **To aid in this, the AMA encourages the acceleration of interoperability of electronic medical health records in order to ensure seamless, timely, secure and accurate exchange of information between VA and non-VA providers and encourages both the VA and physicians caring for veterans outside of the VA to exchange medical records in a timely manner to ensure efficient care.**

The AMA is pleased to support VA's Emergent Suicide Care IFR and we believe the changes outlined above will ensure that veterans receive high quality and timely team-based care while safeguarding taxpayer dollars. If you have any questions, please feel free to contact Margaret Garikes, Vice President, Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409.

Sincerely,

James L. Madara, MD

[14] https://www.mentalhealth.va.gov/docs/data-sheets/2022/2022-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-508.pdf.
[15] https://www.gao.gov/assets/gao-22-105165.pdf.