AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Sherry Dorsey Walker
Chair
House Sunset Committee
Delaware House of Representatives
411 Legislative Avenue
Dover, DE 19901

Re: **Oppose H.B. 141 and H.B. 21**

Dear Chair Dorsey Walker:

On behalf of the American Medical Association (AMA) and our physician and student members, I am writing to express our **strong opposition to House Bill (H.B.) 141 and H.B. 21**. Together these bills would allow all advanced practice registered nurses (APRNs) the ability to provide medical care without any physician involvement. It also sets in place the APRN Compact, which unlike every other licensure compact, preempts state scope of practice laws and creates uniform licensure requirements. Given that previous versions of the APRN Compact failed to garner enough state support to become effective due to these concerns, and only one state has adopted the 2020 version with Delaware the only other state considering it, there is little certainty this new version will have the necessary support to become effective. Yet, H.B. 141 and H.B. 21 taken together will set Delaware on a dangerous, unclear, and unproven path forward. We urge you to oppose.

Data show patients both want and expect a physician to lead their care team. A national survey taken earlier this year revealed 68% of U.S. voters believe it is very important for physicians to be involved in diagnoses and treatment decisions, with an additional 27% of voters believing it is at least somewhat important (95% total). **Yet, H.B. 141 and H.B. 21 take Delaware in a very different direction, by removing physicians entirely from the care team.** This move also does not comport with national legislative trends. Delaware is one of 45 states that require some level of physician involvement for certified nurse anesthetists (CRNAs), one type of APRN, providing anesthesia care or prescribing. It is also one of 35 states that require some level of physician involvement for nurse practitioners (NPs), another type of APRN, to diagnose, treat or prescribe, including 15 states that have a transition to practice requirement like Delaware's existing law.

H.B. 141 removes physicians from the care team

The AMA is concerned that H.B. 141 threatens the health and safety of patients in Delaware by allowing APRNs to provide medical care without any physician collaboration or oversight.

Delaware already allows a path for APRNs to practice independently which the American Academy of Nurse Practitioners (AANP) terms "full practice authority" and yet, H.B. 141 removes the requirement that APRNs seeking independent practice must practice pursuant to a collaboration agreement for two years and a minimum of 4,000 full-time hours. Making matters worse, H.B. 21 would replace this with an extremely weak and vague requirement that APRNs must, "practice for at least 2,080 hours as an APRN in a role and population focus congruent with the applicant's education and training." It is unclear how this language will impact newly graduated APRNs, and it does not require APRNs to practice in collaboration with any other health care professionals during this time frame, including a physician.

Differences in education, training, rigor, and standardization of programs matter

While all health care professionals play a critical role in providing care to patients and all APRNs are important members of the care team, their skillsets are not interchangeable with that of fully trained physicians. This is fundamentally evident based on the difference in education and training. 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, NPs complete only two to three years of education, have no residency requirement, and complete only 500-720 hours of clinical training. CRNAs, as another example, have only two to three years of education, no residency requirement, and approximately 2,500 hours of clinical practice.

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 APRN 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. **NP programs, in addition to other APRN programs, do not have similar time-tested standardizations.** For example, between 2010-2017, the number of NP programs grew by more than 30% with over half of these programs offered mostly or completely online and many programs require students to find their own preceptor. Patients in Delaware deserve to have physicians leading their health care team.

Increasing scope of practice of APRNs can lead to increased health care costs

Moreover, there is strong evidence that removing physicians from the care team, has resulted in increased health care costs due to overprescribing and overutilization of diagnostic imaging and other services. For example, a 2020 study published in the *Journal of Internal Medicine* found 3.8% of physicians (MDs/DOs) compared to 8.0% of NPs met at least one definition of

overprescribing opioids and 1.3% of physicians compared to 6.3% of NPs prescribed an opioid to at least 50% of patients.[1] **The study further found, in states that allow independent prescribing, NPs were 20 times more likely to overprescribe opioids than those in prescription-restricted states.**[2]

Multiple studies have also shown that NPs order more diagnostic imaging than physicians, which increases health care costs and threatens patient safety by exposing patients to unnecessary radiation. For example, a study in the *Journal of the American College of Radiology*, which analyzed the total utilization rate per 1,000 of skeletal x-ray utilization for Medicare beneficiaries from 2003 to 2015, found ordering increased substantially—**more than 400%**—by nonphysicians, primarily NPs and physician assistants during this time frame.[3] A separate study published in *JAMA Internal Medicin*e found NPs ordered more diagnostic imaging than primary care physicians following an outpatient visit. The study controlled for imaging claims that occurred after a referral to a specialist.[4] **The authors opined this increased utilization may have important ramifications on costs, safety, and quality of care. They further found greater coordination in health care teams may produce better outcomes than merely expanding nurse practitioner scope of practice alone.**

Many of these studies have been limited to NPs because few states allow prescriptive authority of clinical nurse specialists, another type of APRN. However, the findings are clear: NPs tend to prescribe more opioids than physicians, order more diagnostic imaging than physicians and overprescribe antibiotics[5]—all which increase health care costs and threaten patient safety. Before expanding the scope of practice of all APRNs, including those newly licensed, we encourage the legislature to carefully review these studies. We believe you will agree that the results are startling and have significant impact on the assessment of risk to the health and welfare of Delaware patients, as well as the impact on the cost of health care in Delaware.

The APRN Compact is not about license portability – but about preempting state scope of practice laws

Finally, we understand H.B. 141 has been indicated as necessary to allow Delaware to enter the APRN Compact (H.B. 21). We urge caution as you consider joining the APRN Compact.

Unlike compacts created for other health care professionals, which focus on license portability, the APRN Compact includes provisions that preempt state scope of practice laws. An earlier

[1] MJ Lozada, MA Raji, JS Goodwin, YF Kuo, "Opioid Prescribing by Primary Care Providers: A Cross-Sectional Analysis of Nurse Practitioner, Physician Assistant, and Physician Prescribing Patterns." Journal General Internal Medicine. 2020; 35(9):2584-2592.
[2] Id.
[3] D.J. Mizrahi, et.al. "National Trends in the Utilization of Skeletal Radiography," Journal of the American College of Radiology 2018; 1408-1414.
[4] D.R. Hughes, et al., A Comparison of Diagnostic Imaging Ordering Patterns Between Advanced Practice Clinicians and Primary Care Physicians Following Office-Based Evaluation and Management Visits. JAMA Internal Med. 2014;175(1):101-07.
[5] Sanchez GV, Hersh AL, Shapiro DJ, et al. Brief Report: Outpatient Antibiotic Prescribing Among United States Nurse Practitioners and Physician Assistants. Open Forum Infectious Diseases. 2016:1-4. Schmidt ML, Spencer MD, Davidson LE. Patient, Provider, and Practice Characteristics Associated with Inappropriate Antimicrobial Prescribing in Ambulatory Practices. Infection Control & Hospital Epidemiology. 2018:1-9.

version of the APRN Compact was adopted in 2015 by the National Council of State Boards of Nursing (NCSBN). The effort, however, came to an abrupt halt because it was adopted by only three states, failing to meet the minimum 10 states required to become effective. The NCSBN adopted a new version of the APRN Compact in 2020. Yet this version includes many of the same failed provisions that caused grave concerns in state legislatures across the country from 2015-2019. **To date, it is noteworthy that, per NCSBN, only one state has adopted the most recent version of the APRN Compact, and Delaware is the only state with pending legislation.** Given the inability to garner enough states to adopt the earlier version of the APRN Compact, there is little certainty the new version will find the necessary support to become effective. We urge caution in moving forward in your consideration of adopting a compact that has previously failed to pass muster, legislatively, across the country.

Conclusion

On behalf of the AMA, we urge you to oppose H.B. 141 and H.B. 21 for all the reasons stated above. We believe these bills combined take Delaware in the wrong direction in terms of how health care is delivered in your great state.

Thank you for the opportunity to provide these comments. If you have any questions, please contact Kimberly Horvath, JD, Senior Legislative Attorney, AMA Advocacy Resource Center, at kimberly.horvath@ama-assn.org.

Sincerely,

James L. Madara, MD

cc: Medical Society of Delaware
Mark Thompson
Kim Gomes
Members, House Sunset Committee