SB 1011 written testimony.pdf
Uploaded by: Mary Scott-Herring
Position: FAV

SB 1011– Health Occupations – Nurse Anesthetists – Drug Authority and Collaboration

Before Senate EHEA Committee

Position – Favorable

March 24, 2022

Dear Chair Pinsky and members of the committee:

My name is Mary Scott-Herring, I am a CRNA living in the seventh district. I hold a doctorate degree from the University of Maryland, and I am an assistant professor at Georgetown University. Many of our students live, train, and plan to practice in Maryland. I administer anesthesia at the University of Maryland and Shock Trauma, and prior to that, Johns Hopkins.

CRNAs provide all levels of anesthesia services to all types of patients, from birth to end of life. There are very few practices that you would NOT find a CRNA at the head of the operating room table. If you have ever had anesthesia, chances are it was a CRNA who administered it.

The Comprehensive addiction and Recovery Act, 2016 (CARA) and Support Act, 2018 extended prescriptive ability to other practitioners (Nurse Practitioners (NPs), Physician Assistants (PAs), Clinical Nurse Specialists (CNSs), Certified Registered Nurse Anesthetist (CRNAs), and Certified Nurse-Midwifes (CNMs) until October 1, 2023, for buprenorphine in office-based settings. Without RX authority, MD residents in need of this treatment cannot be treated by CRNAs after that date, whereas patients in DC and VA can, because Maryland CRNAs do not have prescriptive authority.

The pharmacology education of CRNAs is strong. The curricula at Georgetown, Maryland, and Johns Hopkins, contain about TWICE the pharmacy credit hours as our nurse practitioner counterparts. In fact, a minimum of 90 contact hours of advanced pharmacology must be completed prior to graduation, similar to medical education.

All CRNAs must pass a national certification exam and become board certified to practice. One part of the exam covers over 40 classifications of medications. After

becoming board certified, CRNAs must complete 100 continuing education hours every 4 years, and an assessment test every 8. One of the 4 focus areas of that test is pharmacology.

CRNAs have prescriptive authority in twenty-seven states. In addition to my Maryland CRNA license, I have one in Washington DC. where I have independent prescriptive authority. Maryland is the only state in the DMV area that does not have prescriptive authority for CRNAs.

In 2010, the Institute of Medicine proclaimed that barriers to practice should be removed, and that advanced practice registered nurses like CRNAs be permitted to practice to the fullest extent of their education. It is time for Maryland to remove this barrier to practice for CRNAs and grant them prescriptive authority.

Thank you for your time!

Dr. Mary Scott-Herring DNP, MS, CRNA

SB1011 Fav MANA.pdf
Uploaded by: Michelle Duell
Position: FAV

Maryland Association of Nurse Anesthetists

SB1011 – Health Occupations – Nurse Anesthetists – Drug Authority and Collaboration

Before Senate EHEA Committee

Position – Favorable

March 24, 2022

Chair Pinsky and members of the committee, it is my pleasure to submit the following legislation on behalf of the Maryland Association of Nurse Anesthetists in support of SB1011. This bill would clarify that Maryland Nurse Anesthetists may order, administer, and prescribe non anesthetic medication to patients preoperatively, operatively, and postoperatively. Additionally, it would allow for a nurse anesthetist to prescribe, upon discharge, of up to ten days of medication. Similar legislation has been enacted in twenty-seven (27) other states. Below I have provided more detailed information on the issue before the committee.

I respectfully request a favorable report from the committee.

What is Prescriptive Authority?

The terms "prescriptive authority" and "prescription" are not self-explanatory. In its most narrow and "classic" sense, "prescriptive authority" can mean the ability to complete a "prescription form" which a patient takes to a pharmacist to obtain specified drugs or devices. However, within the practice of healthcare delivery, including anesthesia care, it has a much broader meaning.

It is critical that parties dealing with the issues of prescriptive authority have a mutual understanding concerning what they mean when they refer to "prescriptive authority." Different groups, e.g., nurse anesthetists, pharmacists, nurse practitioners, nurse midwives, and state nurses' associations, sometimes have different views concerning what constitutes "prescriptive authority." Prescriptive authority, therefore, can mean

different things to different groups at different times. In addition, prescriptive authority can mean one thing under federal law and another under state law.

For the purposes of SB1011, “prescriptive authority” includes ordering, administering, dispensing, and prescribing all scheduled classes of drugs. However, prescribing a scheduled 5 drug would require a DEA card and is limited to a 10-day supply.

CRNA Practice in MD – The Need for Prescriptive Authority?

Maryland law provides that a Nurse Anesthetist may “administer anesthetics.”

However, in practice, nurse anesthetists exercise their independent judgment regarding a patient’s needs for other medications and in fact, administers a range of non-anesthetic medications.

(see, Exhibit A for a representative list of medication**)**

Md. HEALTH OCCUPATIONS Code Ann. § 8-513

(b) Functions. --

(1) A nurse anesthetist may perform the following functions:

(i) Perioperative assessment and management of patients requiring anesthesia services.

(ii) **Administration of anesthetic agents**;

(iii) Management of fluids in intravenous therapy; and

(iv) Respiratory care.

(See attached a list of possible medications ordered and administered by nurse anesthetists in an orthopedic case. These medications may also be prescribed in many other cases).

In the past, the customary, everyday practices of nurse anesthetists were typically not considered an exercise of prescriptive authority. The common perception was that nurse anesthetists did not need explicit prescriptive authority under state law to select, obtain, or administer the drugs nurse anesthetists use in their practice.

Under federal law, the DEA has not regarded traditional CRNA practice as "prescribing[i]", most nurse anesthetists have not had to register with the DEA. However, over time, more questions have been raised at individual Maryland facilities about the authority of nurse anesthetists to engage in certain activities concerning the utilization of drugs. (see endnote 1)

Therefore, this legislation is necessary to clarify and codify current practices.

Natasha Hopkins, CRNA, DNP
MANA President 2022

27 States Have Granted Prescriptive Authority to Nurse Anesthetists

CRNA Prescriptive Authority**

State	Prescriptive authority arguably "independent"?[1]	Controlled substance authority, if any[2]
Alaska	Yes	Schedules II-V
Arizona	No; under the direction of a physician or surgeon. Does not include the ability to write or issue a prescription for medications to be filled or dispensed for a patient for use outside of facility settings.	“Controlled substances”
Arkansas	No; collaborative practice agreement	Schedules III-V

Colorado	No; written articulated plan that "documents a mechanism for consultation or collaboration with physicians and other appropriate health care providers"	"Controlled substances"
Connecticut	No; physician who is "medically directing" the prescriptive activity is physically present in the facility; also collaborative agreement for Schedules II and III	Schedules II-V
Delaware	Yes	Schedules II-V
District of Columbia	Yes; Includes refill limitation.	Schedules II-V
Florida	No; protocol with supervising physician	Controlled substances (exclusionary formulary)
Hawaii	Yes	Schedules II-V
Idaho	Yes	Schedules II-V
Illinois	No; clinical privileges or a written collaborative agreement	Schedules II-V
Iowa	Yes	"Controlled substances"
Kentucky	No; collaborative agreement	Schedules II-V
Louisiana	No; collaborative practice agreement required for writing prescriptions. Supervision/ direction required for perioperative prescribing (e.g., ordering)	Schedules II-V
Maine	Yes, but limited to CRNAs in CAHs and rural hospitals. Includes supply and refill limitations.	Schedules III, IIIN, IV and V
Massachu-setts	No; written guidelines, authority limited to perioperative period	"Controlled substances"

Minnesota	Yes; only for purposes of providing nonsurgical pain therapies for chronic pain symptoms, CRNAs must have a written prescribing agreement with a physician	Schedules II-V
Missouri	No; collaborative practice arrangement	No controlled substances
Montana	Yes	Schedules II-V
New Hampshire	Yes	“Controlled substances”
New Jersey	No; joint protocol	“Controlled dangerous substances”
New Mexico	Yes	Schedules II-V
North Dakota	Yes	“Controlled substances”
Ohio	No; under the supervision of a physician, dentist or podiatrist and in accordance with facility written policy. Does not include the ability to prescribe a drug for use outside of the health care facility where the nurse practices.	Refers to “drugs,” does not appear to preclude controlled substances
Oklahoma	No reference; “supervision” required for CRNA practice generally.	Schedules II-V
Oregon	Yes	Schedules II-V
South Dakota	Yes	Schedules II-V
Tennessee	No; must provide board of nursing with the “name of the licensed physician having supervision, control and responsibility for prescriptive services rendered by the nurse”	Schedules II-V
Texas	No; protocols or other written authorization	Schedules III-V

Vermont	Yes	No reference; does not appear to preclude controlled substances
Virginia	No; under supervision, and to a patient requiring anesthesia, as part of the periprocedural care of such patient (defined as “the period beginning prior to a procedure and ending at the time the patient is discharged”)	Schedules II-VI
Washington	Yes	Schedules II-V
West Virginia	No; collaborative agreement required for three years	Schedules III-V
Wisconsin	No; collaborative relationship	Schedules II-V
Wyoming	Yes	Schedules II-V

KEY:
NPA: Nurse practice act
BON: Board of nursing

**This chart is not intended to be a complete summary of all requirements for prescriptive authority. See each state’s law or rules for more detailed requirements.

---

[1] Prescriptive authority is arguably "independent" if it is not contingent upon significant physician involvement. If prescriptive authority is not “independent,” type of physician involvement is noted. See each state’s law or rules for specific requirements.

[2] Controlled substance schedules noted, if specified. If prescriptive authority is not “independent,” level of physician involvement may vary based on controlled substance schedule. See each state’s law or rules for specific requirements.

Exhibit A

Commonly Used and Immediately Available Medications for Orthopedic Anesthetics

- **Preop**
  - *PONV prophylaxis*
    - Scopolamine
    - Emend
    - Dexamethasone
  - *Antibiotics*
    - Ancef
    - Vancomycin
    - Clindamycin
    - Gentamycin
    - Flagyl
    - Cefoxitin
- **Intra-op**
  - *Induction*
    - Propofol
    - Etomidate
    - Ketamine
    - Fentanyl
    - Versed
    - Lidocaine
    - Succinylcholine
    - Rocuronium
    - Vecuronium
  - *Maintenance*
    - Morphine
    - Dilaudid

  - Desflurane
  - Sevoflurane
  - Nitrous Oxide
- *Emergence*
  - Sugammadex
  - Neostigmine
  - Glycopyrolate
  - Hydralazine
  - Metoprolol
  - Esmolol
  - Labetolol
  - Ephedrine
  - Phenylephrine
  - Dipenhydramine
- *Emergency*
  - Epinephrine
  - Norepinephrine
  - Calcium
  - Atropine
  - Narcan
  - Flumazenil
  - Heparin
  - Hydrocortisone
  - Albuterol
  - Tranexamix Acid
  - Furosemide
- *Blocks*
  - Ropivicaine
  - Bupivicaine
  - Exparel
  - Duramorph

- **Postop**
  - *Analgesia*
    - Oxycodone
    - Hydrocodone
    - Tramadol
    - Tylenol/Ofirmev
    - Ketorolac
  - *PONV rescue*
    - Zofran
    - Droperidol
    - Haldol

---

[i] The "traditional" practice of nurse anesthetists - ordering and directly administering controlled substances and other drugs preoperatively, intraoperatively, and postoperatively - does not constitute "prescribing" under federal law. This interpretation of federal law is based in part on the definition of "prescription" found in federal Drug Enforcement Administration (DEA) regulations. Those regulations define "prescription" as follows:

> The term *prescription* means an order for medication which is dispensed to or for an ultimate user but does not include an order for medication which is dispensed for immediate administration to the ultimate user. (e.g., an order to dispense a drug to a bed patient for immediate administration in a hospital is not a prescription.) [21 CFR 1300.01(b)(35); this definition was formerly located at 21 CFR 1306.02(f)]

The DEA stated in a preface to proposed regulations published in February 1991 that the direct administration, or the ordering of controlled substances preoperatively, intraoperatively or postoperatively by a nurse anesthetist does not involve prescribing within the meaning of 21 CFR 1306.02(f) (now 21 CFR 1300.01(b)(35)). While the proposed regulations were later withdrawn, the DEA has confirmed that the statement regarding nurse anesthetists in the preface still remains DEA policy. This makes sense, because the DEA's statement was based on existing DEA regulations (e.g., the federal definition of "prescription") that remained in effect despite the withdrawal of the February 1991 proposal.

2022 ACNM SB 1011 Senate Side.pdf
Uploaded by: Robyn Elliott
Position: FAV

AFFILIATE OF
AMERICAN COLLEGE of NURSE-MIDWIVES
With women, for a lifetime®

Committee:	**Senate Education, Health, and Environmental Affairs Committee**
Bill:	**Senate Bill 1011 - Health Occupations - Nurse Anesthetists - Drug Authority and Collaboration**
Hearing Date:	**March 24, 2022**
Position:	**Support**

The Maryland Affiliate of the American College of Nurse-Midwives supports *Senate Bill 1011 – Health Occupations – Nurse Anesthetists – Drug Authority and Collaboration.* The bill would establish prescriptive authority for certified registered nurse anesthetists (CRNAs) within certain parameters specified in law.

We support ensuring our colleagues in other advanced practice registered nursing (APRN) professions can practice to the full extent of their education and training. CRNAs graduate from clinical education programs with the education needed to prescribe medications within their practice areas.

Maryland patients would have more seamless clinical experiences if CRNAs could prescribe medication. In many settings, CNRAs are the primary point of patient contact for anesthesia services. could the flow of clinical services is improved when CRNAs can prescribe for their patients.

Thank you for your consideration of our testimony. We ask for a favorable report on this legislation. If we can provide any additional information, please contact Scott Tiffin at stiffin@policypartners.net.

2022 MDAC SB 1011 Senate Side.pdf
Uploaded by: Robyn Elliott
Position: FAV

Maryland Dental Action Coalition

10015 Old Columbia Road, Suite B-215
Columbia, Maryland 21046
www.mdac.us

Committee: **Senate Education, Health, and Environmental Affairs Committee**

Bill Number: **Senate Bill 1011 - Health Occupations - Nurse Anesthetists - Drug Authority**

Hearing Date: **March 24, 2022**

Position: **Support**

The Maryland Dental Action Coalition (MDAC) supports *Senate Bill 1011 – Health Occupations – Nurse Anesthetists – Drug Authority.* The bill will provide for prescriptive authority to certified registered nurse anesthetists (CRNAs). CRNAs play an important role in the delivery of oral health care, particular for children. When young children need several dental procedures, they sometimes need to be sedated to ensure the dentist can provide the services safely. In these instances, dentists often utilize ambulatory surgery centers to deliver care; and many ambulatory surgery centers utilize CRNAs for sedation and anesthesia care.

Thank you for your consideration of our testimony, and we urge a favorable vote. If we can provide any further information, please contact Robyn Elliott at relliott@policypartners.net or (443) 926-3443.

2022 MNA SB 1011 Senate Side.pdf
Uploaded by: Robyn Elliott
Position: FAV

Committee:	**Senate Education, Health, and Environmental Affairs Committee**
Bill:	**Senate Bill 1011 - Health Occupations - Nurse Anesthetists - Drug Authority and Collaboration**
Hearing Date:	**March 23, 2022**
Position:	**Support**

The Maryland Nurses Association (MNA) supports *Senate Bill 1011 – Health Occupations – Nurse Anesthetists – Drug Authority and Collaboration*. The bill creates parameters for certified registered nurse anesthetists (CRNA) to prescribe medications for their patients during the postoperative period.

CRNAs, just as other advanced practice registered nurses (APRN), should be able to prescribe medications. Their clinical education includes the coursework needed to be a safe and effective prescriber. In some settings, they are the primary point of contact with patients for anesthesia services. It is inefficient when CRNAs cannot directly prescribe to their patients and unnecessarily delay care. Patients deserve and need a more seamless health care system.

We ask for a favorable report on this legislation. If we can provide additional information, please contact Scott Tiffin at stiffin@policypartners.net.

14 - SB1011 - FIN - MBON - LOS.docx.pdf
Uploaded by: State of Maryland
Position: FAV

Maryland

Board of Nursing

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

March 24, 2022

The Honorable Paul G. Pinsky
Chair, Senate Education, Health, and Environmental Affairs Committee
2 West Miller Senate Office Building
Annapolis, MD 21401-1991

RE: SB 1011 – Health Occupations – Nurse Anesthetists – Drug Authority – Letter of Support

Dear Chair Pinsky and Committee Members:

The Maryland Board of Nursing (the Board) respectfully submits this letter of support for Senate Bill (SB) 1011 – Health Occupations – Nurse Anesthetists – Drug Authority. This bill authorizes a nurse anesthetist to prescribe, order, and administer drugs, including controlled dangerous substances, subject to certain limitations.

Certified Registered Nurse Anesthetists (CRNAs) are independent advanced practice registered nurses (APRNs) who plan and deliver anesthesia, pain management, and procedural care to patients of all health complexities. CRNAs must be licensed registered nurses (RNs) with critical care nursing experience. Built on this foundation, they must successfully complete a comprehensive didactic and clinical practice curriculum at an accredited nurse anesthesia program. In current practice, CRNAs provide anesthesia in collaboration with surgeons, dentists, and physician anesthesiologists. The standards of practice for a CRNA allow them the flexibility to practice in hospitals, non – operating room anesthetizing areas, ambulatory surgical centers, and office – based settings.[1]

The pandemic has brought many challenges into the healthcare setting, particularly for Marylanders in rural and underserved communities. There have been incredible limitations for healthcare practitioners in being able to provide adequate and expeditious care. Individuals in need of anesthesia services or pain management care were burdened with finding an available practitioner within their community. The Board believes it is essential to increase access to healthcare services for all Marylanders. Allowing CRNAs the capability to prescribe, order, and administer drugs would provide an additional avenue, among other solutions.

Maryland Health Occupations Article (Title 8) and Code of Maryland Regulations (COMAR) stay silent with respect to CRNAs prescribing controlled dangerous substances and other drugs. In contrast, 27 states authorize CRNAs to order, prescribe, and administer anesthetic and non – anesthetic medications, including our neighboring states Delaware, District of Columbia,

[1] Scope of Nurse Anesthesia Practice. American Association of Nurse Anesthesiology

---

Virginia, and West Virginia. The Board believes this discipline of APRNs are qualified to assess aspects of anesthesia care based on their education, training, licensure, and certification. The provisions of SB 1011 fall within a CRNA's scope and standards of practice.

For the reasons discussed above, the Board of Nursing respectfully submits this letter of support for SB 1011.

I hope this information is useful. For more information, please contact Iman Farid, Health Policy Analyst, at (410) 585–1536 (iman.farid@maryland.gov) or Rhonda Scott, Deputy Director, at (410) 585–1953 (rhonda.scott2@maryland.gov).

Sincerely,

Gary N. Hicks
Board President

The opinion of the Board expressed in this document does not necessarily reflect that of the Department of Health or the Administration.

SB1011 Fav MANA.pdf
Uploaded by: William Kress
Position: FAV

Maryland Association of Nurse Anesthetists

SB1011 – Health Occupations – Nurse Anesthetists – Drug Authority and Collaboration

Before Senate EHEA Committee

Position – Favorable

March 24, 2022

Chair Pinsky and members of the committee, it is my pleasure to submit the following legislation on behalf of the Maryland Association of Nurse Anesthetists in support of SB1011. This bill would clarify that Maryland Nurse Anesthetists may order, administer, and prescribe non anesthetic medication to patients preoperatively, operatively, and postoperatively. Additionally, it would allow for a nurse anesthetist to prescribe, upon discharge, of up to ten days of medication. Similar legislation has been enacted in twenty-seven (27) other states. Below I have provided more detailed information on the issue before the committee.

I respectfully request a favorable report from the committee.

What is Prescriptive Authority?

The terms "prescriptive authority" and "prescription" are not self-explanatory. In its most narrow and "classic" sense, "prescriptive authority" can mean the ability to complete a "prescription form" which a patient takes to a pharmacist to obtain specified drugs or devices. However, within the practice of healthcare delivery, including anesthesia care, it has a much broader meaning.

It is critical that parties dealing with the issues of prescriptive authority have a mutual understanding concerning what they mean when they refer to "prescriptive authority." Different groups, e.g., nurse anesthetists, pharmacists, nurse practitioners, nurse midwives, and state nurses' associations, sometimes have different views concerning what constitutes "prescriptive authority." Prescriptive authority, therefore, can mean

different things to different groups at different times. In addition, prescriptive authority can mean one thing under federal law and another under state law.

For the purposes of SB1011, “prescriptive authority” includes ordering, administering, dispensing, and prescribing all scheduled classes of drugs. However, prescribing a scheduled 5 drug would require a DEA card and is limited to a 10-day supply.

CRNA Practice in MD – The Need for Prescriptive Authority?

Maryland law provides that a Nurse Anesthetist may “administer anesthetics.”

However, in practice, nurse anesthetists exercise their independent judgment regarding a patient’s needs for other medications and in fact, administers a range of non-anesthetic medications.

(see, Exhibit A for a representative list of medication**)**

Md. HEALTH OCCUPATIONS Code Ann. § 8-513

(b) Functions. --

(1) A nurse anesthetist may perform the following functions:

(i) Perioperative assessment and management of patients requiring anesthesia services.

(ii) **Administration of anesthetic agents**;

(iii) Management of fluids in intravenous therapy; and

(iv) Respiratory care.

(See attached a list of possible medications ordered and administered by nurse anesthetists in an orthopedic case. These medications may also be prescribed in many other cases).

In the past, the customary, everyday practices of nurse anesthetists were typically not considered an exercise of prescriptive authority. The common perception was that nurse anesthetists did not need explicit prescriptive authority under state law to select, obtain, or administer the drugs nurse anesthetists use in their practice.

Under federal law, the DEA has not regarded traditional CRNA practice as "prescribing[i]", most nurse anesthetists have not had to register with the DEA. However, over time, more questions have been raised at individual Maryland facilities about the authority of nurse anesthetists to engage in certain activities concerning the utilization of drugs. (see endnote 1)

Therefore, this legislation is necessary to clarify and codify current practices.

Natasha Hopkins, CRNA, DNP
MANA President 2022

27 States Have Granted Prescriptive Authority to Nurse Anesthetists

CRNA Prescriptive Authority**

State	Prescriptive authority arguably "independent"?[1]	Controlled substance authority, if any[2]
Alaska	Yes	Schedules II-V
Arizona	No; under the direction of a physician or surgeon. Does not include the ability to write or issue a prescription for medications to be filled or dispensed for a patient for use outside of facility settings.	“Controlled substances”
Arkansas	No; collaborative practice agreement	Schedules III-V

Colorado	No; written articulated plan that "documents a mechanism for consultation or collaboration with physicians and other appropriate health care providers"	"Controlled substances"
Connecticut	No; physician who is "medically directing" the prescriptive activity is physically present in the facility; also collaborative agreement for Schedules II and III	Schedules II-V
Delaware	Yes	Schedules II-V
District of Columbia	Yes; Includes refill limitation.	Schedules II-V
Florida	No; protocol with supervising physician	Controlled substances (exclusionary formulary)
Hawaii	Yes	Schedules II-V
Idaho	Yes	Schedules II-V
Illinois	No; clinical privileges or a written collaborative agreement	Schedules II-V
Iowa	Yes	"Controlled substances"
Kentucky	No; collaborative agreement	Schedules II-V
Louisiana	No; collaborative practice agreement required for writing prescriptions. Supervision/ direction required for perioperative prescribing (e.g., ordering)	Schedules II-V
Maine	Yes, but limited to CRNAs in CAHs and rural hospitals. Includes supply and refill limitations.	Schedules III, IIIN, IV and V
Massachu-setts	No; written guidelines, authority limited to perioperative period	"Controlled substances"

Minnesota	Yes; only for purposes of providing nonsurgical pain therapies for chronic pain symptoms, CRNAs must have a written prescribing agreement with a physician	Schedules II-V
Missouri	No; collaborative practice arrangement	No controlled substances
Montana	Yes	Schedules II-V
New Hampshire	Yes	“Controlled substances”
New Jersey	No; joint protocol	“Controlled dangerous substances”
New Mexico	Yes	Schedules II-V
North Dakota	Yes	“Controlled substances”
Ohio	No; under the supervision of a physician, dentist or podiatrist and in accordance with facility written policy. Does not include the ability to prescribe a drug for use outside of the health care facility where the nurse practices.	Refers to “drugs,” does not appear to preclude controlled substances
Oklahoma	No reference; “supervision” required for CRNA practice generally.	Schedules II-V
Oregon	Yes	Schedules II-V
South Dakota	Yes	Schedules II-V
Tennessee	No; must provide board of nursing with the “name of the licensed physician having supervision, control and responsibility for prescriptive services rendered by the nurse”	Schedules II-V
Texas	No; protocols or other written authorization	Schedules III-V

Vermont	Yes	No reference; does not appear to preclude controlled substances
Virginia	No; under supervision, and to a patient requiring anesthesia, as part of the periprocedural care of such patient (defined as “the period beginning prior to a procedure and ending at the time the patient is discharged”)	Schedules II-VI
Washington	Yes	Schedules II-V
West Virginia	No; collaborative agreement required for three years	Schedules III-V
Wisconsin	No; collaborative relationship	Schedules II-V
Wyoming	Yes	Schedules II-V

KEY:
NPA: Nurse practice act
BON: Board of nursing

**This chart is not intended to be a complete summary of all requirements for prescriptive authority. See each state’s law or rules for more detailed requirements.

---

[1] Prescriptive authority is arguably "independent" if it is not contingent upon significant physician involvement. If prescriptive authority is not “independent,” type of physician involvement is noted. See each state’s law or rules for specific requirements.

[2] Controlled substance schedules noted, if specified. If prescriptive authority is not “independent,” level of physician involvement may vary based on controlled substance schedule. See each state’s law or rules for specific requirements.

Exhibit A

Commonly Used and Immediately Available Medications for Orthopedic Anesthetics

- **Preop**
  - *PONV prophylaxis*
    - Scopolamine
    - Emend
    - Dexamethasone
  - *Antibiotics*
    - Ancef
    - Vancomycin
    - Clindamycin
    - Gentamycin
    - Flagyl
    - Cefoxitin
- **Intra-op**
  - *Induction*
    - Propofol
    - Etomidate
    - Ketamine
    - Fentanyl
    - Versed
    - Lidocaine
    - Succinylcholine
    - Rocuronium
    - Vecuronium
  - *Maintenance*
    - Morphine
    - Dilaudid

  - Desflurane
  - Sevoflurane
  - Nitrous Oxide
- *Emergence*
  - Sugammadex
  - Neostigmine
  - Glycopyrolate
  - Hydralazine
  - Metoprolol
  - Esmolol
  - Labetolol
  - Ephedrine
  - Phenylephrine
  - Dipenhydramine
- *Emergency*
  - Epinephrine
  - Norepinephrine
  - Calcium
  - Atropine
  - Narcan
  - Flumazenil
  - Heparin
  - Hydrocortisone
  - Albuterol
  - Tranexamix Acid
  - Furosemide
- *Blocks*
  - Ropivicaine
  - Bupivicaine
  - Exparel
  - Duramorph

- **Postop**
  - *Analgesia*
    - Oxycodone
    - Hydrocodone
    - Tramadol
    - Tylenol/Ofirmev
    - Ketorolac
  - *PONV rescue*
    - Zofran
    - Droperidol
    - Haldol

---

[i] The "traditional" practice of nurse anesthetists - ordering and directly administering controlled substances and other drugs preoperatively, intraoperatively, and postoperatively - does not constitute "prescribing" under federal law. This interpretation of federal law is based in part on the definition of "prescription" found in federal Drug Enforcement Administration (DEA) regulations. Those regulations define "prescription" as follows:

> The term *prescription* means an order for medication which is dispensed to or for an ultimate user but does not include an order for medication which is dispensed for immediate administration to the ultimate user. (e.g., an order to dispense a drug to a bed patient for immediate administration in a hospital is not a prescription.) [21 CFR 1300.01(b)(35); this definition was formerly located at 21 CFR 1306.02(f)]

The DEA stated in a preface to proposed regulations published in February 1991 that the direct administration, or the ordering of controlled substances preoperatively, intraoperatively or postoperatively by a nurse anesthetist does not involve prescribing within the meaning of 21 CFR 1306.02(f) (now 21 CFR 1300.01(b)(35)). While the proposed regulations were later withdrawn, the DEA has confirmed that the statement regarding nurse anesthetists in the preface still remains DEA policy. This makes sense, because the DEA's statement was based on existing DEA regulations (e.g., the federal definition of "prescription") that remained in effect despite the withdrawal of the February 1991 proposal.

UNFAVORABLE.SB1011.MDRTL.L.Bogley.pdf
Uploaded by: Laura Bogley
Position: UNF

UNFAVORABLE STATEMENT

SB1011 - Health Occupations - Nurse Anesthetists - Drug Authority

Laura Bogley, JD, Director of Legislation

On behalf of the Board of Directors and members of Maryland Right to Life, I oppose this legislation as written and respectfully request your amendment or unfavorable report.

As written, SB 1011 would diminish existing professional standards of patient care by allowing nurse anesthetists to prescribe controlled dangerous substances and other drugs without consultation with a physician. Without specific language excluding the application of this bill to abortion, nurse anesthetists would be authorized to prescribe lethal chemical abortion drugs, putting more pregnant at risk of injury and death.

Current Maryland law allows only a licensed physician to perform abortions. The State of Maryland must ensure that all pregnant women have access to quality health carewhich includes, at minimum, a complete obstetric examination by a licensed medical physician. Physician examinations are necessary to determine pregnancy, gestational age, underlying medical conditions and risks and any pregnancy complications, including ectopic pregnancies.

By authorizing the distribution of chemical abortion pills without first requiring a full obstetric examination by a licensed physician, this Assembly will be negligent in providing for the health and safety of pregnant women in Maryland.

POSITION STATEMENT- Put Patients Before Profits

Maryland Right to Life (MDRTL) opposes introduction or passage of any bill dealing with the 'scope of practice' of any health care professional which doesn't include language excluding abortion. Scope or independence of practice typically describes the procedures, actions, and processes that a healthcare practitioner is permitted to undertake in keeping with the terms of their professional license.

We take this position because it has long been the strategy of the pro-abortion movement to use a broad definition of that 'scope' as a means to increasing the number of lower health care professionals licensed to provide abortion services. Expanding the number of people who can provide abortion will increase the number of unborn children being killed and will put more women at risk of substandard medical care, injury and death.

One of the few pro-life protections in the Maryland Code is the legal requirement that only a licensed physician may perform abortions. A physician's examination is essential for the health of pregnant women, in order to properly diagnose gestational age, pre-existing medical conditions and potential pregnancy complications, including ectopic pregnancy. 26 women already have been needlessly killed by the use of chemical abortion pills and several due to the lack of a physician's examination and missed diagnosis of ectopic pregnancy.

The abortion industry is asking the state to authorize them to put profits over patients. The medical scarcity in abortion practice is a matter of medical ethics, as 9 out of 10 ob/gyn's refuse to commit abortions because they recognize the scientific fact that a human fetus is a living human being. The abortion industry's solution is three-fold: (1) authorize lower-skilled workers and non-physicians to perform abortion, (2) authorize abortionists to remotely prescribe abortion pills across state lines, AND (3) circumvent the physician requirement by implementing telabortion through a variety of providers.

We strongly urge you to protect pregnant women in Maryland and other states by preserving the physician only requirement for all abortions (both surgical and chemical) and by making it clear that it is not within the scope or independence of practice of lower health care professionals to provide or perform abortion.

BACKGROUND- Commoditizing Abortion

In the early twentieth century, Margaret Sanger founded the American Birth Control League that was later called the Planned Parenthood Federation of America. Sanger was a racist and a eugenicist who believed that birth control and forced sterilization would help to curb the growth of "unfit" populations, particularly African Americans and established her clinic in Harlem, a primarily African-American borough of New York. Sanger, who later served as president of the International Planned Parenthood Federation, was instrumental in legalizing contraception in the United States.

In the late 1960s and early 1970s, underground abortionists wanted to legitimize their abortion practices as "mainstream medical care". Adopting the eugenics philosophy of Margaret Sanger, they realized that while middle and upper class women could afford contraceptive care, abortion could be marketed to poor and minority women as an affordable birth control option. By classifying abortion as "health care", abortionists would be able to recover payment for their services and be incentivized to "sell" more abortions.

Abortionist Dr. Bernard Nathanson, co-founded the National Abortion Rights Action League, to lobby for the legalization of abortion. Abortion advocates assured judges, legislators, and the American public that legalizing abortion would be beneficial to the health and well-being of American women. Proponents argued, if abortion were legal, the procedure would be safer for women because it would become an accepted part of "mainstream medical care," proper surgical procedures would be followed, and skilled and reputable gynecologists and surgeons would perform the procedure.

Dr. Nathanson, who later converted to being a pro-life advocate, admitted that he had taken part in fabricating the number of women who died from illegal "back alley" abortions prior to 1993. What he reported to the Supreme Court and others as tens of thousands of deaths, was in reality only 100 women in 1972. Another 100 women were killed in 1972 as the result of legal abortions, in the few states that authorized exceptions to their abortion prohibitions.

In December 1996, the National Abortion Federation (NAF), with funding from the Kaiser Family Foundation, convened a national symposium to explore how CNMs, NPs, and PAs could participate more fully in abortion service delivery nationwide. In 1997 they presented a symposium entitled, "The role of physician assistants, nurse practitioners, and nurse–midwives in providing abortions: strategies for expanding abortion access." (National symposium, Atlanta, GA, 13-14 December 1996. Washington, DC: National Abortion Federation; 1997).

There is even a 'tool kit' entitled "Providing Abortion Care: A Professional Tool Kit for Nurse-Midwives, Nurse Practitioners and Physician Assistants" (2009). It was developed as a guide for health care professionals who want to include abortion as being within their scope of practice.

<u>This session the Maryland Legislative Agenda for Women states that their goal in part is to expand access to abortion by authorizing "advanced practice clinicians" including nurse practitioners, certified nurse midwives, nurse midwives and physicians assistants to provide abortion, and to ensure those abortions are covered by health insurance, especially for minority women through taxpayer funded Medical Assistance.</u>

In recent years, MDRTL has opposed several bills attempting to expand the scope of practice of doulas, certified nurse midwives, and even pharmacists, that was broad enough to include participation in abortion (either surgical or chemical) and authorization for reimbursement through the Maryland Medical Assistance Program (Medicaid). These bills would divert public funds away from other legitimate health care services of these practice areas.

"D-I-Y" ABORTIONS

While the Supreme Court imposed legal abortion on the states in their 1973 decisions Roe v. Wade and Doe v. Bolton, the promise was that abortion would be safe, legal and rare. But in 2016 the Court's decision in *Whole Woman's Health v. Hellerstedt*, prioritized "mere access" to abortion facilities and abortion industry profitability over women's health and safety.

The proliferation of chemical abortion pills is taking abortion further outside the spectrum of "health care" as most women are prescribed these lethal pills without the benefit of a physician's examination. Pregnant women and girls are left alone to hemorrhage until their unborn child is flushed out of their system and then flushed into public sewerage.

Despite the fact that Maryland law permits only a licensed physician to perform abortions, the abortion industry is taking advantage of recent telemedicine policies adopted to manage Covid-19 related medical scarcity issues. Abortionists now serve a tangential role either on paper as medical directors for clinics or as remote prescribers of abortion pills, even across state lines.

Chemical Abortion makes up 40% of current pregnancies in the United States. With the broad application of telemedicine policies that enable "telabortion", or the remote sale and distribution of chemical abortion pills, that number is expected to increase to as much as 75%.

The abortion industry itself has referred to the use of abortion pills as "Do-It-Yourself" abortions, claiming that the method is safe and easy. But chemical abortions are **4 (four) times more dangerous than surgical abortions**, presenting a high risk of hemorrhaging, infection, and even death. With the widespread distribution of chemical abortion pills, the demand on Emergency Room personnel to deal with abortion complications has increased 250%.

Last session, MDRTL advised legislators that the Biden administration intended to remove Food and Drug Administration (FDA) REM safeguards that prohibited the remote sale of chemical abortion pills and required a physician's examination in order to obtain abortion pills. Those FDA safeguards were officially removed in December 2021, leaving pregnant women and girls exposed to the predatory TELABORTION practices of the abortion industry.

Many of the bills MDRTL opposed in 2021 involved the establishment of distribution chains for chemical abortion pills including through telehealth appointments, pharmacists, vending machines and school-based health centers. Pro-life legislators were unsuccessful in attaching pro-life amendments to these bills yet still supported broad telehealth authorization and provider reimbursements.

STATE OF PREGNANCY CARE IN 2022

The practice of abortion in America has become the **"red light district"** of medicine, populated by dangerous, substandard providers. With the proliferation of chemical abortion pills, the abortion industry itself has exposed women to "back alley" style abortions, where they bleed alone without medical supervision or assistance.

Legalizing abortion has failed to eliminate substandard medical care, kept people without medical licenses from performing abortions, ended the use of dirty, unsanitary procedure rooms and unsterile, inadequate instrumentation, ensured competent post-abortive care, or prevented women from dying from unsafe abortions.

More importantly, legalizing abortion has failed to provide for the legitimate reproductive health care needs of women. Abortion blood money is fueling political campaigns and dictating the prioritization of public funding for abortion, diverting funds from legitimate reproductive health care including reliable birth control methods, quality prenatal care, parenting education and support, foster care reform and affordable adoption programs.

The state has failed to analyze and report data examining the connection between abortion and maternal health and mortality, including subsequent preterm births, miscarriages and infertility. The state participates in normalizing abortion, ignoring the mental health needs of large numbers of women and girls suffering from Post-Abortion Syndrome including severe depression and anxiety.

CONCLUSION

Women in Maryland deserve better than more of the same abortion politics. State lawmakers must take immediate action to confront and remedy the abortion industry's dangerous practices and the rejection of medically appropriate health and safety standards of patient care.

For these reasons, Maryland Right to Life urges your amendment to exclude abortion purposes, including the prescription and distribution of chemical abortion drugs from the application of this bill. If you cannot guarantee that this bill will not expand abortion access, we ask you to reject the bill as a whole.

MSA Letter of Information - House Bill 55 & Senate

Uploaded by: Barbara Brocato

Position: INFO

MARYLAND SOCIETY OF ANESTHESIOLOGISTS

Date: March 24, 2022

Committee: The Honorable Senator Paul Pinsky, Chair
Senate Education, Health and Environmental Affairs Committee

Bill: Senate Bill 1011- Health Occupations - Nurse Anesthetists - Drug Authority

House Bill 55 - Health Occupations - Nurse Anesthetists - Drug Authority

Position: Letter of Information

The Maryland Society of Anesthesiologists (MSA) is a State component society of the American Society of Anesthesiologists (ASA). The MSA is a non-profit physician organization dedicated to promoting the safest and highest standards of the profession of anesthesiology in the State of Maryland. Our purpose is to advocate on behalf of our members for their patients through policy, education, and research.

As introduced Senate Bill 1011 "authorizes a nurse anesthetist to prescribe, order, and administer drugs, including specified controlled dangerous substances (CDS), subject to certain limitations." The Bill reflects the amendments added to House Bill 55.

We appreciate the Maryland Association of Nurse Anesthetists for working together with us on areas of concern with the bill as introduced. The outcome of those discussions are the House Sponsor amendments that:

1. Removed references to "Podiatry" throughout the bill, and
2. Delete the following lines as it pertains to the prescriptive authority:
   House Bill 55 (1st Reader) Page 2, line 29 thru Page 3, line 2:
   [(IV) WITHOUT OBTAINING APPROVAL FROM A PRACTITIONER WITH WHOM THE NURSE ANESTHETIST COLLABORATES UNDER SUBSECTION (C) OF THIS SECTION.]

With these amendments included in HB55 as it passed the House and reflected in SB1011 as introduced, the MSA takes a neutral position. We thank the proponents and Sponsor for addressing our concerns.

For additional information please contact Dan Shattuck, Executive Director at mdashq@gmail.com.