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.

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[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

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[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.