CNS Prescriptive Authority Fact sheet 2021.pdf

Uploaded by: Claudia Tilley
Position: FAV

CNS Prescriptive Authority Fact Sheet

Chesapeake Bay Affiliate of the National Association of Clinical Nurse Specialists

What is a CNS?

A Clinical Nurse Specialist (CNS) is a Master or Doctorate prepared Advanced Practice Registered Nurse (APRN) whose role is to improve outcomes in patient care. The CNS is an expert in clinical practice, patient education, research, evidence-based practice, consultation, and influences the three spheres of impact: patient care, nursing, and systems.

What is Prescriptive Authority?

Prescriptive authority is the ability to order medicines, imaging, bloodwork, physical therapy, occupational therapy, home care, home health supplies, hospice care, and more.

Why do Marylanders need CNS Prescriptive Authority?

- Expanded Access to Care - especially for vulnerable populations
  - Close the gaps that the COVID pandemic has exposed in our healthcare system
  - Address Health Equity - equal access to high-quality care for underserved populations
- Create cost savings for hospital, patients, insurance companies and communities
- Improve patient safety - prevent delay in needed care
  - Improve health care delivery by assisting with transitions from hospital to home care

There is a Disconnect between Federal and Maryland Law

- CNSs have authority to prescribe buprenorphine (Suboxone/Subutex) through the SUPPORT Act.
- CNSs are permanently authorized by the CARES Act to order home care, home health supplies, hospice care, and can be reimbursed for services.

Maryland is at risk for losing CNSs

Pennsylvania, Virginia, Delaware, D.C. and 36 other states have CNS prescriptive authority.

Support prescriptive authority for Clinical Nurse Specialists and build a better healthcare system for Maryland

Scan for more information & real-world stories. Questions?
MD.CNS.RX@gmail.com
https://cbanacns.enpnetwork.com

MAAPC proudly supports our CNS Colleagues!
TheMAAPC@gmail.com
https://maapconline.enpnetwork.com

CNS Prescriptive Authority SB 513 Written Testimon

Uploaded by: Claudia Tilley

Position: FAV

Support

SB 513 Health Occupations – Clinical Nurse Specialists – Prescribing Authority

February 8, 2022
I support the passage of SB 513 Health Occupations – Clinical Nurse Specialists – Prescribing Authority sponsored by Senator Eckardt.

I am a Clinical Nurse Specialist with 26 years of experience in nursing. I am the Patient Education Specialist and diabetes educator for UM Shore Regional health which provides healthcare to five counties on Maryland's eastern shore. As the diabetes educator I am consulted for hospitalized patients who have uncontrolled diabetes or hospitalized with an insulin pump.

When consulted for diabetes education, often a hospitalist (a hospital-based physician or nurse practitioner) will either ask my opinion or be receptive to my suggestions in relation to diabetes related medications and other orders (like glucose monitoring frequency) during a patient's hospitalization and when preparing for discharge.

There are also times when a hospitalist will ask for an endocrinology provider consult for medication and/or management recommendations for a patient. In this case the endocrine nurse practitioner or the endocrinologist, who see patients in clinic, must arrange time away from clinic to travel to the hospital for the consult. There are occasions where this may be several days. Waiting for the endocrinology consult can delay appropriate care and/or discharge leading to elevated inpatient costs. Delayed discharge of one patient delays the availability of a bed for another patient waiting in the emergency room. As a Clinical Nurse Specialist with prescriptive authority, I can fill this gap in care for these patients, save the patients extra time in the hospital, and save the hospital money.

In addition, anytime a patient is admitted to the hospital with an insulin pump, the diabetes educator is consulted. According to hospital policy, patients who wear insulin pumps may continue using their pump while hospitalized as long as they meet specific criteria and are mentally sound to safely manage their pump, however, they need an order by a provider for this. I have encountered times where the hospitalist did not complete insulin pump orders in a timely fashion on admission, but other orders for medication have been written. This is a huge safety issue in that a patient could have an insulin infusing through their pump and also have orders for insulin in the electronic medical record. The risk is that the patient could receive an extra dose of insulin which may cause a rapid drop in blood sugar. Hospitalists, like nurses, are stretched thin, especially during this pandemic. They often are challenged to see a large volume of patients daily. As a Clinical Nurse Specialist with prescriptive authority, I can write these orders and be sure that our hospitalized patients with insulin pumps have safe and appropriate orders for care.

Allowing prescriptive authority for clinical nurse specialists through the passage of SB 513 will expand the availability of expert providers in the healthcare system which will fill gaps in care, improve outcomes and provide cost savings to the hospitals as well as the patients we serve. I urge you to please vote in favor of this bill to improve access to care for all Marylanders including the rural and under-served area of the eastern shore.

Sincerely,
Claudia Tilley MSN, RN, APRN-CNS, AGCNS-BC

CNS Prescriptive Authority Fact sheet 2021.pdf

Uploaded by: Gena Stanek

Position: FAV

CNS Prescriptive Authority Fact Sheet

Chesapeake Bay Affiliate of the National Association of Clinical Nurse Specialists

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MAAPC proudly supports our CNS Colleagues!
TheMAAPC@gmail.com
https://maapconline.enpnetwork.com

Stanek_Support_Written_testimony-Senate_513_final.

Uploaded by: Gena Stanek

Position: FAV

Board Member at Large: Gena Stiver Stanek, MS, RN, APRN-CNS, CNS-BC

Written Testimony of Support

Senate Bill 513 Clinical Nurse Specialist – Prescribing Authority

February 3, 2022

I writing in support of Senate Bill – 513. I've been a Clinical Nurse Specialist (CNS) (an Advanced Practice Nurse like a Nurse Practitioner or Nurse Anesthetist) for over 36 years, 27 of which were at the University of Maryland Medical Center, R. Adams Shock Trauma Center. I currently work in the office of Clinical Practice Professional Development at University of Maryland Medical Center, Baltimore, Maryland and have so for the last 8 years.

I am writing as a board member at large of The Chesapeake Bay Affiliate of the National Association of Clinical Nurse Specialists (CBANACNS) | ENP Network.

A clinical nurse specialist is an advanced practice registered nurse who is prepared at either the Masters level or Doctorate level. We are experts in clinical practice, patient education, improving practice to be in line with the latest research, etc.. We also have patient care related responsibilities supporting the frontline nurses as they care for patients. Our graduate education has the same pharmacology and prescriptive components as our Nurse Practitioner (NP) colleagues as well as other courses unique to the CNS role.

There have been many times when prescriptive authority would have been helpful in expediting care. For example, when I work with frontline nursing staff and a patient has a skin problem, wound care need or a special bed to prevent skin problems, I must go to another advanced practice nurse (Nurse Practitioner) or a physician to write that order. Similarly, if a patient needs a walker to go home or another piece of medical equipment or a device I might need to interrupt a busy surgeon who may be in the operating room to obtain the prescription when I have the education, skill and knowledge to prescribe it efficiently. This can delay a discharge and tie up a bed preventing an ER patient from getting moved to an inpatient room. Coordination of care and expertise are needed to give our patients the best possible care and is essential now more than ever.

Allowing Advanced Practice Registered nurses to practice to the full extent of their education and preparation is critical to meeting the Institute of Medicine's 2020 Future of Nursing Recommendations "to remove barriers to practice and care".

We are looking to this committee to pass this bill which will help improve patient outcomes and care coordination. Please feel free to reach out if I can assist in any way at gstanek1@verizon.net or gstanek@umm.edu

I plan to attach the below:

- A CNS fact sheet with the importance of the Clinical Nurse Specialist Role related to prescriptive authority
    - Note: QR Code in left lower corner of the fact sheet takes you to pertinent supporting documents and real stories told by Maryland CNSs.

Thank you in advance for your support and interest in healthcare improvements.

Sincerely,
Gena Stiver Stanek, MS, RN, APRN-CNS, CNS-BC
Board Member at Large CBANACNS

HFAM Testimony SB 513.pdf
Uploaded by: Joseph DeMattos
Position: FAV

TESTIMONY BEFORE THE
SENATE EDUCATION, HEALTH, AND ENVIRONMENTAL AFFAIRS COMMITTEE
February 10, 2022
Senate Bill 513: Health Occupations - Clinical Nurse Specialists - Prescribing Authority
Written Testimony Only

POSITION: Favorable

On behalf of the members of the Health Facilities Association of Maryland (HFAM), we appreciate the opportunity to express our support for Senate Bill 513. HFAM represents over 170 skilled nursing centers and assisted living communities in Maryland, as well as nearly 80 associate businesses that offer products and services to healthcare providers. Our members provide services and employ individuals in nearly every jurisdiction in the state.

Senate Bill 513 defines a “clinical nurse specialist” and “practice as a clinical nurse specialist” for the purpose of authorizing a clinical nurse specialist to prescribe drugs and durable medical equipment under regulations adopted by the State Board of Nursing. This legislation also alters the definition of an “authorized prescriber” to include clinical nurse specialists, and authorizes a licensed physician to personally prepare and dispense a prescription written by a clinical nurse specialist.

Allowing clinical nurse specialists, as defined in this legislation, to have prescriptive authority can give these nurses the ability to positively impact the quality of healthcare delivery for the people that they serve. Patients and residents can receive faster access to treatments, improved communications, greater efficiency, and cost effectiveness. Nurses are often more directly involved in day-to-day care and thus are more likely to involve patients in the decision-making process about their care.

Across healthcare settings in Maryland and throughout the country, we are fighting this most recent surge of the COVID-19 pandemic with fewer people working in healthcare, and particularly fewer people working in skilled nursing and rehabilitation centers. Workforce recruitment and retention was a challenge before the pandemic and it has only grown more challenging over the last two years.

Tens of thousands of healthcare workers in Maryland have left the field since the start of the pandemic. Licensed healthcare professionals are scarce and all healthcare settings are competing for employees from the same labor pool. Given the workforce crisis we face, it is imperative that we ensure continued access to care and treatment from qualified professionals.

For these reasons, we request a favorable report from the Committee on Senate Bill 513.

Submitted by:

Joseph DeMattos, Jr.
President and CEO
(410) 290-5132

SB513_MONL_fav.pdf
Uploaded by: Lorraine Diana
Position: FAV

February 4, 2022

Senator Adelaide Eckardt
James Senate Office Building, Room 322
11 Bladen St., Annapolis, MD 21401

To Senator Eckardt:

On behalf of the Maryland Organization of Nurse Leaders (MONL), we are writing in support and are favorable of Maryland Senate Bill 513, *The Health Occupations-Clinical Nurse Specialists (CNS)-Prescribing Authority*. The proposed CNS prescribing authority bill authorizes a CNS to prescribe drugs and durable medical equipment within the Maryland State Board of Nursing regulations. The passage of this bill will allow the CNS to be included as an "authorized provider" under the Maryland Pharmacy Act. The CNS is considered an Advanced Practice Registered Nurse (APRN) and is one of four APRN roles that provide necessary healthcare access and care for patients across the state of Maryland. This issue has been a top priority for many years, focused on allowing APRNs to practice to the fullest extent of their education and license.

MONL is comprised of Nurse Leaders from a variety of healthcare settings, including acute care, post-acute care, and academia. MONL's mission of providing direction to the environment that shapes health care delivery in the state of Maryland, has had a positive impact in Maryland for many years.

The Maryland Organization of Nurse Leaders urges legislative leaders to Support SB 513. MONL represents Maryland's Nurse Leaders and nursing constituents across the state, we are confident you will represent on our behalf at this vital time in healthcare, two years into an international pandemic. Thank you for your time, attention, and support.

Sincerely,

Cody Legler, DNP, APRN, President MONL

MONL, Inc.
10045 Baltimore National Pike
A7 PMB 1047
Ellicott City, MD 21042

SB513supportwrittentestimonyLorraine2.10.22.pdf
Uploaded by: Lorraine Diana
Position: FAV

SUPPORT
SB513 Health Occupations Clinical Nurse Specialists Prescribing Authority

February 10, 2022

Good afternoon, Mister Chairman and EHEA Committee. Thank you for the opportunity to present testimony today.

I am offering testimony in support for SB 513.

My name is Lorraine Diana. I am a certified family nurse practitioner and have practiced in Maryland for 41 years.

There are 3 healthcare crises in Maryland. Covid is at the forefront of conversation, as is the critical nursing shortage. The other crisis—equally as grave as Covid—is the opioid crisis.

We have 310 clinical nurse specialists in Maryland. 24.5% of CNSs are in rural areas.

40% of CNSs work in hospital based acute care and outpatient settings, like Sharon and Marianne.

CNSs in hospitals rose to the occasion to provide superior and tireless care to Covid patients but were handicapped by not being able to prescribe medications, rehab care, home health and home medical equipment.

You heard from my colleagues today and how they must rely upon other providers to obtain necessary and sometimes lifesaving prescriptions.

60% or 188 of our CNSs are certified as psyche mental health providers and are located throughout Maryland.

Under the Federal SUPPORT ACT of 2018, CNSs were authorized to prescribe medications to treat opioid use disorder, but Maryland law prohibits CNSs from prescribing.

Since 1991, under COMAR, Psyche mental health CNSs manage therapies including medications for their patients without the ability to ***prescribe*** those medications.

This causes a gap for patients with opioid use disorder and disproportionately affects the poor and minorities especially in Baltimore City and rural Maryland, who would benefit from treatment with suboxone prescribed monthly, rather than methadone dispensed daily.

Adding the ability to prescribe suboxone for CNSs will allow 310 ***more*** providers to address the Maryland opioid crisis.

CNSs are highly educated and nationally certified and must conform to standards for practice determined by their certifying organizations.

CNSs must recertify in their specialties every 5 years just like nurse practitioners and must complete 25 hours of continuing education in Pharmacology every 5 years to remain certified.

We recognize the concerns the Radiologists expressed regarding wording in the proposed regulations for CNSs and have submitted an amendment to this bill that is identical to the recommendations made by the Radiologists.

40 states and the VA Medical System have granted CNSs prescribing authority. It's time to close the gap in Maryland

Thank you. I ask for a favorable report on SB 154.

Thank you, Senator Eckardt, for sponsoring this bill.

Sincerely,
Lorraine Diana, MSN, RN, CRNP
Legislative Co Chair, The Maryland Academy of Advanced Practice Clinicians
Ldianaart@aol.com

FINAL_Statement_Letter Support of SB0513_02-08-202

Uploaded by: Maranda Jackson-Parkin

Position: FAV

02/08/2022

To whom it concerns: Maryland Senate SB0513

First, I would like to thank chairman Pinsky, Vice chair Kagan and members if the committee.

In the State of Maryland, we are very fortunate to have two Clinical Nurse Specialist Graduate programs, specifically the University of Maryland and Johns Hopkins School of Nursing. Combined these institutions graduate an estimated 30-35 students annually that are able to "sit-for" for the national board to become certified as a clinical nurse specialist. A Clinical Nurse Specialist (CNS) is a licensed registered Nurse that has completed a graduate level program (Masters or Doctoral) from an accredited educational institution and has passed a national certification examination.

As one of the four advanced practice roles, the core educational requirements for the CNS programs have some "overlap". Advanced Pharmacology, Advanced physiology and pathophysiology, and Advanced physical assessment are the 3-core course for all APRNS. This is in addition to prior professional practice as a registered nurse (RN), academic coursework specific for practice, and the completion of direct clinical practice often taking 3-5 years to complete. For the CNS in a Doctor of Nursing practice (DNP) (BSN to DNP) program 1080 clinical hours are required for graduation. Then a national board exam must be passed to gain certification for clinical practice. To maintain the certification and support practice, CNS must complete 150 continuing education units are required every 5 years of which 25 are pharmacology. The CNS possesses the educational knowledge, clinical reasoning, and decision-making however, they are unable to prescribe.

The cornerstone of CNS practice is collaboration. The healthcare environment requires a team-based approach, also known as "multi-disciplinary care". The National Academies of Medicine support this as a "best practice" to achieve safe, effective, and quality patient outcomes. The unique knowledge and skill each discipline brings to the healthcare environment is respected and utilized to meet the needs of the individual. The discipline of nursing offers a holistic approach and to discount the unique value, knowledge, and strength of nursing by comparison to other disciplines is to diminish the value of them all. COVID-19 has taught us the value and power of a multi-disciplinary approach and the need to practice to the full extent of education. Granting prescriptive authority will optimize CNS practice.

In conclusion, as a dually certified CNS, NP, and assistant professor teaching in a CNS program I am aware of the practice limitations. Students expressing interest in the CNS role

acknowledge this limitation, frequently opting for the NP role. Granting prescriptive authority to CNS will help retain some of the prior mentioned CNS graduates in the State of Maryland versus losing them to practice in Delaware, West Virginia, Virginia, or the District of Columbia where CNS have been granted prescriptive authority. Support the CNS role in Maryland by helping to retain clinical nurse specialist and support their practice within the state by approval of SB0513.

Thank you for your time and attention.
Respectfully,
Maranda Jackson-Parkin, PhD, RN, CRNP, ACNP, CCNS, CCRN-K, CNE

NACNS letter of SUPPORT SB513.pdf
Uploaded by: Marianne Hiles
Position: FAV

Support

SB 513: HEALTH OCCUPATIONS – CLINICAL NURSE SPECIALISTS – PRESCRIBING AUTHORITY.

January 26, 2022

The National Association of Clinical Nurse Specialists (NACNS) **SUPPORTS** *Senator Adelaide Eckardt's Senate Bill 513: HEALTH OCCUPATIONS – CLINICAL NURSE SPECIALISTS – PRESCRIBING AUTHORITY*.

Clinical Nurse Specialists (CNSs) are advanced practice registered nurses (APRNs) who practice at an advanced level of nursing. This practice is enhanced through well-grounded knowledge and understanding of advanced pharmacologic principles (NACNS, 2021). NACNS (2019) supports autonomous prescribing of "medications, therapeutics, diagnostic studies, equipment, and procedures to manage the health issues of patients." (pg. 26).

"The CNS provides advanced direct and indirect care to complex and vulnerable populations in a variety of health care settings" (NACNS, 2021). CNSs need prescriptive authority in order to provide comprehensive and safe patient care. NACNS endorses prescribing and ordering privileges be granted by State Boards of Nursing and/or health care systems for CNS practice (NACNS, 2021).

As the national organization for Clinical Nurse Specialists, we ask the Committee for a favorable vote on SB 513.

Sincerely,

Jan Powers PhD, RN, CCNS, CCRN, NE-BC, FCCM, FAAN
President, NACNS
11130 Sunrise Valley Dr. #350
Reston, VA 20191
Office: 703-436-0092
jpowers@nacns.org
president@nacns.org
https://nacns.org

National Association of Clinical Nurse Specialists. (2019). *Statement on Clinical Nurse Specialist Practice and Education* (3rd ed.). Author.

National Association of Clinical Nurse Specialists. (2021). *2021 National Association of Clinical Nurse Specialists' Position Statement on Prescribing for the Clinical Nurse Specialist*. https://nacns.org/advocacy-policy/position-statements/national-association-of-clinical-nurse-specialists-position-statement-on-prescriptive-privilege-for-the-clinical-nurse-specialist/

SUPPORT for SB513- FREDERICK HEALTH.pdf

Uploaded by: Marianne Hiles
Position: FAV

Frederick Health

Frederick Health
400 West Seventh Street
Frederick, MD 21701
P 240-566-3300

Senator Adelaide Eckardt
322 James Senate Office Building
11 Bladen Street
Annapolis, MD 21401

Re: SB 513: Health Occupations-Clinical Nurse Specialists-Prescribing Authority

February 7, 2022

Dear Senator Eckardt,

As an organization whose mission is to positively impact the well-being of every individual in our community, I am writing to express our SUPPORT for Senate Bill 513: Health Occupations-Clinical Nurse Specialists-Prescribing Authority.

Frederick Health is committed to evidence-based care in our hospital and in our community. It is our team of health professionals, especially our Clinical Nurse Specialist team, who have expertise in the delivery of high-quality healthcare that impacts outcomes for the patients we serve. As care has transitioned out of the hospital and into the community, gaps in care have emerged especially in remote areas with limited access to qualified health care providers. Care provided in the community to avoid hospital readmission has become a priority. Outpatient clinics can care for patients until they can see their provider and keep patients out of the hospital, improving their health and well-being. These clinics could be run by Clinical Nurse Specialists, however at this time, they cannot adjust medications, order durable medical equipment, home health care or other necessary therapies to support patients at home.

In order to continue our mission to positively impact the well-being of every individual in our community, we fully support the Senate Bill 513 granting prescriptive authority to Clinical Nurse Specialists.

Sincerely,

Cheryl Cioffi, DNP, RN, NEA-BC, FACHE
Senior VP, Chief Operating Officer

SUPPORT SB513 Marianne Hiles-Written Testimony.pdf

Uploaded by: Marianne Hiles

Position: FAV

SUPPORT

SB 513 Clinical Nurse Specialists-Prescribing Authority

February 7, 2022

Improving outcomes in pregnancy

I have been a Registered Nurse (RN) for 29 years and a Clinical Nurse Specialist (CNS) since 2011. I have spent the majority of my 29 years in nursing caring for pregnant and postpartum women and their newborns. My graduate and post-graduate work as a CNS has been in the care of this population of patients with a particular interest in pregnant and postpartum patients impacted by opioid use disorder (OUD) and their newborns experiencing neonatal abstinence syndrome (NAS). Pregnancy is a critical time point in a woman's life. Pregnant women do not wake up and decide they are going use drugs. Women with OUD become pregnant. They have a chronic relapsing disease that impacts not only the woman but her newborn. Women with OUD know this and are motivated to change during pregnancy. We need more providers to help them.

While providers in Maryland who can prescribe buprenorphine for OUD are increasing, most providers are not educated in the needs of pregnant patients and the impact of neonatal abstinence syndrome on the newborn. Our wonderful OB providers are experts in the care of pregnant women, but often not in the treatment of OUD. Additionally, MANY do not have the necessary waiver training to prescribe buprenorphine. This is particularly challenging when pregnant patients come to the hospital in withdrawal from heroin, fentanyl, and other opiates. There is often no one able to start our pregnant patients on medications for OUD, to manage their withdrawal or their complex medical needs related to OUD.

It is I, as a CNS, who advise the OB providers on the proper care and medications to support the patient while in the hospital. It has been my job to develop polices, order-sets, and procedures for pregnant women with OUD when they come to the birthing unit and through their postpartum stay.

It is evident there is a gap in care in both the hospital and community for pregnant patients with OUD.

Federally, the SUPPORT ACT of 2018, granted CNSs the ability to prescribe buprenorphine to patients, but in the state of MD, I cannot without prescriptive authority.

One of the main reasons I became a CNS was to improve outcomes for women and newborns impacted by OUD, including prescribing treatment for this chronic relapsing disease. Integrating OUD into provider practices is much needed in our communities, but there is still a gap in this care to pregnant women. Having prescriptive authority would fill this gap by allowing me and other CNSs to provide buprenorphine therapy to pregnant women and support our OB providers in the care of this high-risk population.

I need prescriptive authority to impact the outcomes of pregnant and parenting patients in Frederick County and the state of Maryland and to improve the outcomes in newborns and families impacted by OUD. I URGE you to vote favorably for SB 513 in order to make a difference for women and families in our state.

Most Sincerely,
Marianne Hiles, MSN, RN, APRN-CNS, ACNS-BC, RNC-LRN, C-EFM
Clinical Nurse Specialist

Home Address:
22239 Trentworth Way
Clarksburg, MD 20871
mlhiles@earthlink.net

Work Address:
Frederick Health Hospital
400 West 7th Street
Frederick, MD 21701

Favorable Testimony

Uploaded by: Nicole Livanos

Position: FAV

NCSBN
Leading Regulatory Excellence

111 E. Wacker Drive, Suite 2900 · Chicago, IL 60601-4277

February 10, 2022

The Honorable Senator Paul G. Pinsky, Chair
Education, Health and Environmental Affairs Cmte.
2 West, Miller Senate Office Building
Annapolis, Maryland 21401

Honorable Senator Cheryl C. Kagan, Vice Chair
Education, Health and Environmental Affairs Cmte.
2 West, Miller Senate Office Building
Annapolis, Maryland 21401

Support of: Senate Bill 513- CNS Prescribing

Dear Chair Pinsky, Vice Chair Kagan, and Distinguished Members of the Education, Health, and Environmental Affairs Committee:

On behalf of the National Council of State Boards of Nursing, I am writing to express our support for Senate Bill 513, a bill to provide for prescriptive authority for the advanced practice registered nurse (APRN) role of clinical nurse specialist (CNS). As an independent, not-for-profit organization representing the board of nursing from each state, including Maryland, and author along with 40 other organizations of the 2008 Consensus Model for APRN Regulation (Consensus Model), we are supportive of the enactment of Senate Bill 513 to further align Maryland with the national standards for practice and regulation of the CNS role.

Clinical Nurse Specialists are one of four APRN roles and are expert clinicians who are educated and trained to diagnose and treat illness, manage disease, and prevent illness and risk behaviors among individuals, groups and communities. Clinical nurse specialists are educated at a master's level or higher in their role and population foci, have completed courses in advanced pharmacology, advanced physiology, and advanced physical assessment, and obtain and maintain national certification. This is identical to those standards met by their clinical nurse practitioner colleagues in Maryland who are valued and safe prescribers.

Decades of research demonstrate APRNs are safe practitioners with quality patient outcomes. Evidence of this safe and quality care can be witnessed today across Maryland, where patients enjoy safe and independent care provided by all four APRN roles. Granting prescriptive authority for CNS' will increase access to care, allow CNS' to practice to the full extent of their education and certification, all while maintaining safe practice.

Thank you for the opportunity to testify on this important matter.

Sincerely,

Nicole Livanos, JD MPP
Associate Director, State Advocacy and Legislative Affairs
National Council of State Boards of Nursing

312.525.3600
ncsbn.org

SB513 Thurman written testimony.pdf

Uploaded by: Paul Thurman

Position: FAV

SB513: Senator Eckardts HEALTH OCCUPATIONS – CLINICAL NURSE SPECIALISTS – PRESCRIBING AUTHORITY

February 8, 2022

I support the passage of ***SB513: Senator Eckardts HEALTH OCCUPATIONS – CLINICAL NURSE SPECIALISTS – PRESCRIBING AUTHORITY.***

I am currently a Nurse Scientist at the R Adams Cowley Shock Trauma Center, University of Maryland Medical Center in Baltimore, MD and an Assistant Professor in the Adult-Gerontology Acute Care Nurse Practitioner (ACNP)/Adult-Gerontology Clinical Nurse Specialist (CNS): Trauma/Critical Care/Emergency Doctor of Nursing Practice (DNP) that is a blended ACNP/CNS practice-focused doctorate. Prior to this, I was a Clinical Nurse Specialist (CNS) for the Trauma Resuscitation Unit, Multi Trauma Critical Care Unit, Lung Rescue Unit, and Hyperbaric Oxygen Chamber from 2007 – 2019. I receive my education as a CNS from the blended program that I am now faculty in 2007 while it was a Master's of Science degree. The American Association of Critical Care Nurses Certification Corporation has certified me as both an Acute Care Nurse Practitioner and Acute Care Clinical Nurse Specialist by completing their certification exams.

As a Critical Care CNS, I was the clinical expert for extracorporeal therapies including Continuous Renal Replacement Therapy for acute kidney injury, Molecular Adsorbent Recirculating System for acute liver failure, and plasmafiltration for treatment of many inflammatory conditions. As the expert, I created the evidence based policies and protocols associated with these treatments. Other nurse practitioners and physicians consult with me in these therapies use. As a CNS, I am not permitted to order the protocols that I created. I must rely on other nurse practitioners, who graduated from the same program and hold the same certifications to place the order because their role allows for prescriptive authority.

As a CNS working within a hospital, I am accountable for quality and regulatory metrics, such as restraint use. I must rely on a nurse practitioner in Multi Trauma Critical Care to modify restraint orders per my suggestions, who incidentally were hired and trained by me as Registered Nurses and then graduated from the same program that I attended.

I chose to practice as a CNS because I wanted to have the greatest effect with interventions focused on a population of patients rather than primarily working with one patient at a time. As part of my role, I do work individually with patients, as mentioned above, in managing therapies for their disease; however, I am hindered because of my lack of a full scope of practice relying on others to place orders at my suggestion.

I hope this provides some rationale for my support of SB513: Senator Eckardts: Delegate Cullison HEALTH OCCUPATIONS – CLINICAL NURSE SPECIALISTS – PRESCRIBING AUTHORITY.

Sincerely

Paul Thurman, PhD, RN, ACNPC, CCNS

Statement support for HB276- 2022F Educational Req

Uploaded by: Paul Thurman

Position: FAV

Statement of Program of Study for Clinical Nurse Specialist program

A Clinical Nurse Specialist (CNS) is a licensed registered Nurse that has completed a graduate level educational program (Masters or Doctoral) from an accredited educational institution and has passed a national certification examination.

The core educational elements of all advanced Practice Registered nurse (APRN) are **1] advanced physiology and pathophysiology, 2] advanced health assessment across the life span, and 3] clinical pharmacology and therapeutics across the life span**. These combined courses comprise the "3 -P's" fulfilling national requirements for APRN programs. Additional course requirements to support CNS clinical practice in the healthcare environment include research and evidenced-based practice, Information and technology systems, health promotion within populations, over 1000 hours of clinical, in addition to diagnosis and management courses.

This is an example of the University of Maryland School of Nursing Adult-Gerontology Acute Care Nurse Practitioner -Adult-Gerontology Clinical Nurse Specialist Program plan of study. This is considered a blended program, meaning students completing the required courses and clinical hours are eligible to take board examinations for a nurse practitioner (NP) and CNS. While the educational requirements are equivalent, within the State of Maryland, many graduates pursue NP practice due to the limited scope of practice of the CNS. The CNS is not able to practice to the full extent of their education and training due to lack of prescriptive authority, unlike the NP.

The State of Maryland has two universities that offer the CNS specialty, Johns Hopkins, and University of Maryland, both program curricula are provided. **The 3-P's are in Bold**

DNP: Adult-Gerontology Acute Care Nurse Practitioner / Adult-Gerontology Clinical Nurse Specialist

Semester and Course Number/Title	Credit/Clinical Hours
Fall Year 1	
1] NPHY 612: Advanced Physiology and Pathophysiology	**3 credits**
2] NURS 723: Clinical Pharmacology and Therapeutics Across the Life Span	**3 credits**
3] NDNP 819: Advanced Health Assessment Across the Life Span	**4 credits**
NRSG 785: Professional Writing	1 credit
Total:	**11 credits**
Spring Year 1	
NRSG 790: Methods for Research and Evidence-Based Practice	3 credits
NRSG 795: Biostatistics for Evidence-Based Practice	3 credits
NDNP 820: Diagnosis and Management 1: Intro to Diagnostic Reasoning	2 credits
NDNP 821: Diagnosis and Management 1: Intro to Diagnostic Reasoning Clinical	2 credits (90 Hours)
Total:	**10 credits**

Semester and Course Number/Title	Credit/Clinical Hours
Summer Year 1	
NRSG 782: Health Systems & Health Policy: Leadership & Quality Improvement	3 credits
NDNP 804: Theory for Evidence-Based Practice	3 credits
NPHY 620: Pathological Alteration in the Critically Ill	2 credits
Total:	**8 credits**
Fall Year 2	
NDNP 814: Practice Leadership within Complex Health Care Systems	3 credits
NDNP 817: Practice Leadership within Complex Health Care Systems Clinical Practicum	2 credits (90 hours)
NDNP 822: Diagnosis and Management 2: Common Health Conditions, Episodic and Chronic	4 credits
NDNP 823: Diagnosis and Management 2: Common Health Conditions, Episodic and Chronic Clinical Practicum Seminar	3 credits (135 Hours)
Total:	**12 Credits**
Spring Year 2	
NDNP 807: Information Systems and Technology Improvement/Transformation Heath Care	2 credits
NDNP 808: Information Systems and Technology Improvement/Transformation Health Care Practicum	1 credit (45 Hours)
NDNP 810: DNP Project Identification	1 credit
NDNP 824: Diagnosis and Management 3: Acute and Chronic Complex Conditions	4 credits
NDNP 825: Diagnosis and Management 3: Acute and Chronic Complex Conditions Clinical Practicum/Seminar	3 credits (135 Hours)
Total:	**11 credits**
Summer Year 2	
NURS 834: Translating Evidence to Practice	3 credits
NDNP 826: Diagnosis and Management 4: Integration of Multiple Health Problems and Complex Clinical Syndromes	2 credits
NDNP 827: Diagnosis and Management 4: Integration of Multiple Health Problems and Complex Clinical Syndromes: Clinical Practicum/ Seminar	2 credits (90 Hours)
NDNP 811: DNP Project Development	1 credit
Total:	**8 credits**
Fall Year 3	
NRSG 780: Health Promotion and Population Health	3 credits
NDNP 812: DNP Project Implementation	1 credit (45 hours)

Semester and Course Number/Title	Credit/Clinical Hours
NDNP 828: Diagnosis and Management 5: Advanced Practice/Clinical Nurse Specialist Roles in Health Care Delivery Systems-Clinical	4 credits (180 hours)
NDNP 891: Advanced Practice/Clinical Nurse Specialist Roles in Health Care Delivery Systems	3 credits
Total:	**11 credits**
Spring Year 3	
NDNP 813: DNP Project Evaluation/Dissemination	1 credit (45 hours)
NURS 810: Evidence-Based Health Policy	3 credits
NDNP 829: Diagnosis and Management 6: Integration of Practice and Leadership: Clinical Practicum/Seminar	5 credits (225 hours)
Total:	**9 credits**
Total: 80 Credits (56 Didactic/24 Clinical Credits [1,080 Clinical Hours])	

https://www.nursing.umaryland.edu/academics/doctoral/dnp/agnp-cns/

Johns Hopkins University School of Nursing Adult-Gerontological Acute Care Nurse Practitioner
PLAN OF STUDY - 4 YEAR PLAN

Fall I (5 Credits)

Biostatistics for Evidence-Based Practice (3) Health Finance (2)

Spring I (7 Credits)
The Research Process and Its Application to Evidence-Based Practice (3)
1] Advanced Pathophysiology/Physiology (4)

Summer I (6 Credits)
Health Promotion and Risk Reduction Across the Lifespan (2)
2] Clinical Pharmacology (4)

Fall II (8 Credits)
Context of Healthcare for Advanced Nursing Practice (3)
3] Advanced Health Assessment and Measurement (3)
Health Information Systems and Patient Care Technology (2)

Spring II (7 Credits)
Philosophical, Theoretical & Ethical Basis of ANP (3) Diagnostics Skills and Procedures for APN (2) Advanced Nursing Health Policy (2)

Summer II (6 Credits, 112 Clinical Hours)
Intro to Acute Care (4, 56 Clinical Hours) Problem Discovery (2, 56 Clinical Hours)

Fall III (9 Credits. 168 Clinical Hours)
Acute Care I (6, 168 Clinical Hours) Nursing Inquiry for EBP (3)

Spring III (9 Credits, 224 Clinical Hours)
Translating Evidence into Practice (3) Acute Care II (4, 168 Clinical Hours)
Project Advancement (2, 56 Clinical Hours)

Summer III (7 Credits, 168 Clinical Hours)
Analysis and Evaluation of Individuals and Populations (3) Acute Care III (4, 168 Clinical Hours)

Fall IV (8 Credits, 280 Clinical Hours)
Acute Care IV (6, 224 Clinical Hours) Project Application (2, 56 Clinical Hours)

Spring IV (6 Credits, 56 Clinical Hours)
Organizational and Systems Leadership (2) Clinical Data Management and Analyses (2)
Project Evaluation and Dissemination (2, 56 Clinical Hours)

* Curriculum, credit hours, and sequencing are subject to change.
** Up to 16 credits can be applied from the JHSON MSN (Entry into Nursing) Program to the DNP Advanced Practice Track.
***A minimum of 1000 practice hours is required for DNP.

Johns Hopkins School of Nursing Adult-Gerontological Health & Adult Critical Care Clinical Nurse Specialist PLAN OF STUDY - 4 YEAR PLAN

Fall I (8 Credits)
Biostatistics for Evidence-Based Practice (3)

Context of Healthcare for Advanced Nursing Practice (3) Health Finance (2)

Spring I (7 Credits)
The Research Process and Its Application to Evidence-Based Practice (3)
1] Advanced Pathophysiology/Physiology (4)

Summer I (6 Credits)
Health Promotion and Risk Reduction Across the Lifespan (2)
2] Clinical Pharmacology (4)

Fall II (6 Credits) *** - Required Immersion, Dates TBD, Onsite or Online
Philosophical, Theoretical & Ethical Basis of ANP (3)
3] Advanced Health Assessment and Measurement (3) Human Growth and Development (1) ***
Spring II (6 Credits)
Organization and Systems Leadership (2) Advanced Nursing Health Policy (2)
Health Information Systems and Patient Care Technology (2)

Summer II (5 Credits, 56 Clinical Hours)
Clinical Judgement I (3) Problem Discovery (2, 56 Clinical Hours)

Fall III (9 Credits, 168 Clinical Hours)
Nursing Inquiry for EBP (3) Clinical Judgement II (3) Clinical Practicum I (3, 168 Clinical Hours)

Spring III (9 Credits, 280 Clinical Hours) - Required Onsite Immersion, Dates TBD
Translating Evidence into Practice (3) Clinical Practicum II (4, 224cl) Project Advancement (2, 56 Clinical Hours)

Summer III (9 Credits, 168 Clinical Hours)
Analysis and Evaluation of Individual & Population Health (3) Clinical Judgement III (3)
Clinical Practicum III (3, 168 Clinical Hours)

Fall IV (6 Credits, 280 Clinical Hours)
Clinical Practicum IV (4, 224 Clinical Hours)
Project Application (2, 56 Clinical Hours)

Spring IV (4 Credits, 112 Clinical Hours) - Required Immersion, Dates TBD, Onsite or Online
Clinical Data Management (2) Project Evaluation and Dissemination (2, 56 Clinical Hours)

* Curriculum, credit hours, and sequencing are subject to change.
** Up to 16 credits can be applied from the JHSON MSN (Entry into Nursing) Program to the DNP Advanced Practice Track.
*** Human Development Across the Lifespan is a required course for CNS Pediatric Critical Care students only.
**** A minimum of 1000 practice hours is required for DNP.

2022 ACNM SB 513 Senate Side.docx.pdf
Uploaded by: Scott Tiffin
Position: FAV

Committee:	**House Health and Government Operations Committee**
Bill:	**Senate Bill 513 - Clinical Nurse Specialists - Prescribing Authority**
Hearing Date:	**February 10, 2022**
Position:	**Support**

The Maryland Affiliate of the American College of Nurse Midwives (ACNM) supports *Senate Bill 513 – Clinical Nurse Specialists – Prescribing Authority.* Certified nurse-midwives (CNMs) work alongside clinical nurse specialists (CNS) in many settings including clinical programs that support individuals throughout pregnancy and during the postpartum period. CNSs have the clinical education and training to prescribe to their patients. Since CNSs do not have prescriptive authority under Maryland law, CNS' must turn to other providers to write prescriptions for patients. This needlessly disrupts the care of patients, and can delay the patient getting prescriptions. If Maryland's health care system is to function effectively and efficiently, we need to ensure practitioners are able to provide all the services for which they are qualified. Therefore, we ask for a favorable report. If we can provide any further information, please contact Scott Tiffin at stiffin@policypartners.net.

2022 MNA SB 513 Senate Bill.pdf

Uploaded by: Scott Tiffin

Position: FAV

Committee: **House Health and Government Operations Committee**

Bill: **Senate Bill 513 – Clinical Nurse Specialists - Prescribing Authority**

Hearing Date: **February 10, 2022**

Position: **Support**

The Maryland Nurses Association (MNA) supports *Senate Bill 513 – Clinical Nurse Specialists – Prescribing Authority.* The bill authorizes clinical nurse specialists (CNSs) to prescribe medications to their patients.

MNA supports this legislation because of the importance of the role of CNSs. Just as with other advanced practice registered nurses (APRNs), CNSs have the education and experience to diagnose and treat patients in a wide range of settings. In today's health care environment, CNSs are particularly important, as they also focus on assessing and making recommendations for health systems changes to support best practices. With Maryland's Total Cost of Care Model and increased focus on the integration of different health care settings, Maryland should be supporting the work of CNSs.

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

Support Testimony

Uploaded by: Senator Eckardt Senator Eckardt
Position: FAV

Addie C. Eckardt
Legislative District 37
Caroline, Dorchester, Talbot
and Wicomico Counties

Budget and Taxation Committee

Health and Human Services
Subcommittee

Joint Committees
Administrative, Executive,
and Legislative Review

Audit

Children, Youth, and Families

Fair Practices and
State Personnel Oversight

Pensions

THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

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District Office
601 Locust Street, Suite 202
Cambridge, MD 21613
410-221-6561

Testimony for Senate Bill 513
Health Occupations – Clinical Nurse Specialists – Prescribing Authority
Education, Health, and Environmental Affairs Committee
February 10, 2022

Chairman Pinsky and Members of the Committee:

Thank you for the opportunity to present **Senate Bill 513 – Health Occupations – Clinical Nurse Specialists – Prescribing Authority.**

Senate Bill 513 would expand the scope of practices for Clinical Nurse Specialists to include prescriptive authority and the ability to order durable medical equipment. The CNS would be designated as an “authorized prescriber”.

As the need for expanded practices increase among professional, the addition of prescriptive authority improves continuity of care and access to care as soon as it is necessary.

There is a need for more nurses in the field, especially during the ongoing labor shortage and pandemic. Senate Bill 513 would allow for necessary expansions in the authority of nurses. Existing budgeted resources would cover the cost of implementing this bill within the Board of Nursing.

An amendment has been submitted to clarify the role of Clinical Nurse Specialists when ordering diagnostic tests.

Thank you for your consideration and I respectfully ask for a favorable report of Senate Bill 513.

Best regards,

Senator Addie C. Eckardt

Final.CBANACNS Support letter.SB513.2.04.22.pdf

Uploaded by: Sharon Allan

Position: FAV

Board of Directors
President Dr. Sharon H. Allan, DNP, RN, ACNS-BC, *Treasurer* Jennifer Helzer, MSN, APRN-CNS, CCNS, CCRN,
Secretary Gena Bergvall DNP, CRNP-BC, AGCNS-BC, CCRN, CNRN

Support

SB513 Clinical Nurse Specialists – Prescribing Authority

Feb 4, 2022
The Chesapeake Bay (Maryland) Affiliate of the National Association of Clinical Nurse Specialists (CBANACNS) supports passage of Senator Adelaide C. Eckardt **SB 513 Clinical Nurse Specialists – Prescribing Authority**

I am a doctorally prepared clinical nurse specialist with over 45 years of experience as a registered nurse, 17 years as an advanced practice clinical nurse specialist in Maryland, and the President of CBANACNS. The Clinical Nurse Specialist is one of "4" advanced practice nursing roles prepared at the Master's or Doctoral level, educated and trained to diagnose, treat disease and illness **and prescribe**. Currently 80% of the 50 states and US Department of Veterans Affairs have granted CNSs prescribing privileges – Maryland still has not.

CNSs are change agents working across the continuum of healthcare to improve patient outcomes, increase access to quality care, identify and decrease patient safety hazards – all based on evidence-based best practices. It is within the CNS education, training and scope of practice to be able to prescribe. Prescribing is a complex process and not limited to medication orders. CNSs across Maryland want their voice to be heard – granting prescribing authority to the CNS would fill gaps in care, help patients function better at home, meet needs of the patients for medications, non-pharmaceutical agents, effective treatment plans, improve continuity of care, reduce length of hospital stay and decrease hospital readmissions.

This bill will allow the CNS prescribing authority to optimize patient access to and the delivery of quality healthcare, filling the gaps. We urge a favorable report on this bill. If you need further information, please contact me at sallan808286@gmail.com

Respectfully,
Dr. Sharon H. Allan, DNP, RN, ACNS-BC
President CBANACNS
187 Rock Ridge Road
Millersville, MD 21108

Final.SB 513 Oral testimony.SHA.2.4.22.pdf

Uploaded by: Sharon Allan

Position: FAV

Sharon H. Allan, DNP, ACNS-BC – President – Maryland Chapter of National Association Clinical Nurse Specialists

Oral Testimony

SB 513
Titled: Clinical Nurse Specialists - Prescribing Authority

Thank you Senator Eckardt for your generous sponsorship and thank you Chairman Pinsky, Vice-Chair Kagan, and committee members for allowing time to hear my testimony in support of SB 513.

Dr. Sharon Allan, I am a doctoral prepared clinical nurse specialist with over 45 years of experience as a registered nurse, 17 years as an advanced practice clinical nurse specialist in Maryland, and the President of Chesapeake Bay Affiliate (Maryland Chapter) of the National Association of Clinical Nurse Specialists. The Clinical Nurse Specialist is one of "4" advanced practice nursing roles prepared at the Master's or Doctoral level, educated and trained to diagnose, treat disease and illness, **and prescribe**. Currently 80% of the 50 states and US Department of Veterans Affairs have granted CNSs prescribing privileges – Maryland still has not.

CNSs are change agents working across the continuum of healthcare to improve patient outcomes, increase access to quality care, identify and decrease patient safety hazards and are on the frontline of work done to set evidence-based nursing standards of care. The CNS is not a duplicate role to the other Advance Practice roles but able to fill the gaps and partner with Medical Providers to make improvements in the efficiency and effectiveness of healthcare delivery.

Prescribing is a very complex process that involves much more than ordering medications. Prescribing authority would allow the CNS to follow through on their patient treatment plans, to order patient referrals, lab work, diagnostic tests, titrate medications, order specialty equipment such as a pressure relieving bed, walker, wheelchair, wound care supplies – all of which promote quality management of even the most vulnerable and complex patients.

Not having prescribing authority is crippling to the continuity of quality care. I live this frustration every day in my role managing post-operative cardiac surgery patients after discharge. The time it takes for a patient to obtain an appointment with their Primary Care physician and / or Cardiologist can take 6-10 weeks after discharge home. I fill this gap in care, managing these patients. I identify and diagnose changes in their medical status, develop treatment plans and make adjustments in their medications to keep them safe and prevent readmissions to the hospital. Current Maryland law preventing trained and educated CNSs from having prescribing authority means that I need to interrupt the workflow of another provider, taking them away from what they do best, simply to sign my orders. The CNS does not live in a silo, we are collaborative team members working as strong patient advocates, doing what we do best, respected by the other healthcare providers – All done to provide the BEST care to our patients. Granting CNSs prescribing authority will only improve this care.

I stand in strong support of this bill and am asking you to vote favorably in support of SB 513.
Thank you,

Dr. Sharon H. Allan, DNP, ACNS-BC
187 Rock Ridge Rd
Millersville, MD 21108

Written Testimony.SAllan.SB 513.2.4.2022.pdf

Uploaded by: Sharon Allan

Position: FAV

Clinical Story in Support of SB 513 Clinical Nurse Specialist Prescribing Authority

Delay in access to care is a current reality for patients managed and cared for by Clinical Nurse Specialists (CNSs) in those few states where CNS prescribing authority is denied. Maryland is currently one of those states denying the CNS prescribing authority. The CNS manages patients across the health care system (inpatient, outpatient, transitions of care from ICU-to -stepdown-to-home in both rural and urban settings). Prescribing authority will allow the CNS to improve patient outcomes, increase patient and health care provider satisfaction and improve the efficiency, effectiveness and efficacy of care provided.

Clinical Story

Working as a Clinical Nurse Specialist (CNS) at a large Academic Medical Center I manage post-operative Cardiac Surgery patients transitioning to and following their discharge to home. The CNS is key in the management of these patients until they are able to be transitioned to the care of their Cardiologist and/or Primary Care provider, with appointments **occurring 6-8 weeks after the patient is discharged home**. The CNS is able to fill this gap in care through safe and quality patient management of this population of patients until they can be safely transitioned to the care of their medical team in the community.

During this "transition period" the CNS manages patient symptoms, communicates plan of care with other members of the patient's care team in the home – all important to improve patient outcomes, decrease readmissions, and meet the medical needs of these patients.

As a CNS I identify the need for changes in a patient's medication regimen in order to decrease signs of fluid retention, dehydration, heart rate, rhythm and blood pressure issues – all to improve patient health status. The CNS is able to diagnose if patient symptoms warrant lab tests and interpret those lab results **but not order the lab tests**.

The CNS identifies changes in a patient's medical status and assesses if the patient would benefit from getting specific referrals to PT, OT or requires medical equipment (walker, wheelchair, hospital bed). **Yet the CNS managing these patients must stop the workflow and find a medical provider who has prescriptive authority to sign their orders**. This process results in a delay in access to needed care, a breakdown in the continuity of care, pulling another health care provider away from their tasks at hand.

Delay in treatment is a patient safety issue due to another provider entering a medication, lab or medical equipment order on a patient they are not managing…...**ALL because Maryland has not yet authorized the CNS prescribing authority. The CNS is trained and educated, and within their scope of practice to prescribe.** There is justification and a huge need for the CNS who manages a population of patients along Cardiac Surgery service lines to have prescribing authority.

Dr. Sharon H. Allan DNP, ACNS-BC
Department of Cardiac Surgery
The Johns Hopkins Hospital
Home Address: 187 Rock Ridge Road, Millersville, MD 21108

SB 513 -CNS prescriptve authority 2022.sd final.pd

Uploaded by: Shirley Devaris

Position: FAV

Bill No. SB 513 **Committee:** Senate Education, Health, and Environmental Affairs
Title: **<u>Health Occupations – Clinical Nurse Specialists – Prescribing Authority</u>**
Hearing Date: February 10, 2022 **Position:** Favorable
Witness: Shirley Devaris, RN, BSAD, MSA, JD (shirleydevaris@yahoo.com)

Good afternoon, Mr. Chairman, Madam Vice Chair and members of the committee.

My name is Shirley Devaris, and I am offering testimony in support of this bill based on my 19 years of experience with regulating nursing practice, first as staff to the former House Environmental Matters Committee, and then as Director of Legislative Affairs for the Board of Nursing before retiring.

In 2010 the Institute of Medicine released the landmark report, "The Future of Nursing". A key recommendation of that report was to remove legislative and regulatory barriers for Advanced Practice Registered Nurses (APRN) to allow them to practice to the full extent of their education and training and enable them to efficiently provide the care their patients need. That same recommendation has been repeated in every subsequent report on "The Future of Nursing". Today we are again faced with another crisis in nursing and now, more than ever, need our APRNs to be able to practice to the full extent of their education and training. This bill furthers that important recommendation from the Institute of Medicine by granting prescriptive authority to Clinical Nurse Specialists.

Clinical Nurse Specialists are APRNs and have been a part of the health care system in the United States for more than 60 years. They have always been independent practitioners in Maryland. Thirty-nine states have prescriptive authority for Clinical Nurse Specialists. Qualifications for certification as a Clinical Nurse Specialist require the successful completion of an approved CNS graduate program at the master's level or higher and certification by a national certifying body in addition to their nursing degree.

A Clinical Nurse Specialist provides advanced direct and indirect care to complex and vulnerable populations in a variety of health care settings. As change agents, Clinical Nurse Specialists design evidence-based interventions to meet patient, nurse, and organizational needs. To provide comprehensive and safe patient care to specialty populations, the Clinical Nurse Specialist must assess, use differential diagnoses, and create plans of care that are tailored to the individual. The plans of care include activities of prescribing as well as consultative, rehabilitation, and supportive services.

Maryland has regulated Clinical Nurse Specialists since 1990 when regulations (COMAR 10.27.12) were adopted for Nurse Psychotherapists in Independent Practice - Clinical Nurse Specialists (PMH/APRN). These regulations, since 1990, have authorized PMH/APRNs to utilize pharmacologic agents in their practice but do not provide authority to prescribe pharmacologic agents. The result is that a PMH/APRN has to find another health care provider with prescriptive authority who must first establish a client relationship with the patient before they can prescribe the medications that the PMH/APRN recommends. Not only is this costly and time consuming but adds a barrier to efficient care. There are 188 Clinical Nurse Specialists in Maryland certified as nurse psychotherapists who are eligible to prescribe if necessary to fulfil a treatment plan.

Clinical Nurse Specialists who are not PMH/APRNs are regulated under COMAR 10.27.27. Their practice is similarly adversely impacted by not having prescriptive authority. They develop elaborate care plans for complicated cases and then have to wait for someone else to write the necessary orders to implement the care plans. Additionally, those plans often include home health care that has to be ordered by someone, other than the Clinical Nurse Specialist, with prescriptive authority. All clinical nurse specialists have authority under federal regulations to prescribe and administer Suboxone, without physician oversight, for the treatment of Opioid Use Disorder (OUD). Allowing them to prescribe will improve access to treatment for OUD.

Under federal law reimbursement is authorized for home health care and durable medical equipment when ordered by a Clinical Nurse Specialist. Federal regulations allow Clinical Nurse Specialists to renew orders for hospice care. The US Department of Veterans Affairs granted full prescriptive authority to Clinical Nurse Specialists in 2016. A Clinical Nurse Specialist can prescribe in any state when working in a VA hospital.

Prescriptive authority for all APRNS will prepare Maryland for the APRN compact. The National Council of State Boards of Nursing supports full practice authority for Clinical Nurse Specialists as does the National Association for Clinical Nurse Specialists. Scope of practice bills like this have become a tug of war between competing professional interests and often result in curtailing access to health care for our citizens. We cannot afford to keep any fully qualified health care provider from giving all the care that they are capable of giving.

Please give this bill your favorable consideration. Thank you.

SB 513 Health Occupations Clinical Nurse Specialis

Uploaded by: Tammy Bresnahan
Position: FAV

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1-866-542-8163 | Fax: 410-837-0269
aarp.org/md | md@aarp.org | twitter: @aarpmd
facebook.com/aarpmd

SB 513 Health Occupations - Clinical Nurse Specialists - Prescribing Authority
FAVORABLE
Senate Education, Health, and Environmental Affairs Committee
February 10, 2022

Good Afternoon Chairman Pinsky and members of the Senate Education, Health and Environmental Affairs Committee. I am Tammy Bresnahan, Director of Advocacy for AARP Maryland. AARP MD has over 850,000 members in Maryland. AARP Maryland and its members supports **SB 513 Health Occupations - Clinical Nurse Specialists - Prescribing Authority**. AARP MD thanks Senator Eckardt for bringing this important legislation to the Maryland General Assembly. She has been a champion for nurses.

SB 513 defines "clinical nurse specialist" and "practice as a clinical nurse specialist" for the purpose of authorizing clinical nurse specialists to prescribe drugs and durable medical equipment under regulations adopted by the State Board of Nursing. Further SB 513 alters the definition of "authorized prescriber" for purposes of the Maryland Pharmacy Act to include clinical nurse specialists; and authorizing a licensed physician to personally prepare and dispense a prescription written by a clinical nurse specialist.

Nurses do remarkable things for the people they serve. For many family caregivers, nurses are lifesavers, providing care for their older loved ones at home — often after a hospitalization or while treating a serious medical condition. They are one of the reasons many older Americans are able to continue to live at home, where they want to be — and not in costly institutions such as nursing homes.

Clinical nurses have completed additional education and training at the master's or doctoral level. This means they're qualified to diagnose and treat patients, order and evaluate diagnostic tests, prescribe medications and more. They should be able to practice to the full extent of their training.

Every American deserves a highly skilled nurse when and where nursing skills are needed. A richly skilled, effectively integrated nursing workforce — with enough professionals to meet the need — is essential to delivering high-quality health care.

AARP believes that high-quality; patient-centered health care for all will require remodeling many aspects of the health care system, especially nursing. Nurses should be able to practice to full extent of their education and training. State nurse practice should be amended to all Advance Practice Registered Nurse to fully and independently practice as defined by their education and certification.

These changes could mean for Older Marylanders:

- Less travel to medical offices for a family caregiver to organize, instead allowing a nurse practitioner to prescribe certain prescriptions at a patient's home.
- Removal of outdated barriers that prohibit nurse practitioners from providing care to their patients to the full extent of their education and training.
- Additional opportunities for patients to get routine health care in a variety of settings close to home, like medical offices, community health centers, in the workplace and at home.
- Medical or nursing tasks may be delegated to a trained home-care worker instead of falling on the family caregiver.

As part of our caregiving campaign, AARP has been working across the states to give nurses more authority to heal, and already, progress has been made. AARP members are watching for policy solutions and legislation that would fully realize nurses' potential contribution to a patient-centered, transformed health care system in the following areas:

- **Removing Barriers to Practice and Care**: Modernize outdated policies (public and private) and change state and federal laws and regulations to allow nurses to practice to the full extent of their education and training.
- **Patient-Centered Transformed Health Care System**: Advances and contributions to the research, advocacy and communications strategies through the national network of professional and health care related stakeholders.

For these reasons AARP respectfully request a favorable report on SB 513. For questions or additional information, please feel free to contact Tammy Bresnahan, Director of Advocacy at tbresnahan@aarp.org or by calling 410-302-8451.

SB 513 MANA FAV.pdf
Uploaded by: William Kress
Position: FAV

Maryland Association of Nurse Anesthetists

SB 513 – Health Occupations – Clinical Nurse Specialists – Prescribing Authority

Before Senate Education, Health, and Environmental Affairs Committee

Position – Favorable

February 6, 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 SB 513. SB 513 would allow Clinical Nurse Specialists (CNS) to prescribe drugs and durable medical equipment to their patients. The scope of their prescriptive authority will be appropriately determined by The Maryland Board of Nursing (BON) through their regulatory authority.

SB 513 will allow CNS to provide care and treatment to the full level of their training and education. As you may know, CNS are advance practice nurses and are highly trained and educated. To become a CNS, the candidate must; 1) obtain a Bachelor of Science in nursing; 2) obtain a license as a registered nurse; 3) achieve a minimum of 500 supervised clinical hours in a specialty; 4) obtain a Master of Science in nursing or a Doctor of Nursing Practice; and finally, 5) obtain certification from the American Nurses Credentialing Center or the American Association of Critical-care Nurses.

CNS serve a vital role in ensuring access to care and serve in many practice areas including Pediatrics, Women’s health Geriatrics, Psychiatric health Rehabilitation services, Wound care, Pain management, Oncology Critical care and Emergency room service. SB 513 would create efficiencies in care and would result not only in improved patient care, but reduced cost over the entire healthcare system.

I respectfully request a favorable report from the committee on SB 513.

Natasha Hopkins, CRNA DNP
President, MANA

10 - SB 513 - X - EHEA - BON - LOSWA.docx.pdf

Uploaded by: Heather Shek

Position: FWA

Board of Nursing

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

February 10, 2022

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

RE: SB 513 – Health Occupations – Clinical Nurse Specialists – Prescribing Authority – Letter of Support with Amendments

Dear Chair Pinsky and Committee Members:

The Maryland Board of Nursing (the Board) respectfully submits this letter of support with amendments for SB 513 – Health Occupations – Clinical Nurse Specialists – Prescribing Authority. This bill defines the terms "clinical nurse specialist" and "practice as a clinical nurse specialist" for the purpose of authorizing clinical nurse specialists to prescribe drugs and durable medical equipment under regulations adopted by the State Board of Nursing. This bill alters the definition of "authorized prescriber" for purposes of the Maryland Pharmacy Act. This bill additionally authorizes a licensed physician to personally prepare and dispense a prescription written by a clinical nurse specialist.

Clinical Nurse Specialists (CNSs) are advanced practice registered nurses (APRNs) who use their expertise to assess, diagnose, treat, and manage patients of all health complexities. CNSs must be licensed registered nurses (RNs) with graduate preparation (Master's or Doctorate) from an accredited clinical nurse specialist program. The current standards of practice for CNSs allow them the flexibility to serve the pediatric, geriatric, and women's health population; to practice in critical care or emergency room settings; to assess psychiatric evaluations or rehabilitation; to treat pain, wounds, and stress related illnesses.

According to the National Council of State Boards of Nursing (NCSBN), 39 states currently allow independent prescribing for the CNS[1]. A CNS must complete, at a minimum, three separate comprehensive graduate level courses to exercise prescribing and ordering responsibilities. These courses must include advanced health/physical assessment, advanced physiology/pathophysiology, and advanced pharmacology. Additional research into independent practice of the CNS specialty demonstrates the following outcomes: reduced hospital costs and length of stay, reduced frequency of emergency room visits, improved pain management

[1] CNS Independent Prescribing Map. National Council of State Boards of Nursing (NCSBN). 2021.

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practices, increased patient satisfaction with nursing care, and reduced medical complications in hospitalized patients.[2]

The pandemic has brought many challenges into the healthcare setting, particularly for Marylanders in underserved communities. There have been incredible limitations for healthcare practitioners in being able to provide adequate and expeditious care. The Board believes it is essential to authorize CNSs to practice to the full extent of their education and training. Allowing CNSs the ability to practice independently and autonomously would provide an additional avenue amongst other solutions to increase access to healthcare services for all Marylanders.

Maryland Health Occupations Article Title 8 (Nurse Practice Act) currently authorizes multiple advanced practice registered nurse (APRN) designations to have prescriptive authority. The Board respectfully submits this amendment to broaden the bill language to encompass Title 8.

On page 3. Section 12-101. Lines 23 – 24.
"…advanced practice **REGISTERED** nurse with prescriptive authority under [**§ 8–508 OR § 8–514**] **TITLE 8** of this article…"

On page 4. Section 12-102. Lines 4 – 5.
"…**AN ADVANCED PRACTICE REGISTERED NURSE WITH PRESCRIPTIVE AUTHORITY UNDER [§ 8–508 OR § 8–514] TITLE 8** of this article…"

For the reasons discussed above, the Board of Nursing respectfully submits this letter of support with amendments for SB 513.

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.

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[2] Impact of the Clinical Nurse Specialist Role on the Costs and Quality of Health Care. National Association of Clinical Nurse Specialists (NACNS).

SB513.UNFAV.OVIEDO.pdf
Uploaded by: Enrique Oviedo
Position: UNF

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February 8, 2022

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

RE: Oppose – SB 513: Health Occupations - Clinical Nurse Specialists - Prescribing Authority

Dear Chairman Pinsky and Honorable Members of the Committee:

As a psychiatrist working in Maryland, I would urge you to oppose Senate Bill 513: Health Occupations - Clinical Nurse Specialists - Prescribing Authority (SB 513), which would authorize clinical nurse specialists (CNSs) to prescribe controlled substances, including opioids, without explicitly requiring a physician's involvement. Having spoken with colleagues who have experience worked with CNSs, the consensus is that CNSs do not have adequate training to prescribe and manage patient's medical care without physician involvement and oversight. The responsibility of prescribing psychiatric medications and medications for substance use disorder treatment, including controlled substances such as opioids (e.g. buprenorphine) and benzodiazepines is substantial. If used improperly, these medications can cause serious disability or even lead to death. Of concern, SB 513 does not provide any limits as to the type of medications a CNS could prescribe, including narcotics. Maryland patients are best serviced when patient care is physician led, and when prescribing of medication involves a physician.

For these reasons, I urge this honorable committee to have an unfavorable report on SB 513.

Respectfully submitted,

Enrique Oviedo, MD

Board Certified Adult, Child & Adolescent, and Addiction Psychiatrist

MDDCSAM UNFAV Nurse Specialists SB 513.pdf
Uploaded by: Joseph Adams, MD
Position: UNF

MDDCSAM is the Maryland state chapter of the American Society of Addiction Medicine whose members are physicians and other health providers who treat people with substance use disorders.

SB 513 Health Occupations - Clinical Nurse Specialists - Prescribing Authority
Senate Education, Health, and Environmental Affairs. February 10, 2022

OPPOSE

MDDCSAM is opposed to granting prescribing authority to Clinical Nurse Specialists, who have historically never prescribed medication.

The training of Clinical Nurse Specialists is not the same as that received by Nurse Practitioners, in ways that are pertinent to the ability to prescribe medication.

Prescribing opioid pain medications is an example of a high risk activity. Clinical Nurse Specialists are often hospital-based, and perioperative opioid prescribing has been identified as a significant factor in the development of "New Persistent Opioid Use." 4 - 8% of patients undergoing common surgeries develop New Persistent Opioid Use long-term, based on the way these medications are currently prescribed. This is now one of the most common complications of surgery, and is likely a contributor to the development of opioid use disorder. (See references).

We strongly urge an unfavorable report .

Joseph A. Adams MD, FASAM, Chair, Public Policy Committee

REFERENCES:

"Perioperative Opioid Prescribing has been Associated with Persistent Opioid Use"
www.cdc.gov/acute-pain/postsurgical-pain/index.html

Michigan OPEN (Opioid Prescribing Engagement Network). https://michigan-open.org

Brescia AA, et al. Impact of Prescribing on New Persistent Opioid Use After Cardiothoracic Surgery. Ann Thorac Surg. 2019 Oct;108(4):1107-1113.

Young JC, et al. Postsurgical Opioid Prescriptions and Risk of Long-term Use: An Observational Cohort Study Across the United States Ann Surg. 2019 Aug 9.

Brummett CM, et al. New Persistent Opioid Use after Minor and Major Surgical Procedures in US Adults. JAMA Surg.2017;152:e170504.

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UNFAVORABLE.SB513.MDRTL.L.Bogley.pdf

Uploaded by: Laura Bogley

Position: UNF

UNFAVORABLE STATEMENT

SB 513 - Health Occupations - Clinical Nurse Specialists - Prescribing 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 513** would diminish existing professional standards of patient care by allowing clinical nurse specialists to prescribe drugs in the absence of a physician. Without specific language excluding the application of this bill to abortion, nurse specialists would be authorized to prescribe lethal chemical abortion drugs, putting more pregnant at risk for injury and death. This bill must be considered in the broader legislative context in which this new prescribing authority could be combined with dispensing authority and the commitment of public tax dollars to reimburse providers for abortion.

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.

PHYSICIANS EXAM REQUIRED FOR PREGNANCY

One of the few protections for pregnant women 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.

While prescription authority may be reasonable for legitimate health care purposes, it is not appropriate for abortion. The State of Maryland must ensure that all pregnant women have access to quality health care which 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.

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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

The abortion industry is asking the state to authorize them to put profits over patients.

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.

The medical scarcity in abortion practice is a matter of medical ethics not provider scarcity, 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.

"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 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

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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.

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 only a tangential role either on paper as medical directors for clinics or as remote prescribers of abortion pills, even across state lines.

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 but still supported broad telehealth authorization and provider reimbursements.

WEAPONS OF MASS DESTRUCTION

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%.

Chemical abortion pills are the new **Weapons of Mass Destruction** and could kill as many as 1 million preborn children each year and put their mothers at higher risk of injury and death. 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.

Maryland Right to Life urges this Assembly to classify those lethal drugs typically used to kill preborn children in chemical abortions as Controlled Dangerous Substances in the Annotated Code of Maryland and to regulate their use and distribution appropriately. Lethal drugs used for the purposes of chemical abortion, currently include mifepristone, misoprostol and methotrexate, but other drugs are being used experimentally and also should be regulated. None of these lethal drugs are currently listed as either "prescription drugs" or contained in any of the Schedules of Controlled Dangerous Substances.

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ABORTION COERCION

Under current Maryland law, there is no explicit measure prohibiting any individual from coercing a woman into abortion.

The *majority* of women who have had abortions (64%) report afterward that they were pressured into the decision. Coercion encompasses any situation in which a pregnant mother is made to feel – by any means – that she has *no choice* but an abortion. Coercion sends a mother into the belief that *either the baby dies or I will die or suffer great harm.*

The State of Maryland has an obligation to provide for the health and safety of pregnant women and to regulate the use and distribution of chemical abortion pills. The proliferation of chemical abortion pills through telabortion and distribution through non-physicians and lower level healthcare workers, will put pregnant women at greater risk of abuse and coercion.

Without a physician's examination to confirm medical eligibility for chemical abortion as well as to confirm that the pregnant woman has consented to chemical abortion, these pills can be distributed to and utilized by sexual abusers and **sex traffickers** to continue to victimize women and girls.

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

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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.

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.

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.

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.

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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.

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Kumar MD UNFAV SB 513.pdf
Uploaded by: Sanaz Kumar
Position: UNF

February 8, 2022

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

Re: Oppose SB 513: Health Occupations – Clinical Nurse Specialists – Prescribing Authority

Dear Chairman Pinksy and Honorable Members of the Committee:

As a licensed and practicing physician in Maryland, I am writing to urge you to **OPPOSE** Senate Bill 513: Health Occupations – Clinical Nurse Specialists - Prescribing Authority (SB 513), which would authorize clinical nurse specialists (CNSs) to prescribe controlled substances without physician involvement or oversight.

If passed, this legislation would unnecessarily put Marylanders' health and safety at risk. While CNSs play an important role on some medical teams, their training programs are not designed to prepare them for the specific role of diagnosing and treating patients. CNS training programs are designed to teach CNSs broad theory of how to manage healthcare teams, how to apply research to practice, how to apply statistics to nursing practice, etc. Their instruction on diagnosing and prescribing may be limited to a few classes and shadowing other providers. Unfortunately, this level of training is inadequate to safely make medical diagnoses, understand drug-drug interactions, understand how a medication may affect other organ systems, and appreciate uncommon side effects with can be fatal.

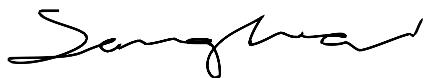
I have spoken with medical professionals who work with CNSs, and they were all in agreement that CNSs do not have appropriate expertise to prescribe medications and analyze laboratory data. CNSs may have an important role on some teams, but it is not in the capacity to prescribe medications.

Furthermore, HB 276 does not provide limits on the type of medications a CNS could prescribe. In Maryland, the opioid epidemic has been exacerbated by the epidemic, and we must ensure that these kinds of medications are not overprescribed.

Please do not equate making healthcare more accessible with making healthcare safe. Safety must be a priority for all Maryland residents.

For these reasons, I urge an unfavorable report of SB 513.

Respectfully Submitted,



Sanaz Kumar, MD
Board-Certified Adult, Child and Forensic Psychiatrist

SB0513_UNF_MedChi_Health Occs. - Clinical Nurse Sp

Uploaded by: Steve Wise

Position: UNF

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TO: The Honorable Paul G. Pinsky, Chair
Members, Senate Education, Health, and Environmental Affairs Committee
The Honorable Adelaide C. Eckardt

FROM: J. Steven Wise
Pamela Metz Kasemeyer
Danna L. Kauffman
Christine K. Krone

DATE: February 10, 2022

RE: **OPPOSE** – Senate Bill 513 – *Health Occupations – Clinical Nurse Specialists – Prescribing Authority*

The Maryland State Medical Society (MedChi), the largest physician organization in Maryland, **opposes** Senate Bill 513.

Senate Bill 513 defines the term "clinical nurse specialist" (CNS) and sets forth the scope of practice for a CNS. MedChi has significant questions about the role of the CNS as currently defined versus what their role would become if Senate Bill 513 were to pass, as set out below.

The term CNS is included in the statutory definition of "Advanced Practice Nurse" (HO §8-101) and requires that a CNS be licensed as a registered nurse and "certified to practice as a CNS". Beyond that, the statute provides no definition on the role of a CNS or their scope of practice. However, existing regulations of the Board of Nursing provide that a CNS' scope includes: 1) "continuous improvement of patient outcomes and nursing care", 2) acting "in accordance with the core competencies of the National Association of Clinical Nurse Specialists…", 3) "creating therapeutic environments through mentoring and system changes", and 4) "practicing with individual clients, families, groups and populations of clients." These regulations provide very little guidance in terms of what tasks and duties a CNS may undertake.

Senate Bill 513 would expand the scope of a CNS beyond that of even a Nurse Practitioner (NP), another type of Advanced Practice Nurse (scope found at HO §8-101(m)), by allowing the CNS to "order, perform, and interpret…diagnostic tests". While *laboratory* tests are included in the statute outlining the scope of practice for an NP, *diagnostic* tests are not. MedChi does not believe that the scope of a CNS should be broadened beyond even that of a NP.

In addition, Senate Bill 513 would allow a CNS to "prescribe drugs and durable medical equipment…" While NPs are permitted to prescribe, MedChi is not certain that the CNS receives the same training, experience, and mentorship in prescribing medications that an NP does, so as to warrant this authority. We have been in communication with representatives of the CNSs in this regard and are reviewing information they have provided.

For now, MedChi has too many unanswered questions about the role of the CNS and the changes proposed in the legislation. Accordingly, MedChi would ask the Committee to oppose Senate Bill 513.

For more information call:
J. Steven Wise
Pamela Metz Kasemeyer
Danna L. Kauffman
Christine K. Krone
410-244-7000

SB 513 - Oppose - MPS WPS.pdf
Uploaded by: Thomas Tompsett
Position: UNF

February 7, 2022

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

RE: Oppose – SB 513: Health Occupations - Clinical Nurse Specialists - Prescribing Authority

Dear Chairman Pinsky and Honorable Members of the Committee:

The Maryland Psychiatric Society (MPS) and the Washington Psychiatric Society (WPS) are state medical organizations whose physician members specialize in diagnosing, treating, and preventing mental illnesses, including substance use disorders. Formed more than sixty-five years ago to support the needs of psychiatrists and their patients, both organizations work to ensure available, accessible, and comprehensive quality mental health resources for all Maryland citizens; and strive through public education to dispel the stigma and discrimination of those suffering from a mental illness. As the district branches of the American Psychiatric Association covering the state of Maryland, MPS and WPS represent over 1000 psychiatrists and physicians currently in psychiatric training.

MPW/WPS urge you to oppose Senate Bill 513: Health Occupations - Clinical Nurse Specialists - Prescribing Authority (SB 513), which would authorize clinical nurse specialists (CNSs) to prescribe controlled substances, including opioids, without explicitly requiring a physician's involvement. While CNSs are valuable members of the health care team, Maryland simply should not authorize them to prescribe without physician involvement.

Medicare patient safety requirements[1], for example, require CNSs to work in collaboration with a physician; in the absence of a state law about collaboration, CNSs must still work in collaboration with a physician to be reimbursed. SB 513 does not make sense for Maryland patients since our myopic laws only require advanced practice nurses to collaborate with physicians for the first eighteen months of their practice. If Medicare, one of the largest payers in our nation, requires CNSs to work in collaboration with physicians at all times, Maryland law should specify this relationship as well and not delegate that decision to the Board of Nursing.

Maryland patients are best served when medications are prescribed with physician involvement. Regarding psychiatric medications, specifically, these powerful drugs do not stop at the patient's brain; they affect many systems of the body such as the heart, lungs, stomach, and kidneys. Seriously disabling or deadly side-effects of the medications can occur if psychiatric medications are prescribed and managed improperly. Furthermore, patients

[1] 42 C.F.R. § 410.76

Washington
Psychiatric Society

needing more than one drug at a time for comorbid physical conditions, such as heart disease or diabetes and mental illness, are at risk for potentially serious drug interactions. More than half of all patients with a mental disorder also have one or more physical ailments. For patient safety purposes, CNSs working in a health care team that includes a physician is imperative.

Additionally, SB 513 does not provide limits as to the type of medications a CNS could prescribe, which means they would be authorized to prescribe opioids and narcotics. Maryland is already facing an opioid epidemic, and confronting this epidemic includes making sure opioids are not overprescribed. Adding additional health care providers to the list of those who may prescribe without physician involvement is not the answer to combatting over-prescribing.

For all the reasons above, MPS/WPS urges this honorable committee to give an unfavorable report to SB 513. MPS/WPS would welcome the opportunity to work with the sponsor, committee, and proponents to facilitate evidence-based, proven programs such as Collaborative Care or telehealth that can assist Maryland patients experiencing mental illness or substance use disorders.

If you have any questions with regard to this testimony, please feel free to contact Thomas Tompsett Jr. at tommy.tompsett@mdlobbyist.com.

Respectfully submitted,
The Maryland Psychiatric Society and the Washington Psychiatric Society
Legislative Action Committee