March 18, 2022

The Honorable Delegate Shane E. Pendergrass
House Health & Government Operations Committee
House Office Building - Room 241
Annapolis, MD 21401

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

Dear Chairman Pendergrass 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.

MPS/WPS **strongly 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.

To begin, 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 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.

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. The following illustrates the somatic impacts of psychiatric medications:

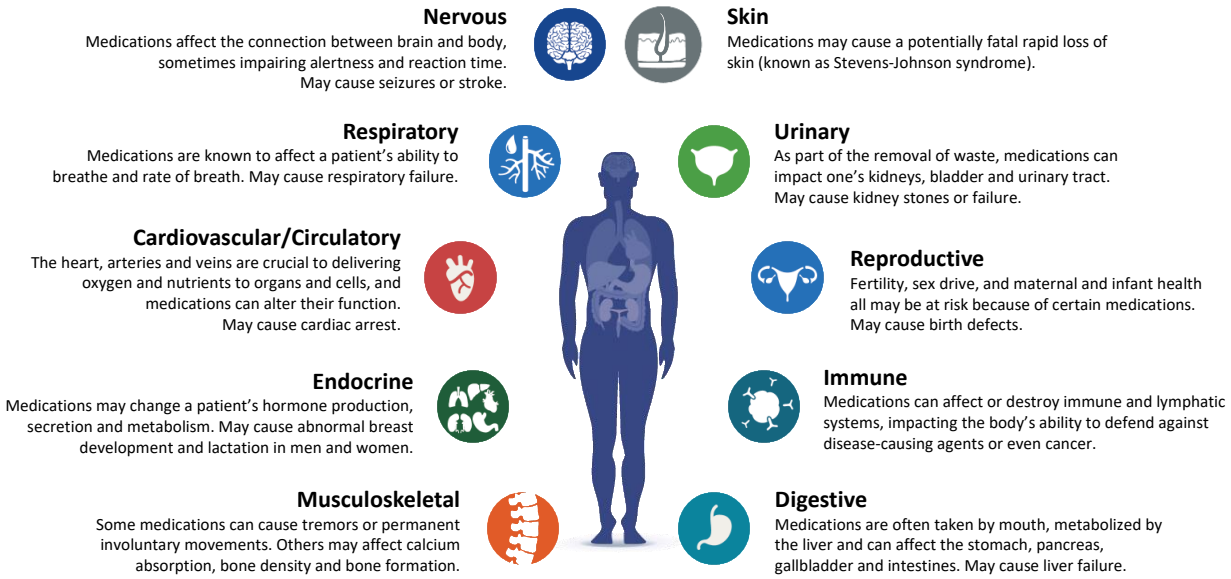
[1] 42 C.F.R. § 410.76

MARYLAND PSYCHIATRIC SOCIETY

Washington Psychiatric Society

Psychiatric Medications Affect All Body Systems

Safe, appropriate prescribing requires expert medical knowledge of all body systems.



Furthermore, patients 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.

A 2020 study[2] looked at the potential opioid overprescribing as providers who met at least one of the following: (1) prescribed any opioid to > 50% of patients, (2) prescribed ≥ 100 morphine milligram equivalents (MME)/day to > 10% of patients, or (3) prescribed an opioid > 90 days to > 20% of patients. Among 222,689 primary care providers, the study concluded that nurse practitioners (NPs) and physician assistants (Pas) practicing in states with **independent**

[2] https://pubmed.ncbi.nlm.nih.gov/32333312/

prescription authority were 20 times more likely to overprescribe opioids than NPs/PAs in prescription-restricted states. Furthermore, while most NPs/PAs prescribed opioids in a pattern similar to physicians, NPs/PAs had more outliers who prescribed high-frequency, high-dose opioids than did physicians. The question then becomes, why would the State risk any more opioid overdose deaths by making these drugs more accessible for general consumption?

When the Maryland General Assembly granted NPs prescribing authority it compared NPs with physicians and decided NPs' practice was essentially close enough to a physician's and therefore should have this authority. Today, as we debate this policy, the same body is comparing CNSs not with physicians but instead with NPs. Physicians should remain the point of comparison or Maryland runs the risk of only widening the knowledge gap for prescribing.

CNSs are not NPs. CNSs are trained to become clinical experts in their field and base their practice on research and theory. Their studies focus more on case management, educational teaching skills, and inter-dependencies involving clinical practice. In addition, they are educated to function in one, two, or three of the "spheres of influence", namely, patient management, clinically directing or managing a nursing staff of a large department or nursing facility, and being intimately involved with the organization management of the health care system. CNDs have the education and expertise to lead the nursing staff in education and improving the patient care process. A CNS acts as an active consultant, is frequently involved in management roles, and assists to develop policies. CNS assess, plan, and intervene in complex cases providing support to nursing staff, patients, and their family members. Finally, CNS can also manage the staff of a large department of nursing.

On the other hand, NPs' course of study is primarily focused on providing medical care to a diverse population in a variety of primary care, long-term, and acute care settings. NPS typically work under the indirect supervision of physicians and use their expertise to consult on patient care. They diagnose chronic illnesses, manage acute episodes, promote disease prevention, perform health assessments, and order and interpret diagnostic tests. As you can see, the clinical experience is where these two types of advanced practice nurses diverge; the same clinical experience necessary to appropriately prescribe medication.

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