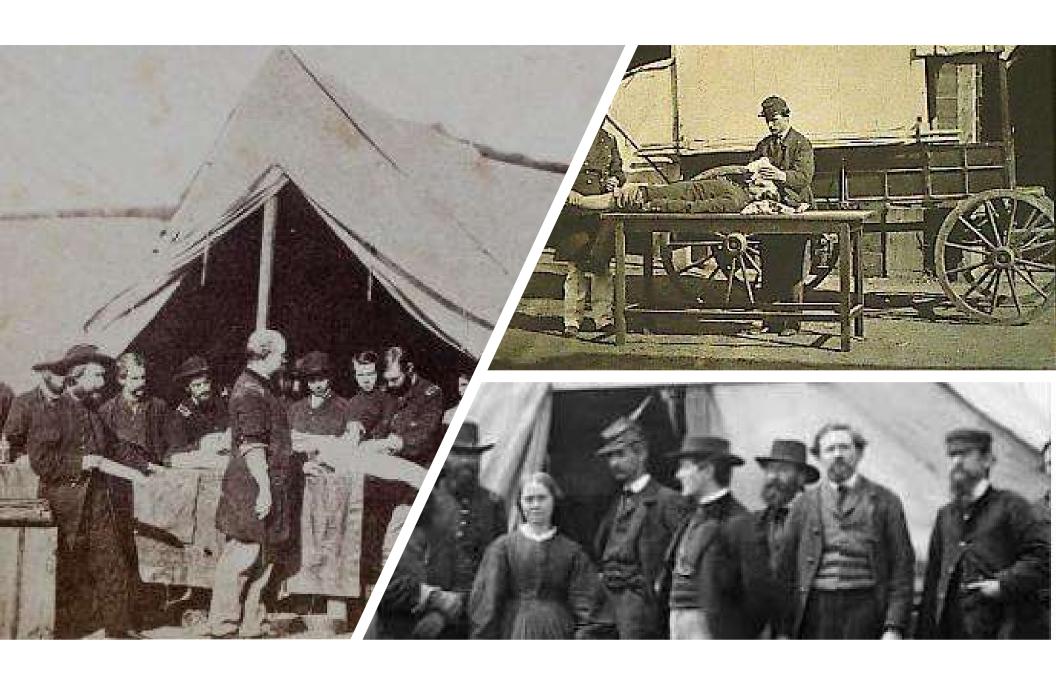




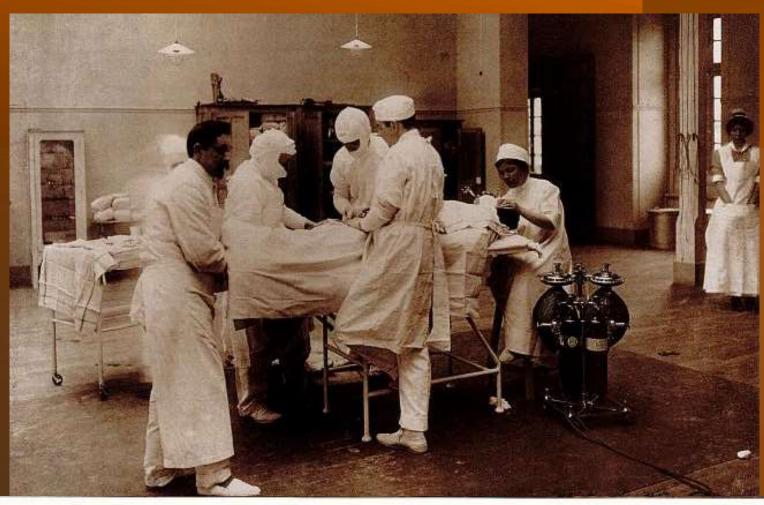


# Timeless Quality Care Nurse Anesthesia Prior to the American Association of Nurse Anesthetists



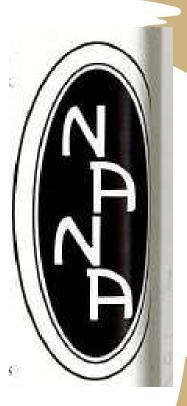
 Alice Magaw Kessel (1860–1928), anesthetist to Drs. William J. and Charles H. Mayo, who referred to her as "the Mother of Amesthesia." (AANA)





Agatha Hodgins administered anesthesia during World War I. Hodgins and others from Lakeside Hospital in Cleveland, Ohio, were part of the Lakeside Unit which served at the American Ambulance Hospital in Neuilly, France. Part of Hodgins' work was training others in the use of nitrous oxide-oxygen anesthesia.

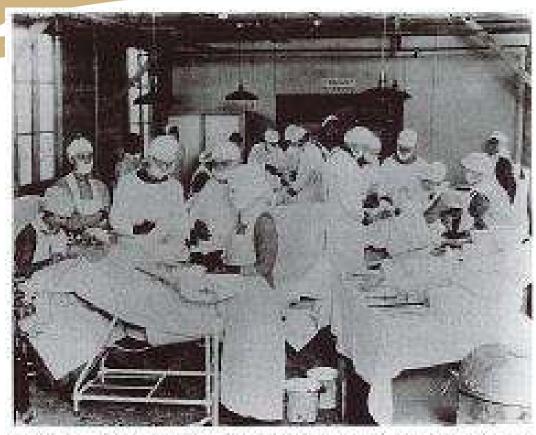




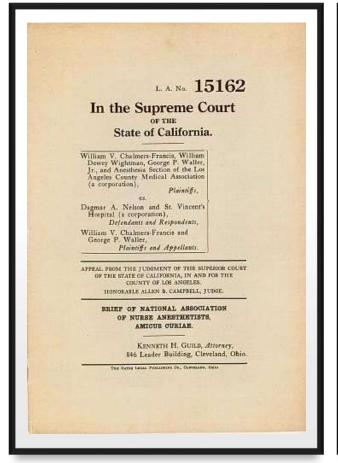


8. Dr. George W. Crile with his Lakeside Unit, American Ambulance, January 13, 1915. Agotha Hodgins is sexted at the left. (AANA)





 Norse anesthetists serve in Base Hospital No. 52, Hume Marne, France. 1918. (US Army Center of Military History)





Verne C. Hunt, MD (AANA)



Dagmar Nelson (AANA)





## From NANA to AANA

Eight years after the National Association of Nurse Anesthetists was founded in Cleveland, the Association was reincorporated in Illinois as the American Association of Nurse Anesthetists. Shown are a membership card from 1939 and the certificate of incorporation from the state of Illinois.

# Watchful Care of the Sleeper

The look of The Bulletin (left) changed yet again, with the new name of the Association appearing on the cover. Above, the AANA seal, with the design "Watchful Care of the Sleeper by the Light of the Lamp of Learning," was adopted. The seal shows Morpheus, god of dreams, watching over the sleeping Hypnos, god of sleep. A contest was held to select the seal, and the winning entry was designed by members Louise Schwarting and Lennie Dearing, with W.W. Bowen, MD, and artist Hugh Mosher. The seal remains in use to this day, appearing on the cover of the current AANA Journal.





 Ira P. Gunn, CRNA, MLN, FAAN (LTC, USA, retired), has distinguished herself in many areas relating to nurse anesthesia, including practice, research, education, publications, consultation, credentialing, and government relations. (AANA)

# THE BULLETIN

of the

AMERICAN ASSOCIATION of NURSE ANESTHETISTS

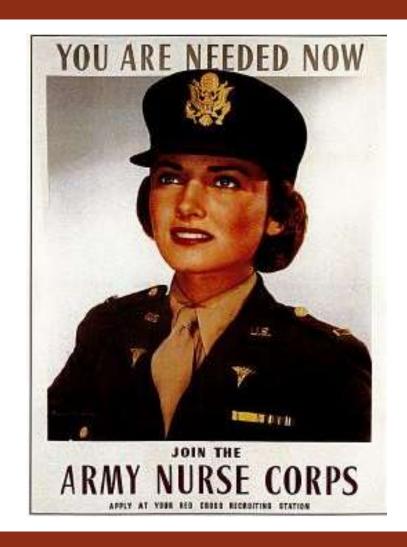
FEBRUARY 1940

VOLUME 8

NUMBER 1









Florence McQuillen was appointed the AANA's first executive director, a position she held for 22 years. Upon her retirement in 1970, McQuillen assumed the titles of director emeritus and consultant to the Board of Trustees. In 1981, she was the recipient of the Agatha Hodgins Award for Outstanding Accomplishment. President Kay Wagner, CRNA, who presented the award, remarked that McQuillen was "influential in virtually all areas of the Association's growth and expansion."

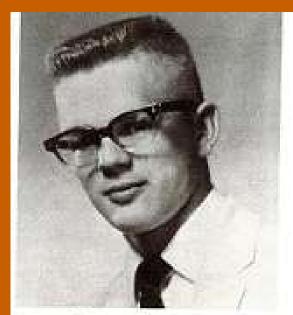


## Men in Nurse Anesthesia

At left, nurse anesthetist Edward Lyon, the first man commissioned in the U.S. Army Nurse Corps, received congratulations from Doris Nugent, president of the New York Association of Nurse Anesthetists. (U.S. Army Photograph) On a lighter note (below), the male members of the AANA organized and presented their own skit for the State Night Friendship Dinner at the Annual Meeting—the Mr. Ann S. Thesia beauty contest!

## Olmsted and Shoemaker: Died While Serving Their Country

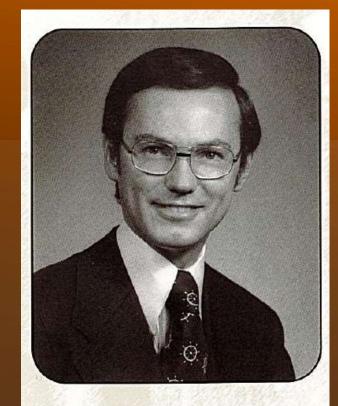
Of the 10 nurses who lost their lives in the Vietnam conflict, two were CRNAs. First lieutenants Jerome Olmsted and Kenneth. Shoemaker, assigned to the Army's 67th Evacuation Hospital in Qui Nhon, were killed in the crash of a C-47 transport plane carrying wounded from Pleiku to Qui Nhon. The crash killed all 26 on board. Olmsted had been an AANA member since August 1966 and Shoemaker since January 1967. Both graduated from anesthesia school in 1966—Olmstead from St. Francis Hospital in La Crosse, Wis., and Shoemaker from St. Joseph's Hospital in Lancaster, Pa.



Jerome Olmsted, CRNA



Kenneth Shoemaker, CRNA



First Male President

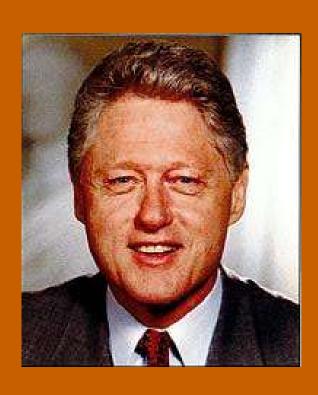
John Garde, CRNA, became the

AANA's first male president.



32. AANA President 1973–74, Goldie D. Brangman, CRNA, first black president of the Association, in the Washington office of US Representative Al Ulmann (D. Ore), vice-chairman of the House Ways and Means Committee. AANA membership of black women was approved in 1944. (AANA)





# Presidential Speaker

Former U.S. President Bill Clinton, whose mother was a nurse anesthetist, was the keynote speaker at the 2006 Annual Meeting in Cleveland, Ohio.



Founded Aug 24, 1937

1937 Pierina G. Egan

1938 Pierina G. Egan

1939 Hellon Gandy

1940 Martha Puett

1941 Dixie Lee Diefenderfer

1942 Hellon Gandy

1943

1944 Mary Gough

1945 Beatrice Pitt

1946 Halloween W. Bertram

1947 Billie Glover

1948

1949 Dolly Piff

1950 Dolly Piff

1951 Halloween W. Hert

1952 Helen Loving

1953 Sister Mary Agnes Claire

1954 Sister Mary Agnes Claire

1955 Mary R. Powell

1956 Mary Ann Reinhart

1957 Emma R. Gilbert

1958

1959 Emily D. Carter

1960 Jeanne Anderson

1961 Jeanne Anderson

1962 Annie K. Huff

1963 Lynn Welsh

1964 Shirtey Kennedy

1965 Esther McConville

1966 Douglas J. Smith

1967 Anna Clark

1968 Dave Heise

1969 Virginia Shaw

1970 Carolyn R. Rathburn

1971 Pauline Davis

1972 Margaret Benefield

1973 Patrick McGee

1974 Sister Mary Manuela Mierejewski

1975 Benjamin Rosenbluth

1976 Patsy Bynum

1977 Stephen Johnson

1978 Peter Wipfli

1979 Edna Duncan

1980 LeeDora Casto

1981 Virginia Shaw

1982 June Tucker

1983 June Tucker

1984

1985

1986 Charles Garrett

1987 Jim Hoerth

1988 Mona Holbrook

1989 Charles D. Heise

1990 Mona Holbrook

1991 Deborah Ann Gouchoe

1992 Robert Going

1993 William Brasher

1994 Deborah Day

1995 Kent Schmidt

1996 Deborah Day

1997 Marjori e Sagonda

1998 William Brasher

1999 John Martin

2000 William Brasher

2001 William Brasher

2002 Tom LeBlanc

2003 Tom LeBlanc

2004 Victor Long

2005 Victor Long

2006 Bob Rawls

2007 Bob Rawls

2008 Victor Long

2009 Victor Long

2010 Don Mordecai

2011 Don Mordecai

2012 Steven McKitrick

2013 Steven McKitrick

2014 Elizabeth Schultz

2015 Elizabeth Schultz

2016 Brenda Toland

2017 Brenda Toland

2018 Maria Roberson

2019 Jennifer Schmitt

2020 Jason Wauson

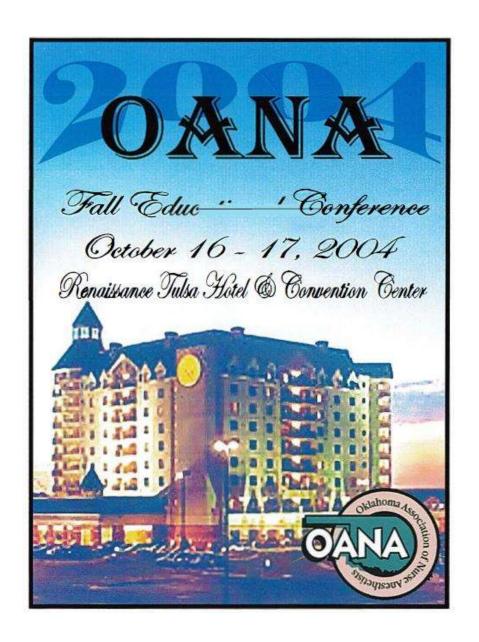
2021 Leah Coyle

2022 James Hilfiger

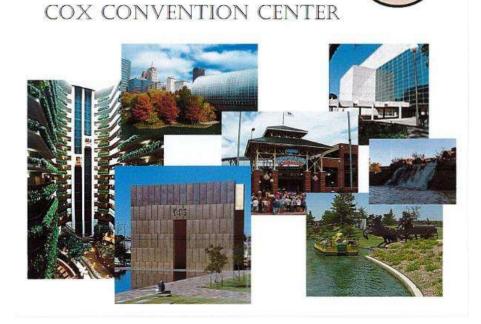
2023 Alexia McWaters

2024 Sean Klufa

**The Wise Guys** 







OANA
LEGISLATIVE
TIMELINE
1993-2020

**SB275 OANA-PAC** SB1577 **SB1638** SB1133 SB479 SB1455 HB1394 SB1086 SB792 PR TROUBLE PR HELP STRATIGIC FUND SB544 HB1351 **AG OPINIONS' BON REQUEST SB364 SB781 SB570 SB801 OPT OUT** 

ENROLLED SENATE BILL NO. 275

By: Monson of the Senate

and

Paulk of the House

An Act relating to the Oklahoma Pharmacy Act, the Oklahoma Nursing Practice Act and the Uniform Controlled Dangerous Substances Act; amending 59 O.S. 1991, Sections 353.6 and 353.7, as amended by Sections 5 and 6. Chapter 199. O.S.L. 1993, 355, 355.1, 567.3a, as last amended by Section 13, Chapter 318, O.S.L. 1996, Section 5, Chapter 186, O.S.L. 1996, and 567.7, as last amended by Section 6, Chapter 186, O.S.L. 1996 (59 O.S. Supp. 1996, Sections 353.6, 353.7, 567.3a, 567.4a and 567.7), which relate to meetings for examination of applicants, definitions, prescriptive authority recognition and licensure; providing for certain authority for certain nurses under certain circumstances; removing limit on number of times certain examination shall be held; expanding rulemaking jurisdiction of the State Board of Pharmacy; modifying definitions; expanding list of entities exempt from certain requirement; authorizing certified registered nurse anesthetists to order, select, obtain and administer drugs subject to certain conditions; requiring certain list; requiring termination of certain authority under certain circumstances; requiring promulgation of rules by the Oklahoma Board of Nursing to establish a Formulary Advisory Council; requiring development of inclusionary drug formulary; providing for composition and operational needs of Council; clarifying statutory references; stating application for licensure and renewal fee; amending 63 O.S. 1991, Sections 2-101, as last amended by Section 14 or Enrolled House Bill No. 1436 of the 1st Session of the 46th Oklahoma

- 9. "Nurse-midwifery practice" means providing management of care of normal newborns and women, antepartally, intrapartally, postpartally and gynecologically, occurring within a health care system which provides for medical consultation, medical management or referral, and is in accord with the standards for nurse-midwifery practice as defined by the American College of Nurse-Midwives;
  - 10. a. "Certified registered nurse anesthetist" means any person who holds a license to practice as a registered nurse in this state and who:
    - has successfully completed the educational program of a school of nurse anesthetists accredited by the American Association Council on Accreditation of Nurse Anesthetists Anesthesia Educational Programs,
    - is certified by the American Association Council
      on Certification of Nurse Anesthetists as a
      Certified Registered Nurse Anesthetist within one
      (1) year following completion of such educational
      program, and continues to maintain such
      certification current recertification by the
      Council on Recertification of Nurse Anesthetists,
    - e. (3) administers anesthesia under the supervision of a medical doctor, an osteopathic physician or a dentist licensed in this state and under conditions in which timely onsite consultation by such doctor, osteopath or dentist is available, and
    - d. (4) has received a certificate of recognition from the Board.
    - b. A certified registered nurse anesthetist, under the supervision of a medical doctor, osteopathic physician or dentist licensed in this state, and under conditions in which timely, on-site consultation by such medical doctor, osteopathic physician or dentist is available, shall be authorized, pursuant to rules adopted by the Oklahoma Board of Nursing, to order, select, obtain and administer legend drugs, Schedules II through V controlled substances, devices, and medical gases only when engaged in the preanesthetic preparation and evaluation; anesthesia induction, maintenance and emergence; and postanesthesia care. A certified registered nurse anesthetist may order, select, obtain and administer drugs only during the perioperative or periobstetrical period.
    - c. A certified registered nurse anesthetist who applies for authorization to order, select, obtain and

- application fee established pursuant to this section.
- d. The authority to order, select, obtain and administer drugs shall be terminated if a certified registered nurse anesthetist has:
  - (1) ordered, selected, obtained or administered drugs outside of the certified registered nurse anesthetist scope of practice or ordered, selected, obtained or administered drugs for other than therapeutic purposes, or
  - (2) violated any provision of state laws or rules or federal laws or regulations pertaining to the practice of nursing or the authority to order, select, obtain and administer drugs.
- e. The Oklahoma Board of Nursing shall notify the Board of Pharmacy within two (2) working days after termination of or a change in the authority to order, select, obtain and administer drugs for a certified registered nurse anesthetist.
- f. The Board shall provide by rule for biennial application renewal and reauthorization of authority to order, select, obtain and administer drugs for certified registered nurse anesthetists. At the time of application renewal, a certified registered nurse anesthetist shall submit documentation of a minimum of eight (8) units of continuing education, completed during the previous two (2) years, in advanced pharmacology relating to the administration of anesthesia, as recognized by the Council on Recertification of Nurse Anesthetists.
- g. Any person who is recognized by the Board as a certified registered nurse anesthetist shall have the right to use both the title "Certified Registered Nurse Anesthetist" and the abbreviation "CRNA". No other person shall assume such title or use such abbreviation or any other words, letters, signs, or figures to indicate that the person using the same is a certified registered nurse anesthetist.
- h. This paragraph shall not prohibit the administration of local or topical anesthetics as now permitted by law. Provided further, nothing in this paragraph shall limit the authority of the Board of Governors of Registered Dentists Dentistry to establish the qualifications for dentists who direct the administration of anesthesia;
- 11. "Supervising physician" means an individual holding a

- of Nursing, all of whom shall be appointed by the Oklahoma Board of Nursing.
- c. All professional members of the Formulary Advisory Council shall be in active clinical practice, at least fifty percent (50%) of the time, within their defined area of specialty. The members of the Formulary Advisory Council shall serve at the pleasure of the appointing authority for a term of three (3) years. The terms of the members shall be staggered. Members of the Council may serve beyond the expiration of their term of office until a successor is appointed by the original appointing authority. A vacancy on the Council shall be filled for the balance of the unexpired term by the original appointing authority.
- d. Members of the Council shall elect a chair and a vice-chair from among the membership of the Council. For the transaction of business, at least seven members, with a minimum of two members present from each of the identified categories of physicians, pharmacists and advanced practice nurses, shall constitute a quorum. The Council shall recommend and the Board shall approve and implement an initial exclusionary formulary on or before January 1, 1997. The Council and the Board shall annually review the approved exclusionary formulary and shall make any necessary revisions utilizing the same procedures used to develop the initial exclusionary formulary.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 567.4b of Title 59, unless there is created a duplication in numbering, reads as follows:

- A. 1. The rules regarding authorization for a certified registered nurse anesthetist to order, select, obtain and administer drugs, promulgated by the Oklahoma Board of Nursing pursuant to paragraph 10 of Section 567.3a of Title 59 of the Oklahoma Statutes, shall provide for establishment of a Formulary Advisory Council to develop and submit to the Board recommendations for an inclusionary formulary that lists drugs or categories of drugs that may be ordered, selected, obtained or administered by certified registered nurse anesthetists authorized by the Board to order, select, obtain and administer drugs.
- 2. Such Formulary Advisory Council shall also develop and submit to the Board recommendations for practice-specific standards for ordering, selecting, obtaining and administering drugs for a certified registered nurse anesthetist authorized by the Board to order, select, obtain and administer drugs pursuant to the provisions of the Oklahoma Nursing Practice Act.

therefrom), fiber, oil or cake, or the sterilized seed of such plant which is incapable of germination;

- 24. "Medical purpose" means an intention to utilize a controlled dangerous substance for physical or mental treatment, for diagnosis, or for the prevention of a disease condition not in violation of any state or federal law and not for the purpose of satisfying physiological or psychological dependence or other abuse;
- 25. "Mid-level practitioner" means an advanced practice nurse as defined and within parameters specified in Section 567.3a of Title 59 of the Oklahoma Statutes;
- 26. "Narcotic drug" means any of the following, whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis:
  - a. opium, coca leaves and opiates,
  - a compound, manufacture, salt, derivative or preparation of opium, coca leaves or opiates,
  - c. cocaine, its salts, optical and geometric isomers, and salts of isomers,
  - d. ecgonine, its derivatives, their salts, isomers and salts of isomers, and
  - e. a substance, and any compound, manufacture, salt, derivative or preparation thereof, which is chemically identical with any of the substances referred to in subparagraphs a through d of this paragraph, except that the words "narcotic drug" as used in Section 2-101 et seq. of this title shall not include decocainized coca leaves or extracts of coca leaves, which extracts do not contain cocaine or ecgonine;
- 26. 27. "Opiate" means any substance having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having such addiction-forming or addiction-sustaining liability. It does not include, unless specifically designated as controlled under the Uniform Controlled Dangerous Substances Act, the dextrorotatory isomer of 3-methoxy-n-methyl-morphinan and its salts (dextromethorphan). It does include its racemic and levorotatory forms;
- 27. 28. "Opium poppy" means the plant of the species Papaver somniferum L., except the seeds thereof;
- 28. 29. "Peace officer" means a police officer, sheriff, deputy sheriff, district attorney's investigator, investigator from the Office of the Attorney General, or any other person elected or appointed by law to enforce any of the criminal laws of this state or of the United States;
- 29. 30. "Person" means an individual, corporation, government or governmental subdivision or agency, business trust, estate,

- substance is in the usual course of his such carrier's or warehouser's business or employment;
- 4. An ultimate user or a person in possession of any controlled dangerous substance pursuant to a lawful order of a practitioner;
- 5. An individual pharmacist acting in the usual course of his such pharmacist's employment with a pharmacy registered under this act;
  - 6. A nursing home licensed by this state; and
  - 7. Registered nurses and licensed practical nurses.
- D. The Director may, by regulation rule, waive the requirement for registration and/or or fee for registration of certain manufacturers, distributors, dispensers, prescribers, administrators, or users for scientific purposes if he the Director finds it consistent with the public health and safety.
- E. A separate registration shall be required at each principal place of business or professional practice where the applicant manufactures, distributes, dispenses, prescribes, administers, or uses for scientific purposes controlled dangerous substances.
- F. The Director is authorized to inspect the establishment of a registrant or applicant for registration in accordance with the rules and regulations promulgated by him the Director.
- G. No person engaged in a profession or occupation for which a license to engage in such activity is provided by law shall be registered under this act unless such person holds a valid license of his such person's profession or occupation.
- H. Registrations shall be issued on the first day of November of each year. Registrations may be issued at other times, however, upon certification of the professional licensing board.
- I. The licensing boards of all professions and occupations to which the use of controlled dangerous substances is incidental shall furnish a current list to the Director, not later than the first day of October of each year, of the persons holding valid licenses. All such persons except persons exempt from registration requirements under subsection C of this section shall be subject to the registration requirements of Section 2-101 et seq. of this title.
- J. The licensing board of any professional defined as a midlevel practitioner shall notify and furnish to the Director, not later than the first day of October of each year that such professional holds a valid license, a current listing of individuals licensed and registered with their respective boards to prescribe, order, select, obtain and administer controlled dangerous substances. The licensing board shall immediately notify the Director of any action subsequently taken against any such individual.
- SECTION 12. AMENDATORY 63 O.S. 1991, Section 2-303, as amended by Section 5, Chapter 306, O.S.L. 1996 (63 O.S. Supp. 1996,

- A registrant shall be required to pay double the amount of the above-listed fee for any renewal of registration received more than sixty (60) days late.
- A Ten Dollar (\$10.00) fee shall be charged for a duplicate registration certificate.
- E. Compliance by manufacturers and distributors with the provisions of the Federal Controlled Substances Act, 21 U.S.C., Section 801 et seq., respecting registration, excluding fees, shall be deemed sufficient to qualify for registration under this act.

SECTION 13. AMENDATORY 63 O.S. 1991, Section 2-312, as last amended by Section 10, Chapter 186, O.S.L. 1996 (63 O.S. Supp. 1996, Section 2-312), is amended to read as follows:

Section 2-312. A. A physician, podiatrist, optometrist or a dentist who has complied with the registration requirements of the Uniform Controlled Dangerous Substances Act, Section 2-101 et seq. of this title, in good faith and in the course of such person's professional practice only, may prescribe and administer controlled dangerous substances, or may cause the same to be administered by medical or paramedical personnel acting under the direction and supervision of the physician, podiatrist, optometrist or dentist, and only may dispense controlled dangerous substances pursuant to the provisions of Sections 355, 355.1 and 355.2 of Title 59 of the Oklahoma Statutes.

- B. A veterinarian who has complied with the registration requirements of the Uniform Controlled Dangerous Substances Act, Section 2-101 et seq. of this title, in good faith and in the course of the professional practice of the veterinarian only, and not for use by a human being, may prescribe, administer, and dispense controlled dangerous substances and may cause them to be administered by an assistant or orderly under the direction and supervision of the veterinarian.
- C. An advanced practice nurse who is recognized to prescribe by the Oklahoma Board of Nursing as an advanced registered nurse practitioner, clinical nurse specialist or certified nurse-midwife, who is subject to medical direction by a supervising physician, pursuant to Section 567.3a of Title 59 of the Oklahoma Statutes, and who has complied with the registration requirements of the Uniform Controlled Dangerous Substances Act, in good faith and in the course of professional practice only, may prescribe and administer Schedule III, IV and V controlled dangerous substances.
- D. An advanced practice nurse who is recognized to order, select, obtain and administer drugs by the Oklahoma Board of Nursing as a certified registered nurse anesthetist pursuant to Section 1 of this act and who has complied with the registration requirements of the Uniform Controlled Dangerous Substances Act, in good faith and in the course of such practitioner's professional practice only, may

SECTION 15. REPEALER Section 6 of Enrolled Senate Bill No. 59 of the 1st Session of the 46th Oklahoma Legislature, is hereby repealed.

SECTION 16. This act shall become effective November 1, 1997. Passed the Senate the 14th day of May, 1997.

President of the Senate

Passed the House of Representatives the 19th day of May, 1997.

Speaker of the House of Representatives 4/21/25, 11:34 AM Bill Information

### BILL INFORMATION FOR SB 275

SR 275 by	Monson	and Paulk

and the control of the Carlotte			
SELECT SESSION:	1997 Regular Session	~	Receive Email Updates for this Measure (LENS
ENTER BILL #:	Search		

Public health and safety, providing for regulation of prescriptive authority for Certified Registered Nurse Anesthetists; expanding rulemaking jurisdiction of State Board of Pharmacy; requiring establishment of Formulary Advisory Council. Effective date

Action	Journal Page	Date	Chambe
First Reading	87	02/03/1997	s
Authored by Senator Monson	87	02/03/1997	S
Second Reading referred to Human Resources	190	02/04/1997	S
CR; do pass, amended by committee substitute Human Resources committee	264	02/18/1997	s
coauthored by Paulk (principal House author)	264	02/18/1997	s
General Order, Amended	475	03/10/1997	s
Title stricken	475	03/10/1997	s
Measure passed: Ayes: 35 Nays: 7	475	03/10/1997	s
Referred for engrossment	475	03/10/1997	5
Engrossed to House	501	03/11/1997	s
First Reading	699	03/11/1997	н
Second Reading referred to Public Health	723	03/12/1997	н
CR; Do Pass, as arnended, Public Health Committee	810	03/25/1997	н
Title restored	810	03/25/1997	н
General Order	931	04/08/1997	н
Amended	931	04/08/1997	н
Title stricken	931	04/08/1997	н
Enacting clause stricken	931	04/08/1997	н
Third Reading, Measure passed: Ayes: 56 Nays: 35	931	04/08/1997	н
Referred for engrossment	931	04/08/1997	н
Engrossed, signed, to Senate	937	04/09/1997	н
HAs read	732	04/09/1997	s
HAs rejected, conference requested	826	04/24/1997	s
Conference granted, HC's named Paulk, Lindley, Gray, Stanley, Thornbrugh	1086	04/28/1997	н
SCs named Monson, Cain, Robinson, Weedn, Hendrick	847	04/30/1997	s
CCR read	873	05/07/1997	s

/25, 11:34 AM Enacting clause restored	Bill Information	873	05/07/1997
Title restored		873	05/07/1997
CCR adopted		910	05/14/1997
Measure passed, to House: Ayes: 38 Nays: 5		910	05/14/1997
CCR submitted		1167	05/14/1997
CCR adopted		1182	05/19/1997
Measure passed: Ayes: 78 Nays: 21		1182	05/19/1997
To Senate		1183	05/19/1997
Referred for enrollment		928	05/19/1997
Enrolled, to House		939	05/20/1997
Signed, returned to Senate		1196	05/20/1997
Sent to Governor		946	05/20/1997
Approved by Governor 5-23-97		1012	05/23/1997

1/2

1/27/25, 8:49 AM				SO-2				
State of Oklahoma							EC OFFICE USE ONLY	
[74 O.S.Supp.20		tees (no	GANIZATION on-candidate]			<b>SO-2</b>		
1. NAME OF CO OANA - PAC	MMITTEE (may not include th	e name of a candi	tate):		#	AMENDED	Number Assigned by Ethics Commission 298417	
PO Box 702	MAILING ADDRESS, E-MAI	ADDRESS, &	TELEPHONE NUMBER OF CO	MMITTE	E: Daytime to (405) 325	elephone number 9-6262		
City Norman		tate IK	Zip 73070		Electronic	mailing address		
3. DATE COMMI 10/05/1997	TTEE WAS ORGANIZED:	115	4. TYPE OF COMMITTEE (c [ X ] Political Action (				mmittee Party Committee	
			sure committee describe balle	ot meas		FEC NUMBER [II reg	distared with Federal Election	
7. NAME AND M COMMITTEE (If	andidates for state office AJLING ADDRESS OF COR no association or organiza in of Nurse Anesthetist	PORATION, LA	BOR ORGANIZATION, OR OTI ade, profession or primary int Norman, OK 73070	HER AS: erests o	OCIATION	ommission]; WHICH SPONSORS butors):	OR IS AFFILIATED WITH	
Office Chair	Name (last, first, middle Initial) Long, Victor D	Mailing A electronic Street: 1031 S City, St.,	S Flood Ave Zip: an, OK 73072		code] and	Daytime telephone number (405) 329-1767	f business of officers, Principal place of business Self-employed CRNE M.S.	
Treasurer	Long, Victor D	Street: 1031 S I City, St., Norman E-mail:	Flood Ave			(405) 329-1767	self-employed CRNE CRNA M.S.	
Deputy Treasurer [if appointed]	Kennedy, Bruce	Street: 3909 Sp City, St.,	arkle St			(405) 760-9693	Self-Employed CRNA M.S.	
9. NOTICE OF RI Check only one:	EPORTS AND LATE FILING	S: Check title o	f person who is to receive not	tices of	required fill	: ngs and late filing vi	olations:	
	OF THE RECORDS (if other		ed officers):	P	rincipal pla	ce of business		
Malling address	City	100772000	State Zip	 E	-mail addre	88		
11. DEPOSITORIES: Please list the full name and address of each depository in which the committee will maintain a campaign eccount.  Bank of Oklahoma: PO Box 24128, Oklahoma City, OK			to a	12. STATEMENT OF INTENT: The above committee:  (check one)  [X] INTENDS  [ ] DOES NOT INTEND  to accept contributions or to make experiments in excess of \$500 in the accepting for eachier year for which its abstract is being \$64.				
collected by this	one or any of the app	r any purpose o		funds for to amo	om this car	mpaign as follows. N statement.	nement is being filed. o Surptus funds	
Donate to of			[ ] beb	ant to Si	and general	, named		

14. CERTIFICATION: I certify that the above named officers have accepted their appointments and that the information reported on this form is true,

https://pay.apps.ok.gov/ethics/crs/so2/view\_so2.php?amended=0&reg\_id=298417&action=public&report\_num=22202

complete, and correct.
TREASURER'S Signature [or electronic signature in lieu thereof]

State of Oklahoma EC OFFICE USE ONLY CAMPAIGN CONTRIBUTIONS AND **C1-R** EXPENDITURES REPORT [74 Oklahoma Statutes, Ch 62 App., § 257:10-1-13 and 10-1-14] FAX (405) 521-4905 1.COMMITTEE NAME OANA - PAC 2.COMMITTEE ADDRESS (number and street) PO Box 702 CITY, STATE, and ZIP CODE 298417 Norman, OK 73070 3a,CANDIDATE COMMITTEES ONLY: Candidate's Name Year of General or Special General Election Office Sought 3b.BALLOT MEASURE COMMITTEES ONLY: Title or number of ballot measure supported or opposed Year when ballot measure is on the ballot 4. TYPE(S) OF REPORT [ ] Pre-election [ ] Monthly [ / ] Quarterly [ ] Annual [ ]Amended [ ]FINAL Period Covered by Report, Beginning Apr 01, 2003 Ending Jun 30, 2003 5.CARRY FORWARD amount from line 25 of previous report or transferred from previous campaign. If no previous report or transfer from a previous campaign, leave blank. 5.00 a. Total for this b. Total campaignreporting period to-date [candidate committees) or yearto-date [others] 6.CONTRIBUTIONS ACCEPTED FROM PERSONS OTHER THAN COMMITTEES [see attached schedule A] \$.00 7.CONTRIBUTIONS ACCEPTED FROM COMMITTEES [see attached schedule A1] \$.00 \$.00 8.LOANS, promissory notes or security agreements received [see attached schedule B] 9.OTHER RECEIPTS-refunds, rebates, interest, sale of assets, etc. [see attached schedule C] \$ 00 \$.00 10.TOTAL MONETARY RECEIPTS [total line 6, 7, 8, and 9] 3.00 \$.00 11.IN-KIND CONTRIBUTIONS [see attached schedule D] \$.00 \$ 00 12.FUNDS received from a corporation, labor organization or other person by its political action committee for establishment and solicitation costs [only applicable to non-candidate committees] 12a.WRITTEN agreements, promises, or pledges to make contributions [see attached schedule D1] 5.00 \$.00 13.AGGREGATE TOTAL RECEIPTS [total lines 10, 11, 12 and 12a] S.00 \$4,525.00 a. Total for this b. Total campaignto-date [candidate committees] or yearto-date [others] 14.EXPENDITURES MADE [see attached schedula E] 5.00 15.INDEPENDENT EXPENDITURES AND ELECTIONEERING COMMUNICATIONS [see attached schedulo F] \$.00 \$.00 16.MONETARY TRANSFERS (contributions) to other committees [see attached schedule G] \$.00 \$.00 17-AGGREGATE TOTAL MONETARY EXPENDITURES [add lines 14, 15, and 16] \$.00 \$1.763.65 18.IN-KIND TRANSFERS [see attached schedule H] \$.00 19.EXPENDITURES INCURRED owed but not yet paid [see attached schedule fi \$.00 26.BALANCE ON LOANS OWED BY committee (see attached schedule J) CASH SUMMARY: 21.FUNDS AVAILABLE [repeat amount from line 5] \$.00 22.MONETARY RECEIPTS [repeat line 10, column (a)] \$.00 23.TOTAL MONETARY RECEIPTS (add line 21 and line 22) \$.00 24.DISBURSEMENTS (repeat amount on line 17 column (a)) \$.00 25.FUNDS REMAINING (subtract line 24 form line 23) \$3,711.32 26.Certification: I hereby certify that, during this campaign-lo-date for candidate committees or calendar year-to-date for other committees, the reasuror or deputy tro. contributor statements or is making good-faith requests to obtain contributor statements, as required by the Ethics Commission Rules, I further certify that this report is a true and correct record of this committee's contribution and expenditure transactions and that I have been appointed to file reports on behalf of this committee

Date

X Jun 30, 2003

C-1R

https://pay.apps.ok.gov/ethics/crs/c1r/view\_c1r.php?reg\_id=298417&action=public&report\_num=1322

Treasurer's or Deputy Treasurer's Signature

x Filed by Administrator

EC FORM C-1R [REV. 4/12]

1/2

4/27/25, 8:34 AM

1/1

4/27/25,	8	38	AM
Chate of		i dada	

C-1R

#### CAMPAIGN CONTRIBUTIONS AND **EXPENDITURES REPORT**

C1-R

EC OFFICE USE ONLY

[74 Oklahoma Statutes, Ch 62 App., § 257:10-1-13 and 10-1-14] FAX (405) 521-4905 1.COMMITTEE NAME DANA - PAC 2.COMMITTEE ADDRESS (number and street) PO Box 702 CITY, STATE, and ZIP CODE FEC#

Norman, OK 73070 298417 3a.CANDIDATE COMMITTEES ONLY: Candidate's Name Office Sought Year of General or Special General Election 3b.BALLOT MEASURE COMMITTEES ONLY: Title or number of ballot measure supported or opposed Year when ballot measure is on the ballot 4. TYPE(S) OF REPORT [ ] Pre-election [ ] Monthly [ / ] Quarterly [ ] Annual [ ]Amended [ ]FINAL

Period Covered by Report. Beginning Oct 01, 2009 Ending Dec 31, 2009

5.CARRY FORWARD amount from line 25 of previous report or transferred from previous campaign. If no previous report or transfer from a previous campaign, leave blank. \$15,200.01 a. Total for this b. Total campaign reporting period -date [candidate ommittees] or year o-date [others] 6. CONTRIBUTIONS ACCEPTED FROM PERSONS OTHER THAN COMMITTEES (see attached schedule A) \$17,780.00 \$48,242.50 7.CONTRIBUTIONS ACCEPTED FROM COMMITTEES [see attached schedule A1] \$.00 8.LOANS, promissory notes or security agreements received [see attached schedule B] \$.00 9.OTHER RECEIPTS-refunds, rebates, interest, sale of assets, etc. [see attached schedule C] \$.00 10.TOTAL MONETARY RECEIPTS [total line 6, 7, 8, and 9] \$17,780.00 \$48,242.50 11.IN-KIND CONTRIBUTIONS [see attached schedule D] \$.00 12.FUNDS received from a corporation, labor organization or other person by its political action committee for establishment and solicitation costs [only applicable to non-candidate committees] 12a.WRITTEN agreements, promises, or pledges to make contributions [see attached schedule D1] \$.00 13.AGGREGATE TOTAL RECEIPTS (total lines 10, 11, 12 and 12a) \$17,780.00 348,242,50 a. Total for this b. Total campaign eporting period to-date [candidate committees) or yearo-date [others] 14.EXPENDITURES MADE [see attached schedule E] \$283.32 \$1,591.48 15.INDEPENDENT EXPENDITURES AND ELECTIONEERING COMMUNICATIONS [see attached schedule F] \$ 00 \$ 00 16.MONETARY TRANSFERS (contributions) to other committees [see attached schedule G] \$31,500.00 \$67,450.00 17-AGGREGATE TOTAL MONETARY EXPENDITURES (add lines 14, 15, and 16) \$31,783,32 \$69,041,48 18.IN-KIND TRANSFERS [see attached schedule H] \$.00 19.EXPENDITURES INCURRED owed but not yet paid [see attached schedule [] \$.00 20.BALANCE ON LOANS OWED BY committee [see attached schedule J]

CASH SUMMARY 21.FUNDS AVAILABLE [repeat amount from line 5] \$15,200,01 22.MONETARY RECEIPTS [repeat line 10, column (a)] \$17,780.00 23.TOTAL MONETARY RECEIPTS [add line 21 and line 22] \$32,980,01 24.DISBURSEMENTS [repeat amount on line 17 column (a)] \$31,783,32 25.FUNDS REMAINING (subtract line 24 form line 23) \$1,196,69

26.Certification: I hersby certify that, during this campaign-to-date for candidate committees or calendar year-to-date for other committees, the treasurer or deputy treasurer received contributor statements or is making good-faith requests to obtain contributor statements, as required by the Ethics Commission Fulles, I further peritiy that this report is a true and correct record of this committee's contribution and expenditure transactions and that I have been appointed to the reports on behalf of this committee.

Treasurer's or Deputy Treasurer's Signature

Date

x Victor D Long EC FORM C-1R (REV. 4/12) X Jan 31, 2016

4/27/25, 8:36 AM

#### CAMPAIGN CONTRIBUTIONS AND EXPENDITURES REPORT

**C1-R** Rev 4/12

C-1R

EC OFFICE USE ONLY

FEC#

[74 Oklahoma Statutes, Ch 62 App., § 257:10-1-13 and 10-1-14] FAX (405) 521-4905 1.COMMITTEE NAME

OKCRNA - PAC

2.COMMITTEE ADDRESS (number and street)

PO Box 702

State of Oklahoma

CITY, STATE, and ZIP CODE

Norman, OK 73076

3a.CANDIDATE COMMITTEES ONLY: Candidate's Name

298417 Year of General or Special General Election

Office Sought 3b.BALLOT MEASURE COMMITTEES ONLY: Title or number of ballot measure supported or opposed Year when ballot measure is on the ballot 4. TYPE(S) OF REPORT [ ] Pre-election [ ] Monthly [ | ] Amended [ ] FINAL [ ] Quarterly

Period Covered by Report, Beginning Oct 19, 2010 Ending Dec 31 2010

5.CARRY FORWARD amount from line 25 of previous report or transferred from previous campaign, \$41,305,85 If no previous report or transfer from a previous campaign, leave blank. a. Total for this b. Total campaignreporting period to-date (candidate committees] or year o-date [others] 6. CONTRIBUTIONS ACCEPTED FROM PERSONS OTHER THAN COMMITTEES [see attached schedule A] \$1,500.00 \$55,375.00 7.CONTRIBUTIONS ACCEPTED FROM COMMITTEES [see attached schedule A1] \$.00 \$.00 8.LOANS, promissory notes or security agreements received [see attached schedule B] \$.00 \$.00 9.OTHER RECEIPTS-refunds, rebates, interest, sale of assets, etc. (see attached schedule C) 40 10.TOTAL MONETARY RECEIPTS (total line 6, 7, 8, and 9) \$1,500.0 11.IN-KIND CONTRIBUTIONS [see attached schedule D] \$.00 \$.00 12.FUNDS received from a corporation, labor organization or other person by its political action committee for establishment and solicitation costs [only applicable to non-candidate committees] 12a.WRITTEN agreements, promises, or pledges to make contributions [see attached schedule D1] \$.00 13.AGGREGATE TOTAL RECEIPTS [total lines 10, 11, 12 and 12a] \$55,375.00 \$1,500.00 a. Total for this b. Total campaign reporting period to-date [candidate committees) or yearo-date [others] 14.EXPENDITURES MADE (see attached schodule E) \$677.9 \$1,343.79 15 INDEPENDENT EXPENDITURES AND ELECTIONS ERRING COMMUNICATIONS (see attached schedule FI 8.0 5.00 16.MONETARY TRANSFERS (contributions) to other committees [see attached schedule G] \$13,900.00 \$15,243.79 17.AGGREGATE TOTAL MONETARY EXPENDITURES (add lines 14, 15, and 16) \$1,477.9 18.IN-KIND TRANSFERS [see attached schedule H] \$.00

19.EXPENDITURES INCURRED owed but not yet paid [see attached schedule I] 8.00 20.BALANCE ON LOANS OWED BY committee (see attached schedule J) CASH SUMMARY: 21.FUNDS AVAILABLE [repeat amount from line 5] \$41,305,85 22.MONETARY RECEIPTS [repeat line 10, column (a)] \$1,500.00 342.805.85 23.TOTAL MONETARY RECEIPTS (add line 21 and line 22) 24.DISBURSEMENTS (repeat amount on line 17 column (a)) \$1,477.95 25.FUNDS REMAINING (subtract line 24 form line 23) \$41,327,90

26.Certification: I hereby certify that, during this campaign-to-date for candidate committees or calendar year-to-date for other committees, the treasurer or deputy treasurer received contributor statements or is making good faith requests to obtain contributor statements, as required by the Ethics Commission Rules, I further certify that this report is a true and correct record of this committee's contribution and expenditure transactions and that I have been appointed to file reports on behalf of this committee.

Treasurer's or Deputy Treasurer's Signature

Date

x Victor D Long

X Apr 20, 2011

EC FORM C-1R [REV. 4/12]

C-1R			
6	EC OFFICE I	JSE ONLY	
C1-R	EC OFFICE USE ONLY		
8	Carlone ve	EC#	
	298417		
	Year of General or Speci	al General Election	
orted or opposed	Year when ballot measur	e is on the ballot	
erterly [ ] Annual	[ ] Amended	[ ] FINAL	
g Dec 31, 2011			
evious campaign.	1	450	
1000000	\$20,728.8	6	
	a. Total for this reporting period	<ul> <li>b. Total campaign- to-date [candidate committees] or year- to-date [others]</li> </ul>	
attached schedule A)	\$15,250.0	********	
	\$.0	A POST CONTRACTOR OF THE PARTY AND ADDRESS.	
le B)	\$.0	· Province and the same state of the same state	
chedule C)	\$.0	\$.00	
	\$15,250.0	\$23,300.00	
	\$.0	0 \$.00	
	r \$.0	0 \$.00	
schedule D1]	\$.0	G \$.00	
	\$15,250.0	\$23,300.00	
	a. Total for this reporting period	b. Total campaign- to-date [candidate committees] or year- to-date [others]	
	\$251.0	\$650.09	
		3.00	
attached schedule F)	\$.0	0.00	
attached schedule F)	\$3,000.0	\$31,250.00	
CONTRACTOR DE LA CONTRA	\$3,000.0 \$3,251.0	0 \$31,250.00 \$31,900.09	
CONTRACTOR DE LA CONTRA	\$3,000.0 \$3,251.0 \$.0	\$31,250.00 \$31,900.09 \$5.00	
CONTRACTOR DE LA CONTRA	\$3,000.0 \$3,251.0 \$.0 \$.0	\$31,250.00 \$31,900.00 \$5,00	
fule Gi	\$3,000.0 \$3,251.0 \$.0 \$.0	\$31,250.00 \$31,900.00 \$.00	
tule Gi Cash Summar	\$3,000.0 \$3,251.0 \$.0 \$.0	\$31,250,00 \$31,900,00 \$.00	
tule G]  CASH SUMMAR  ABLE (repeat amount for	\$3,000.0 \$3,251.0 \$.0 \$.0 Y:	\$31,250,00 \$31,900,00 \$.00 \$20,728.86	
CASH SUMMAR ABLE (repeat amount for	\$3,000.0 \$3,251.0 \$.0 \$.0 \$.0 Y: sen line 5] .column (a)]	\$31,250,00 \$31,900,00 \$.00 \$.00 \$20,728,66 \$15,250,00	
tule G]  CASH SUMMAR  ABLE (repeat amount for	\$3,000.0 \$3,251.0 \$.0 \$.0 \$.0 *** *** *** *** *** *** *** *** *** *	\$31,250.00 \$31,900.00 \$5,00	
	Sought orted or opposed where [ ] Annual g Dec 31, 2011 vious campaign.	ECP 298417  Sought Year of General or Specific or the correction of the correction o	

6.Certification: hereby centry that, during this campaign-bo-dale for candidate committees or calendary year-to-date for other committees, the bessure or deputy transcurer received contributor statements or its making good-tailn requests to obtain contributor statements, as required by the Eithets Commission Pulses. In thirder partly that this report is a true and control of this committee is contributor and expenditum transcurences and that have been appointed to the reports on behalf of this committee.

Treasurer's or Deputy Treasurer's Signature Date

x Victor D Long x Jan 30, 2012

EC FORM C-1R (REV. 4/12)

https://pay.apps.ok.gov/ethics/crs/c1r/view\_c1r.php?reg\_jd=298417&action=public&report\_num=71380

4/27/25, 8:41 AM C-1R
State of Oktoberose

## CAMPAIGN CONTRIBUTIONS AND EXPENDITURES REPORT

C1-R

[74 Oklahoma Statutes, Ch 62 App., § 257:10-1-13 and 10-1-14] FAX (405) 521-4905

1.COMMITTEE NAME

OKCRNA - PAC

If no previous report or transfer from a previous campaign, leave blank.

2.COMMITTEE ADDRESS (number and street)

PO Box 702

CITY, STATE, and ZIP CODE

4. TYPE(S) OF REPORT

Norman, OK 73070
3a.CANDIDATE COMMITTEES ONLY: Candidate's Name

EC# FEC#

298417

Office Sought Year of General or Special General Election

Year when ballot measure is on the ballot
[ ] Amended [ ] FINAL

EC OFFICE USE ONLY

Period Covered by Report, Beginning Jan 01, 2012 Ending Mar 31, 2012

3b.BALLOT MEASURE COMMITTEES ONLY: Title or number of ballot measure supported or opposed

[ ] Pre-election [ ] Monthly

5.CARRY FORWARD amount from line 25 of previous report or transferred from previous campaign.

[√] Quarterly [] Annual Ending Mar 31, 2012

[ ] Amended [ ] FIN

\$32,727.81

\$32,727.81

\$32,727.96 \$30,903.59

\$1,824.37

8.15

, 2012

	a. Total for this reporting period	b, Total campaign- to-date [candidate committees] or year- to-date [others]
6.CONTRIBUTIONS ACCEPTED FROM PERSONS OTHER THAN COMMITTEES [see attached schedule A]	\$.15	\$.15
7.CONTRIBUTIONS ACCEPTED FROM COMMITTEES [see attached schedule A1]	\$.00	\$.00
8.LOANS, promissory notes or security agreements received [see attached schedule B]	\$.00	\$.00
9.OTHER RECEIPTS—refunds, rebates, interest, salle of assets, etc. [see attached schedule C]	\$.00	\$.00
10.TOTAL MONETARY RECEIPTS [total line 6, 7, 8, and 9]	\$.15	\$.15
11.IN-KIND CONTRIBUTIONS [see attached schedule D]	\$.00	\$.00
12.FUNDS received from a corporation, labor organization or other person by its political action committee for establishment and solicitation costs [only applicable to non-candidate committees]		0
12a.WRITTEN agreements, promises, or pledges to make contributions [see attached schedule D1]	\$.00	\$.00
13.AGGREGATE TOTAL RECEIPTS [total lines 10, 11, 12 and 12a]	\$.18	\$.15
	a. Total for this reporting period	b. Total campaign- to-date [candidate committees] or year- to-date [others]
14,EXPENDITURES MADE [see attached schedule E]	\$153.59	\$153,59
15.INDEPENDENT EXPENDITURES AND ELECTIONEERING COMMUNICATIONS [see attached schedule F]	\$.00	\$.00
16.MONETARY TRANSFERS (contributions) to other committees [see attached schedule G]	\$30,750.00	\$30,760.00
17.AGGREGATE TOTAL MONETARY EXPENDITURES [add lines 14, 15, and 16]	\$30,903.59	\$30,903.59
18.IN-KIND TRANSFERS [see attached schedule H]	\$.00	\$.00
19,EXPENDITURES INCURRED owed but not yet paid [see attached schedule i]	5.00	ę.
20,BALANCE ON LOANS OWED BY committee [see attached schedule J]	(	
CASH SUMMARY:	-77	M.C.

26.Cartification: I handly cardly that, during this campaign-to-date for cardidate committees or calendar year-to-date for other committees, the treasurer or deputy treasurer received contributor statements or is making good-faith requests to obtain contributor statements, as required by the Ethics Commission Rutes, I further centify that this report is a true and correct record of this committee's certifibution and expenditure transactions and that I have been appointed to file reports on behalf of this committee.

Treasurer's or Deputy Treasurer's Signature

Date

x Victor D Long

X Apr 17, 2012

21.FUNDS AVAILABLE [repeat amount from line 5]

22.MONETARY RECEIPTS [repeat line 10, column (a)]

25.FUNDS REMAINING [subtract line 24 form line 23]

23.TOTAL MONETARY RECEIPTS (add line 21 and line 22)

24.DISBURSEMENTS [repeat amount on line 17 column (a)]

EC FORM C-1R [REV. 4/12]



# URGENT! <u>URGENT!!!</u> <u>URGENT!!!</u>

4/22/08

Your OANA President, Vic Long, will be sending out a very important email this evening (late – after he finishes in the OR) that will require your immediate attention and response.

This email is in regards to SB1577 and anesthesia assistants and will require rapid response from the membership. Please be ready to read Vic's email and take action by Wednesday, April 23<sup>rd</sup> (tomorrow). All efforts are needed again in this grass roots effort so spread the word and be looking for an email this evening from your president.

Thank you in advance for your prompt attention to this matter.

OANA Staff



Compariso	on of Facts
CRNA	AA
CRNA's are a Board Certified, Registered Advance Practice Nurse.	an AA is an allied health professional.
CRNA's are qualified to make independent judgments regarding all aspects of anesthesia care based on their education, licensure and board certification.	the AA develops and implements an anesthesia care plan in an assistant role/capacity.
CRNA's practice in <b>every</b> setting in which anesthesia is delivered.	the AA most frequently practices in the urban hospital setting, he cannot practice where an anesthesiologist is unavailable.
there are approximately 36,000 practicing CRNA's. They safely administer 27 million anesthetics each year in the United States	there are approximately 800 working AA's in the United States.
CRNA's practice under the laws of every state.	AA's are authorized to practice through either licensure or certification in only 9 states and the District of Columbia.
CRNA's are educated and trained to work without anesthesiologist supervision in all 50 states.	AA's MUST work under the close supervision of an anesthesiologist, they cannot work independently and quickly in an emergency situation.
CRNA's have been practicing for <b>over 125 years</b> , they were the first professional group who specialized in anesthesia	AA's have been practicing a little more than 35 years.
There are 108 accredited CRNA schools	There are 5 AA programs
5100 students are enrolled in CRNA programs throughout the country and graduating approximately 1500 per year.	approximately 125 students are enrolled in AA programs, graduating approximately 40 per year.
CRNA's from entry in nursing to graduation in anesthesia compile approximately 6,000 CLINICAL hours.	AA's from program entry to completion compile approximately 2,000 to 2,700 hours and not all are clinical hours.

Comparison of Facts		
CRNA .	AA	
CRNA's spend approximately 7 years in health education upon completion.	AA's spend approximately 24-28 months in allied health education upon completion.	
CRNA Education standards require a minimum of: 135 hours of anatomy, physiology and pathophysiology; 105 hours of pharmacology of anesthetic drugs, chemistry and biochemistry; 45 hours of clinic conferences; 105 hours of principals of anesthesia practice, physics and pain management; 30 hours of research; and 45 hours of professional aspects of Nurse Anesthesia	AA standards and guidelines do not specify minimum hours for each core course of category of core courses.	
Nurse Anesthesia students administer a minimum of 550 anesthesia cases from start to finish on a wide variety of cases before graduation, on average most student transcripts show in excess of 800 cases.	AA programs indicate only clinical hours as a prerequisite to graduation.	
CRNA's are trained to provide anesthesia to patients of all ages, in all kinds of surgery, from simple to the most complex of cases.	The AA curriculum is characterized by training that allows them to assist the anesthesiologist in technical functions only.	
Nurse Anesthetists must successfully pass a board certification examination in order to practice as a CRNA	AA's may practice without certification unless it is required by state law. They are eligible to take the NCCAA examination up to 180 days BEFORE graduation.	
CRNA 's are the predominate provider in the Armed Forces	AA's cannot practice in the Armed Forces.	
At least 13 studes have concluded that CRNA practice is safe.	AA's have NO credible research on Anesthesia Practice.	

- No Senate committee reviewed the bill and rendered its recommendation. No full hearing or debate on the bill's
  merits was held. In an effort to steamful this bare bones AA licensure bill through the legislative process, the bill
  proponents bypassed the expertise of the Senate Business and Labor Committee and the Senate Health and
  Human Services Committee. Reflecting the rushed nature of this bill's journey, the bill lacks many patient safety
  protections. Rebuttal to p. 11:16-25 and p. 12: ; support of p. 23:7-13.
- To our knowledge, there are no employed AAs practicing in any U.S. Veterans Health Administration (VHA)
  hospital. Although AAs were recently authorized to provide care in VA hospitals as a lower-level healthcare
  provider, no VA hospital has actually employed an AA. Rebuttal to p. 12:8-15; p. 13:17-23.
- AAs work in only 16 states. AAs are licensed or certified to practice in only eight states. They are authorized to practice in one other state, Kentucky, if they are also educated and nationally certified as physician assistants. The remaining seven states do not license or certify AAs, but apparently AAs work under broad provisions in those states that allow physicians to delegate their practices. Those laws do not specifically approve or even mention AAs. Contrary to impressions given by the AA bill's supporters, in those seven states where AAs work under physician delegation, the legislature has not specifically approved AAs to practice. In fact, a few of those states, including Michigan and Texas, have rejected bills to license or certify AAs to practice. In addition, Louisiana specifically prohibits AA practice. Rebuttal to p. 13:17-23.
- Although the first few AA programs graduated their first students in the 1970s, the American Society of Anesthesiologists (ASA) did not endorse AAs or actively promote them until 30 years later in 2000. AAs are therefore not an established profession with numbers sufficient to study their safety or provide a long-term track record of patient safety. Rebuttal to p. 14:2-5.
- CRNAs have a higher level of anesthesia education and training than AAs. At the largest AA program at Emory
  University, AAs do not receive clinical training in the administration of regional anesthesia. Clinical training in
  regional anesthesia is mandatory at all accredited nurse anesthesia programs. Rebuttal to p. 15:8-10; 16:16-19.
- During the course of their education, CRNAs will typically have acquired at least 6,000 hours of clinical patient care experience compared to AAs who receive less than 2800. Rebuttal to p. 15:8-10; 16:16-19.
- To the extent Oklahoma is facing a healthcare shortage, the solution is to fund and support educational programs
  for established, proven healthcare providers, CRNAs have been practicing for over 125 years. Funding and
  support should be directed to proven nursing providers, not drained away from nursing. Rebuttal to p. 15:15-20.
- Oklahoma law does not require CRNAs to work under an anesthesiologist's supervision. CRNAs may work under the supervision of a physician, podiatrist or dentist. In hospitals, CRNAs may work under the operating physician's supervision. CRNAs may work under the supervision of these healthcare providers even if an anesthesiologist is available. In other words, CRNAs are not required to work under an anesthesiologist's supervision even if an anesthesiologist is available. Consequently, CRNAs are a much more flexible provider than AAs. Rebuttal to p. 17:4-6; 20:13-16, 22-25.
- CRNAs are educated and trained to provide anesthetics to patients in cooperation with surgeons, anesthesiologists, dentists, podiatrists and other qualified healthcare professionals. AAs must work under anesthesiologists' close supervision in all instances and are educated and trained to work only under an anesthesiologist's supervision. Unlike CRNAs, AAs cannot work without anesthesiologist supervision. This means that two anesthesia providers must be hired: the AA and the supervising anesthesiologist.
   Rebuttal to p. 17:4-6; 20:13-16, 22-25.
- This bill does not have the unanimous support of the medical community. In addition to nursing, which opposes
  this bill, many surgeons and anesthesiologists do not support this bill. Point to support at p. 26:1-8.



4/23/25, 12:58 PM Bill Information

### BILL INFORMATION FOR SB 1577

### SB 1577 by Rice and Derby

SELECT SESSION: 2008 Regular Session

Receive Email Updates for this Measure (LENS)

ENTER BILL #:

Search

Professions and occupations; creating the Oklahoma Anesthesiologist Assistant Act. defining terms; providing procedures. Effective date.

Action	Journal Page	Date	Chambe
First Reading	120	02/04/2008	s
Authored by Senator Leftwich	120	02/04/2008	s
Second Reading referred to Health and Human Resources	271	02/05/2008	s
Reported Do Pass Health and Human Resources committee; pending CR		02/14/2008	s
Reported Do Pass Health and Human Resources committee; CR filed	327	02/18/2008	s
coauthored by Cox (principal House author)	327	02/18/2008	s
General Order, Considered	647	03/04/2008	s
Measure and Emergency passed: Ayes: 47 Nays: 0	648	03/04/2008	s
Referred for engrossment	648	03/04/2008	s
Engrossed to House	689	03/05/2008	s
First Reading	614	03/05/2008	н
Second Reading referred to Economic Development and Financial Services	735	03/10/2008	н
CR; Do Pass, amended by committee substitute Economic Development and Financial Services Committee	1139	04/08/2008	н
Remove Representative Cox as principal House author and substitute with Representative Derby	1139	04/08/2008	н
Emergency removed	1139	04/08/2008	н
General Order	1207	04/15/2008	н
Third Reading, Measure passed: Ayes: 91 Nays: 0	1207	04/15/2008	н
Referred for engrossment	1208	04/15/2008	н
Engrossed, signed, to Senate	1237	04/16/2008	н
HAs read	1319	04/16/2008	s
Pending removal author Senator Leftwich and replace with Senator Rice		04/29/2008	s
Pending coauthorship Senator(s) Paddack, Lamb, Crain		04/29/2008	s
HAs adopted AYES: 31 NAYS: 14	1473	04/30/2008	s
Remove as author Senator Leftwich; authored by Senator Rice	1473	04/30/2008	s
coauthored by Paddack, Lamb, Crain	1473	04/30/2008	s
Measure passed: Ayes: 31 Nays: 14	1473	04/30/2008	s

https://www.oklegislature.gov/BiilInfo.aspx?Bill=SB 1577&Session=0800

4/23/25, 12:58 PM Bill Information

1473	04/30/2008	s
1503	05/06/2008	s
1504	05/06/2008	s
1519	05/07/2008	s
1491	05/07/2008	н
1527	05/07/2008	s
1590	05/13/2008	s
	1473 1503 1504 1519 1491 1527	1473 04/30/2008 1503 05/06/2008 1504 05/06/2008 1519 05/07/2008 1491 05/07/2008 1527 05/07/2008

https://www.oklegislature.gov/BittInfo.aspx?Bitt=SB 1577&Session=0800

1/2

SB 1368
to place
Nurse Anesthesia
under the
Medical Practice Act
2008
51st Legislative Session



### Dear Representative Steele:

I know I mentioned this on Sunday at church, but the more I think about it, I would again like to congratulate you on your recent appointment as Speaker ProTem of the House of Representatives. This is an outstanding honor and as I mentioned could not have happened to a nicer and more deserving person. I have great respect for the job you do and the commitment you show to your constituents of Pottawatomic County and the leadership role to all citizens of Oklahoma.

As you know, I'm a Certified Registered Nurse Anesthetist (CRNA) and practice full time at Unity Health Center, Shawnee, Oklahoma. I am a member of the Oklahoma Association of Nurse Anesthetists (OANA) and also the American Association of Nurse Anesthetists (AANA). I have served in the armed forces for the last 22 years and am currently a Major in the United States Army. I have served in Afghanistan and most recently just returned from a tour of duty in El Paso, Texas, where I relieved other CRNAs who were deployed to Iraq and Afghanistan.

During the last legislative session, which was very difficult and concerning to all Oklahoma CRNAs, we saw Senate Bill 1638 attempt to place us under the Board of Medicine fail. However, Senate Bill 1577 passed and added a third, less trained, anesthesia provider into the state, and further confused the public on who provides anesthesia in the State of Oklahoma.

With that said, my association membership, OANA leadership, and I are concerned that more legislation will be brought forward this session that could harm the relationship between CRNAs, our surgeons, and the delivery of anesthesia services in the State of Oklahoma and especially our rural settings, where we provide greater than 85% of all anesthesia services.

Today in Oklahoma, the outdated and unnecessary restriction of physician supervision weights heavily on my surgeon friends. It is time to move into the future with healthcare delivery, and change to a more appropriate piece of statutory language, which will reflect the true nature of the delivery of anesthesia as it is being delivered in Oklahoma today.

It is time to allow my surgeons to focus on his or her specialty and art and not on the science of anesthesia and/or its delivery, but for us to share our expertise through consultation that will improve the delivery of healthcare to all patients of Oklahoma.

Therefore, my friend, we are proposing legislation in the upcoming session and would ask in advance for your consideration to sponsor our bill. I will provide you with language, answer any questions you may have and would like to sit down at lunch at your convenience with myself, OANA President – Victor Long – and OANA Lobbyists – Steve Edwards and John Bryant – for a complete discussion on these issues.

 $\boldsymbol{I}$  understand the restrictions on your time and thank you for your consideration of this request.

Your Friend.

Major Michael Huff, CRNA, MS Army Reservist

### CRNA PROVISIONS OF THE NURSING PRACTICE ACT SHOULD BE AMENDED - Bulleted

- What's wrong with the CRNA provisions of the Nursing Practice Act today?
  - a. Outdated.
  - b. Not medically necessary.
  - c. Arbitrarily limit the judgment of physicians.
  - d. Limit the full and efficient utilization of CRNAs.
  - Should be changed to a modern and appropriate consultative approach between members of a team.
  - f. Unneeded and ineffective government regulation should be changed.
- If that's true, I agree, so specifically what needs to be changed?
  - a. The level of medical supervision that is unnecessary.
- You know, that current language sounds reasonable enough in theory. What's the real
  - World issue for physicians and CRNAs? I know you wouldn't be here for something that's not important.
    - a. Throughout the United States CRNAs administer approximately 70% the anesthesia.
      - That is true in Oklahoma.
  - b. CRNAs and nobody else administer the great majority of anesthesia.
  - c. Anesthesia has always been within the nurse's scope of practice.
  - d. CRNAs provide essential anesthesia physician will provide needed health care service within his/her specialty.
  - Most treating physicians lack the advanced knowledge and skill needed to actually deliver anesthesia.
  - f. The physician and the CRNA are a team of specialists working together.
    - Each exercising the independent professional judgment of a trained specialist doing what they do best, but working as a team for the patient's good.
  - g. Must the physician "supervise" the CRNA? The informed answer is No.
  - h. CRNAs...
    - · Are well trained and highly skilled.
    - Have professional rules to follow.
    - Have competency oversight to insure continued fitness to practice.
  - Must carry medical malpractice policy equal to that of their physician counterpart.
- 4. What would you substitute in place of the outdated and unneeded "supervision" language and in place of "under conditions in which timely onsite consultation by a [physician] is available?
  - a. The system works best when they consult. Simple.
  - b. No need for detailed prescriptions of one-size fits all restrictive regulation.
  - c. Simply legislate that the trained professionals shall consult with each other.

The amended language in §567.3a (10) (a) would read:

 "(3) Administers anesthesia in consultation with a medical doctor, an osteopathic physician, a podiatric physician or dentist licensed in this state."

The amended language of §567.3a(10)(b) would read:

- "b. A certified registered nurse anesthetist shall be authorized, pursuant to rules adopted by the Oklahoma Board of Nursing, to order, select, obtain and administer legend drugs, Schedule II through V controlled substances, devices, and medical gases in consultation with a medical doctor, osteopathic physician, podiatric physician or dentist licensed in this state."
- 5. When you put it that way, it seems like a good idea as a policy position that is consistent with the limited government that I support. Are there other states that regulate this way? Other examples?
  - a. Montana passed a rule to eliminate restrictive "medical supervision".
  - The military a place where medical supervision of CRNAs is not the restrictive condition that it is under Oklahoma law.
    - 7.4.3 Operating instruction United States Air Force (USAF)

- 7.4.3. Scope of Practice. Certified Registered Nurse Anesthetist:
- 7.4.3.1. Are authorized to provide anesthesia services independently (without clinical supervision or direction) and collaboratively, within the scope of their licensure/national certification and consistent with individually granted clinical privileges for:
- c. Federal government regulation on reimbursement for Medicare and Medicaid anticipates that some states may opt out of any "medical supervision".
- d. Other states who have eliminated restrictive "medical supervision" language:
  - Iowa
     Wisconsin
     Nebraska
     Alaska
     Washington
     New Hampshire
     Kansas
     Idaho
     New Mexico
     North Dakota
     Minnesota
     Oregon

Montana

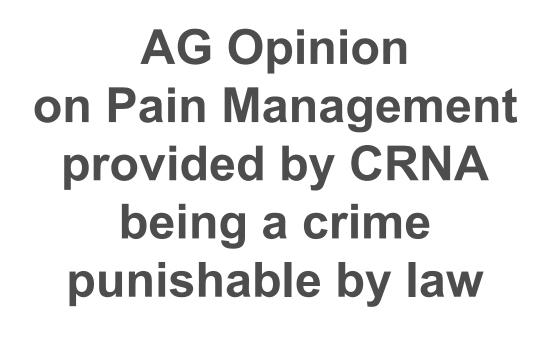
e. States Eligible for An Opt-Out

South Dakota

- Many states do not require CRNAs to be physician supervised. Thirty-nine states do not have a physician "supervision" requirement for CRNAs in nursing or medical laws or regulations. If clinical "direction" requirements are considered in addition to "supervision," 31 states do not have a physician supervision or direction requirement for CRNAs in nursing or medical laws or regulations. Taking into account state hospital licensing laws or regulations as well, 33 states still do not require physician supervision. Taking into account state hospital licensing laws or regulations, 24 states still do not require physician supervision or direction.
- 6. You mentioned that there are possible adverse and unintended consequences of the current level of supervision. Explain that a bit more, please?
  - a. It is simply not clear how the language of the current law will be applied.
  - b. Narrow interpretation may mean that it is unclear whether even safe and efficient practices by physicians in their dealing with CRNAs are possibly unlawful.
  - c. It may subject professionals to unacceptable risks regarding professional discipline issues, or licensure issues, professional liability issues or even issues about their right to seek and retain payment for those services.
  - Fairness means those risks ought to be considered unintended consequences. Unintended consequences should be eliminated.
- Are there other changes to the Nursing Practices Act that are related?
  - a. Yes, by definition CRNAs are a category of advanced practice nurse
    - All other Advanced Practice Nurse categories have standards to govern the proper scope of practice.
    - · There is no such provision for CRNAs, but there should be.
    - The solution is simple. A provision should be added to the law applicable to CRNAs that reads:

"The certified registered nurse anesthetist accepts responsibility, accountability, and obligation to practice in accordance with usual and customary advanced practice nursing standards and functions as defined by the scope of practice/role definition statements of the American Association of Nurse Anesthetists for the certified registered nurse anesthetist.

- 8. If the Nursing Practices Act is amended as you suggest, are there related changes to be done at the same time?
  - a. Yes. The Pharmacy Act and the Controlled Dangerous Substances Act have related provisions that ought to have conforming amendments.



**Sept 2008** 



September 22, 2008

James A Johnson 614 W Broadway Elk City, OK 73644

James Johnson,

It has been 10 days since I wrote last and we still are waiting on the AG opinion that was described in my last email. I feel very good about our argument and view letter but anything can happen and we have seen plenty of manufactured votes in the last several months starting with the AA issue and its backdoor success. We are presently looking at the AA draft rules and as of today I received our first communication back from the AANA. As expected they agreed it was not complete and did not reflect the Act as it was passed. That is no surprise, nor did we expect anything else from the few anesthesiologists that promoted the effort, or would we expect anything else from a committee made up of physicians. To my knowledge, they did not ask us to weigh in on the rules nor did they ask the BON. I have asked our legal council to look the draft over and begin research on our next effort to be made at the public hearing. We may also take this back to the capitol as all rules must be voted on by both bodies of the legislature and the governor. If the rules do not reflect the Act, we will apply strong pressure to see they are not accepted or amended to read like the Act itself. There is talk coming out of Tulsa that the large anesthesia groups may be willing to move in the AA direction. I would like some comments from Tulsa CRNAs to confirm this talk, so please e-mail me with anything you may know so we can be ready to protect the practice rights of Tulsa CRNAs. We want to assure that supervision is to the letter, that ratios are not exceeding the norm for the nation and maybe more restrictive. We do not want CRNAs supervising AAs or AA students. If anesthesiologists want this 3rd provider in the OR then they should carry all burdens, outcomes, and liabilities. With this said, let me move on to the mission of this letter.

We as a membership have faced tough obstacles in the last few months starting with the legislative session and ending with the AGs effort. These are the times we are in and I do not see anything changing when it comes to the physicians and their so called first provider right attitude. It is reflected in all they do from their national effort all the way down to their state associations' and coalition of physician members made up of a mixed bag of specialties. They have already promised a return to SB1638 and I'm sure they have other agendas that we are not aware of. They are probably meeting somewhere as I type this e-mail. I challenge a debate with any CRNA that does not agree that they have agendas and they are marching with their national association's theme in hand as stated in resolution 903 from their house of delegates. We must be ready and proactive or we will be fighting these efforts until we are bankrupt of both monies and energy from committed CRNAs.

I need everyone **starting today** to begin to formulate your own plan on what you can do in your county to promote and sustain the understanding of who a CRNA is, and the valuable and indispensable part you play in the delivery of safe health care to your patients and to the community you serve. We are unknown, we are called Doctors, and it must start to change for us to succeed with our mission. I would like each and every one to begin setting up an appointment

with your legislators both house and senate and start to educate them on whom you are, what you do, and where we are going. These contacts are paramount if we want a voice at the capitol and after this last session it's obvious to me we must change that understanding and change it soon or we will not enjoy any success when it comes to protecting our practice rights or legislating the reality of our practice as we know it. I can go in an office with our lobbyist, be heard and move on, but you at the home districts will solidify the grassroots start we must have and we must have it now. We have provided anesthesia in Oklahoma since the turn of the century and I bet for every 10 people you stop on the street maybe one will know who we are and what we do and I bet 7 of those 10 have received an anesthetic from a CRNA. Let's get the word out and let's begin today, let's build on that outstanding effort that we had in the last seven days of the session where a lot of law makers got educated on who we are.

This e-mail will be copied and sent out to every CRNA in our database and along with it will be a copy of each CRNAs house and senate law makers with all their contact information. The next step is up to you! I cannot force anyone to work for this effort of grassroots communication but I want you to know this association is depending on you and expects help with this difficult task. You must educate these men and women now so when I step in an office, or any of our lobbyists or GRC committee members step in a law maker's office they know who we are, what we do, how we do it, and the reality of our Oklahoma practice. We touch 70+ of 101 members of the House of Representatives, and 40+ senate members of 48 so as you can see we are involved in a lot of communities across this great state. I will be asking for monies soon to pay for additional lobbyists and it cannot fall on a deaf ear. Let me remind you, for the AA issue the anesthesiologists hired 10 lobbyists we know of, and had 13 working at one time. I don't believe we need that many but we must beef up our presence at the capitol and allow Marvin the freedom to direct and define their course. We are asking John Bryant to come aboard now and depending on the November agenda we will need more.

In closing, we will face very difficult times next session and this grassroots effort (the beginning) must start today and never end. Set your appointments while your law maker is in his home district. Help with his or her campaign, donate to his financial needs, get involved and stay involved, educate him or her on CRNAs and our role in his community, our political life does depend on this initiative. Mark your calendar for the fall meeting and come to my legislative sessions on Saturday and let your voice be heard and be part of our plans for the session. The reality of our practice is coming to our capitol this session and we need everyone including physician friends, administrators and hospital executive staff to support this initiative. We will have less opposition to our efforts if this grassroots initiative is rolling along with momentum. I need everyone working on this effort without fail. Stays tuned to your e-mails and please share discussions from your visits with the OANA office or myself.

Committed to you,

Victor Long CRNA, MS, OANA President

P.S. - if you have not been receiving emails from Victor or the OANA please call the OANA office to confirm/update your contact information.

Tom Ivester (D) Purcy D. Walker (D)



December 5, 2008

Dear Membership,

Welcome to the fray! In many of my earlier communications both e-mail and hard copy I have made many comments that have alluded to the effort at hand. If you attended the fall meeting you are a step ahead of where this letter is going.

In review for those of you that did not attend the fall meeting, since the practice meetings with the BON in June of 2007 much has changed and many battles were fought in the political and regulatory arena. The most dangerous and harmful being SB 1638 that attempted to place us under the Board of Medicine. The most troublesome for our future was the success of SB 1577 that added a third provider to the anesthesia delivery system. The potential of a training program for AAs in our state, instead of a CRNA program. This is an obvious effort by anesthesiologists to control the future of anesthesia in Oklahoma with their own educated assistants. The most ridiculous one being the attempt, by a handful of anesthesiologists to obtain a position statement from their board that the practice of pain management is the practice of medicine and that any physician requesting the services of a CRNA to provide chronic or acute pain management is aiding and abetting a crime. The AGs office, in our favor, settled this attempt but in the process made it obvious we are practicing with a set of outdated statutes that do not reflect our practice in Oklahoma. It is time to change that problem and I need each and every one involved, including your money.

Your OANA leadership has voted and agreed to move legislation forward that would eliminate supervision language, replace it with consultation and eliminate the most difficult words of timely and onsite. We have hired three additional lobbyists to assist Marvin York in this effort and we do have language drafted and ready. This last month we have been identifying potential authors and working to secure their favor, with the help of some small groups of dedicated CRNAs that I will introduce in the near future. These groups are breaking the ground, so to speak, in advance of your effort. We have some soft commitments for authorship but now need all of the membership working to obtain more support. We are starting on the House side first and then moving to the Senate. Do not get me wrong, we want to work both simultaneously but your House representatives are the key for now.

You will find attached our first set of talking points, bullet points, and surgeon letter. If you read them carefully and repeatedly, you will easily see the direction to follow as you write letters, set meetings, and prepare your advocacy. Please focus on the House of Representatives with all of your energy. I will communicate to you the time to move to the Senate with this same energy. The talking points are the most coherent effort to date for your advocacy, so use them to your benefit. The surgeon letter is for your surgeon to sign and send to his or her representative or senator. Our surgeons will be a key component to the success of this effort, so we must have them involved. They are exposed by our outdated practice act and must feel the burn of the exposure during your discussions with them. Do not underestimate your service to them or the delivery of health care that this state depends on, especially our rural areas. In your letters and meetings do not forget to emphasize the fact that we are not changing or expanding our scope of practice IN ANY WAY! The opposition will claim this and they will lean very

hard on this misinformation. Be honest and use integrity with all communications, the opposition will not and I believe that will hurt them in the long run.

In conclusion, I know it is the holiday season, and everyone is very busy, but this association needs your help now. The legislators will be home, for the most part, and more available to their constituents. I need you to get their support for our legislation, through education of who you are and what you do. Stand up and be heard, no more sideline observing, get in the fray. Help your association true up our state statutes to reflect the reality of our practice and remove the liability exposure our surgeons feel.

Committed to you and to this effort,

Victor Long OANA President

The list of legislators below, our lobbyist team believe are key contacts to be made immediately and with great effort. Stay tuned to your e-mails for more to come. This communication and attached documents will also be sent to all members in hard copy. Please use your legislative contact documents you received in an earlier mailing to identify your House of Representatives member.

House members: Kris Steele 26, Colby Schwartz 43, Chris Benge 68, David Dank 85, John Enns 41, Larry Glenn 7, Rebecca Hamilton 89, Jeanie McDaniel 78, Randy Terrill 53, Jerry Shoemake 16, Lucky Lamons 82, Mark McCullough 30, Ron Peters 70, John Trebilcock 98, Tad Jones 9, John Wright 76, George Faught 14, Mike Jackson 40, Eddie Fields 36, Corey Holland 51, Charles Ortega 52, Harold Wright 57, Mike Sanders 59, Mike Christian 93, Jason Murphy 31, Shane Jett 27, Gus Blackwell, Danny Morgan, Joe Dorman, John Carey, Ryan Kiesel, Jerry JcPeak, Paul Roan, Ben Sherrer, Mike Brown, Doug Cox, Ann Coody, Lee Denny, Tad Jones, Earl Sears. TW Shannon.

Senate members: Patrick Anderson 19, Brian Crain 39, Glenn Coffee 30, Debbie Leftwich 44, Jim Wilson 3, Connie Johnson 48, Bryce Marlatt 27, Dan Newberry 37, Gary Stanislawski 35, Steve Russell 45, Todd Lamb 47, Sean Burrage 2, J Paul Fumm 6, Charlie Laster 17, Mike Schultz 38, David Myers, Tom Ivester, Kenneth Corn Jonathan Nichols, Johnny Crutchfiels, Don Barrington, Randy Bass, Ron Justice, Mike Johnson

# **Presidential Duties**



March 25, 2009

Ms. Charlene Frizzera Acting Administrator Centers for Medicare & Medicaid Services Department of Health and Human Services 200 Independence Ave., SW Washington, DC 20201

VIA FAX 202-690-6262

Dear Ms. Frizzera:

As the President of the Oklahoma Association of Nurse Anesthetists (0ANA) and our 309 Oklahoma Certified Registered Nurse Anesthetists, I ask you to uphold the decision of the Provider Reimbursement Review Board (PRRB) in the case of *St. Luke Community Healthcare v. BlueCross BlueShield Association / Noridian Administrative Services* (PRRB Decision #2009-D9, 2/25/2009). In this case, the PRRB found that the Medicare Part A reasonable cost based pass-through program for the services of Certified Registered Nurse Anesthetists (CRNAs) may be used to pay qualifying hospitals' costs for CRNAs' reasonable standby services. Our association's members agree with this decision for both practical reasons relating to Medicare beneficiaries' access to care, and for its proper reading of the appropriate statutes, regulations and Medicare payment policy.

As you can see from the attached map of the State of Oklahoma, CRNAs are the sole practitioner in more than half of the counties in Oklahoma and as such, are crucial to the delivery of healthcare in Oklahoma. CRNAs afford these rural facilities, surgical, obsetrical, trauma stabilization, interventional diagnostic and pain management capabilities. Without the availability of anesthesia services delivered by CRNAs, many U.S. rural and Critical Access Hospitals (CAH) would not be able to offer services. Fortunately, the Medicare Part A reasonable cost based pass-through program for the services of nurse anesthetists (42 CFR §412.113(c)) exists to ensure the availability of CRNA services in rural hospitals for Medicare beneficiaries where the facility's case volume is insufficient for Part 3 to economically sustain such services. To ensure that Medicare patients in rural America have access to healthcare requiring anesthesia services, the Medicare Part A reasonable cost based pass-through program has for decades successfully and safely ensured the availability of anesthesia services for Medicare patients, and all services that anesthesia enables, by reimbursing qualifying hospitals the reasonable and necessary costs of such services.

As a matter of policy, upholding the PRRB decision in *St. Luke* is consistent with the PRRB's previous recent decision in the case of *Marias Medical Center v. BlueCross BlueShield* 

Association (PRRB Decision #2008-D-40, Sept. 29, 2008), subsequently overruled by the Administrator Nov. 21, 2008, whom we believe acted in error. The PRRB stated that statutes, regulations, and Medicare payment policy guidelines clearly permit CRNAs' reasonable standby costs to be reimbursable under the Part A reasonable cost pass-through program. The reasonable cost program for anesthesia services (42 CFR §412.113(c)) does not prohibit payment for standby costs. The regulations and statutes cited by the PRRB in both St. Luke and Marias indicate standby costs for CRNA services are reasonable and reimbursable under the pass-through program (42 USC §1395x(V)(1)(A), 42 CFR §413.9(C)(3), and CMS Publication 15.1 §2102.1).

We believe the Administrator erred in relying on provisions governing emergency room services (42 CFR §413.70(b)(4)) to deny payment for CRNAs' reasonable standby services. CRNAs are not normally emergency room personnel. CRNA services are delivered primarily in surgical, interventional diagnostic, and labor and delivery rooms, and incidentally in emergency rooms in both our rural and metropolitan settings. CRNAs' standby availability permits the facilities to safely and cost-effectively offer the full range of healthcare services a rural community requires, including emergency services. Both longstanding Medicare practice and established policy rendered such reasonable costs of CRNA services eligible for reimbursement under the Part A reasonable cost based pass-through program for anesthesia services until the Administrator's recent policy reversal.

Upholding the PRRB decision in *St. Luke* would be consistent with the law, longstanding Medicare practice, and the intent of the Medicare rural pass-through program. It will help ensure the availability of rural healthcare to Medicare beneficiaries by fairly and reasonably reimbursing the reasonable costs of anesthesia services by CRNAs in rural Oklahoma hospitals. The alternative would demand rural hospitals and CRNAs inappropriately bear the burden of ensuring the availability of anesthesia services to Medicare beneficiaries, putting patients' access to a wide range of rural healthcare services at risk in a manner inconsistent with the law and the objectives of the Medicare program.

If you have any questions, please contact me at any of the contact information listed below. Thank you for your time and consideration of this matter.

Sincerely,

Victor D. Long, CRNA, MS President

Attachment

# Pain Management in the Fray

### We have to be very aware for this session, they will be back. -Victor

----Original Message-----

From: Mitch Tobin [mailto:mtobin@aana.com] Sent: Tuesday, December 23, 2008 3:18 PM

To: undisclosed-recipients:

Subject: Louisiana Court of Appeal rules against CRNAs re pain management

This is an e-mail to the AANA's Board of Directors, state nurse anesthetist association presidents and government relations committee (GRC) chairs, staff Directors, and State Government Affairs Division and various other AANA staff, Gene Blumenreich, and the AANA's Government Relations Committee (the AANA office is closed this afternoon due to inclement weather, but I wanted to get you this update as soon as I became aware of it; please note that the AANA office will be closed December 24-26).

Unfortunately, I have disappointing news to share with you concerning the Louisiana pain management litigation. In a decision issued today (December 23, 2008), the Louisiana Court of Appeal, First Circuit, affirmed the Louisiana District Court's judgment earlier this year in favor of an anesthesiologist pain management group (Spine Diagnostics Certer of Baton Rouge), and against the Louisiana State Board of Nursing (LSBN) and an individual CRNA who had performed pain management procedures. Both the Louisiana Association of Nurse Anesthetists (LANA) and the Louisiana Society of Anesthesiologists had intervened in the case as interested parties.

The Court of Appeal opinion is located at <a href="http://www.la-fcca.org/Opinions/PUB2008/2008-12/2008CA0813Dec2008.Pub.22.pdf">http://www.la-fcca.org/Opinions/PUB2008/2008-12/2008CA0813Dec2008.Pub.22.pdf</a>. If the link does not work, go to <a href="http://www.la-fcca.org/contents.htm">http://www.la-fcca.org/contents.htm</a>, click "Opinions," then "2008," then "December 2008," and scroll down until you see a link to the decision (case number "2008CA0813").

The Court of Appeal decision stated that the court did not find that the Distric: Court (which was the trial court in this case) abused its discretion in ruling in favor of Spine Diagnostics and finding that "the statement issued by the LSBN expanded the scope of practice for CRNAs into an area where they have not traditionally practiced and finding that the practice of interventional pain management is not within the scope of practice of a CRNA, but rather is solely the practice of medicine."

LANA and the LSBN will be considering their options (the AANA, of course, will continue to be in close communication with LANA). If an appeal to the Louisiana Supreme Court occurs, a "writ" asking the court to accept the case must be filed by January 22, 2009, within 30 days from the date of the appellate court decision. The Supreme Court would then have discretion whether to accept or deny the appeal.

Regardless of the final outcome, it is important to bear in mind that Louisiana continues to be the only state in the nation to rule that "interventional" pain management is not within CRNA scope of practice. The Louisiana litigation is not binding in any other state and directly affects CRNAs practicing in Louisiana only. This decision, which is extreme in its implications for access to quality, cost-effective CRNA care, is not a national legal precedent. Courts in other states would not necessarily reach a similar conclusion in similar circumstances.

It is the AANA's position that management of both acute and chronic pain is within the professional scope of practice of CRNAs and is not exclusively the "practice of medicine." (See AANA Position Statement 2.11, Position Statement on Pain Management, at <a href="https://www.aana.com">www.aana.com</a> > Resources > Practice Documents; Scope and Standards for Nurse Anesthesia Practice at <a href="https://www.aana.com">www.aana.com</a> > Resources > Practice Documents.) Further, the assertion that "interventional pain management" has not "traditionally" been within CRNA scope of practice is simply wrong.

The AANA will continue to assist LANA in any way possible and understands the extremely serious implications of this judgment. Further, the AANA will continue to fight to support the rights of all CRNAs to deliver chronic pain management services. Meanwhile, as we have counseled you previously, you should be especially vigilant concerning possible attempts to replicate the Louisiana outcome in other states, either through legislation, board of medicine rulemaking, or litigation. In addition, as always, you should be vigilant about the possibility of your state's department of health or its generic equivalent being approached to restrict CRNAs in state hospital or ambulatory surgical center licensing regulations; you should monitor attempt to restrict office practice as well (e.g., through board of medicine regulations).

We will continue to apprise you of any significant developments, and we will post an update on the AANA website as soon as possible.

### Additional Background

In early January 2008, the Louisiana District Court, Judge Janice Clark, issued a judgment in favor of Spine Diagnostics Center of Baton Rouge, and against the LSBN and an individual CRNA who had performed chronic pain management procedures. The lawsuit was prompted by an LSBN favorable advisory opinion regarding CRNA pain management services. Both LANA and the Louisiana Society of Anesthesiologists had intervened in the case as interested parties.

The court's declaratory judgment stated:

- "1. The statement [advisory opinion] issued by the LSBN substantively expands the scope of practice for CRNAs into an area where they have not traditionally practiced, i.e., chronic or interventional pain management.
- 2. The practice of interventional pain management is not within a CRNAs [sic] scope of practice.
- 3. The practice of interventional pain management is solely the practice of medicine.
- 4. The opinion issued by the LSBN is an effort to substantively expand CRNA scope of practice and is an improper attempt at rule making."

Additionally, Judge Clark's judgment provided for a permanent injunction prohibiting the LSBN from enforcing the statement (advisory opinion) and a permanent injunction prohibiting the CRNA defendant from "performing chronic interventional pain procedures in connection with the LSBN statement." The judgment further required the LSBN to remove the advisory opinion from its website and to post the judgment on its website and publish it in the LSBN publication, *The Examiner*.

The LSBN advisory opinion that was the subject of the permanent injunction read, in pertinent part, as follows:

[I]t is within the scope of practice for the CRNA to perform procedures under the direction and supervision of the physician involving the injection of local anesthetics, steroids and analgesics for pain management purposes, peripheral nerve blocks, epidural injections, and spinal facet joint injections when the CRNA can document education, training and experience in performing such procedures and has the knowledge, skills, and abilities to safely perform the procedures based on an order from the physician.

The Court of Appeal decision today (December 23, 2008) affirms Justice Clark's decision as summarized above.

All parties, including the LSBN and LANA and Spine Diagnostics, the American Society of Interventional Pain Physicians, and the Louisiana Society of Anesthesiologists filed appellate briefs that the Court of Appeal considered. In addition, the AANA, the Louisiana Association of Nurse Practitioners, and the Louisiana Hospital Association filed amicus ("friend of the court") briefs in support of the LSBN and LANA. The American Nurses Association, the Louisiana State Nurses Association, and the Louisiana Alliance of Nursing Organizations also jointly filed an amicus brief in support of LANA and the LSBN. The National Council of State Boards of Nursing filed an amicus brief supporting the LSBN. The AANA is grateful to these other organizations for their support.

### Mitch

Mitchell H. Tobin, JD
Senior Director, State Government Affairs
American Association of Nurse Anesthetists
222 S. Prospect Avenue, Park Ridge, IL 60068-4001
Phone: 847-655-1131
Fax: 847-655-813
E-mail: mtobin@aana.com
www.aana.com

### Supporting Our Members-Protecting Our Patients

This email and any attached documents may contain confidential information belonging to the sender and may be legally privileged. This email (and any attachments) is intended only for the use of the intended addressee(s). If you are not the intended recipient(s), please notify the sender immediately and delete or otherwise destroy this transmission.

### Not a turf war

Regarding "House gets bill restricting injections for chronic pain" (news story, Feb. 10): The management of chronic medical diseases is the practice of medicine and should only be practiced by physicians. Chronic pain isn't different from any other chronic disease. Patients must be evaluated, treated and re-evaluated on a long-term basis with continual evolution of treatment. Epidural steroid or "pain injections" are part of this treatment, and nurses are now allowed to administer these injections in Oklahoma. Nurse anesthetists aren't trained to determine the patient's needs based upon the patient's other diseases (diabetes, cancer, etc.) and medication regimen. Nurses haven't trained for years to recognize the symptoms of other diseases, which may be hiding within a patient's pain symptoms. Also, pain injections can have serious complications and a nurse can't prescribe medication or admit a patient to a hospital if necessary, because they're not physicians.

If the need is there, doctors will provide treatment in rural areas. My pain management practice is based in Norman, but we have a satellite clinic in Madill, where we see 20 to 50 patients a month for chronic pain management. State Rep. Pat Ownbey's statement that "no complaints have been filed" is a terrible excuse to let nurses practice medicine. Should nurses also be allowed to manage high blood pressure and diabetes as long as no one complains?

Nurses should not be considered de facto physicians simply because of geography. This isn't a turf war. It is a line that shouldn't be crossed.

Shane Stidham, MD, Oklahoma City

# Oklahoma House gets bill restricting injections for chronic pain

BY MICHAEL MCNUTT Comments 명5 Published: February 10, 2010

Only physicians would be allowed to administer precise pain management injections under a bill approved Tuesday by a House committee.

The House Public Health Committee approved Senate Bill 1133 by a 14-5 vote. It now goes to the full House.

Rep. John Trebilcock, who took over authorship of the bill, said pain management injections into a patient's spinal or neck area must be precisely administered.

"Chronic pain medication is medicine and should be practiced by doctors," said Trebilcock, R-Broken Arrow.

The measure was carried over from last year after it failed to win passage. Efforts to come up with a compromise among a hospital group, doctors and certified registered nurse anesthetists fizzled. Certified registered nurse anesthetists now administer spinal injections to manage pain.

Trebilcock said the practice of chronic pain management is "extremely dar.gerous."

An injection in the wrong spot could cause paralysis or not effectively treat the pain, he said.

Trebilcock said certified nurse anesthetists would be allowed to continue to give other injections. It's estimated the chronic pain injections take up only about 4 percent of their duties, he said.

Marvin York, a lobbyist for the Oklahoma Association of Nurse Anesthetists, said the measure would be a hardship to rural patients, because few rural doctors practice in pain management.

"I can't imagine why any rural legislator ... could possibly be for this bill," he said.

Victor Long of Norman, a certified registered nurse anesthetist, said about 80 percent of the spinal injections for pain are administered by certified registered nurse anesthetists. About 500 certified registered nurse anesthetists are in the state, he said.

Rep. Pat Ownbey, R-Ardmore, said he wondered why the bill was necessary because no complaints had been filed against certified registered nurse anesthetists administering chronic pain management injections.

"Is this a patient issue or a money issue?" he asked fellow committee members. "Make no mistake, this is a turf war."

Trebilcock said doctors are willing to travel to rural areas to administer the injections.

"Rural Oklahoma shouldn't have to settle for less than a doctor when they suffer from chronic pain," he said.

TO:

OKLAHOMA HOUSE MEMBERS

FROM:

OKLAHOMA CERTIFIED REGISTERED NURSE ANESTHETISTS

SUBJECT: SB 1133 CHRONIC PAIN MANAGEMENT

Recently you received e-mail from the president of the Oklahoma Society of Anesthesiologists attempting to "clarify" the issues of SB 1133. As you are aware, there are two sides to every story and by now you have probably heard them both. And the first thing that I can agree with the anesthesiologists about is the bill may be coming the floor of the House soon. But every fact that the doctors have tried to convince you of is **not** fact, is **not** true, and will definitely <u>affect the people of Oklahoma</u>.

Sincerely,

Don Mordecai CRNA MHS President Oklahoma Association of Nurse Anesthetists (918) 424-8007

Steven L. McKitrick CRNA MS MHS Vice President Oklahoma Association of Nurse Anesthetists (405) 642-3500

Victor Long CRNA MS Past President Government Relations Chairman Oklahoma Association of Nurse Anesthetists (405) 834-4952

### SB1133 History:

SB1133 started after a group of anesthesiologists out of Tulsa went to the Okiahoma Board of Nursing and asked them to restrict the practice of Certified Registered Nurse Anesthetists (CRNAs) by ruling that chronic pain management was the practice of medicine. The Oklahoma Board of Nursing declared that there has been NO complaints made to the Board against the CRNAs and so they saw no reason to restrict the practice of chronic pain management done by the CRNAs. The anesthesiologists then went to the Oklahoma Board of Medical Licensure and Supervision and asked the Board to declare that chronic pain management was the practice of medicine and should only be performed by "Doctors." The OBMLS said they did not want to make a ruling on the practice of CRNAs. The Board of Nursing along with the Oklahoma Board of Medical Licensure and Supervision and Representative Mike Shelton wrote a letter to Attorney General Drew Edmondson asking him to rule on this issue. The AG ruled in August 2008 that when Doctors do chronic pain management, it is the practice of Medicine. When CRNAs do chronic pain management it is the practice of Nursing. The issue was then brought to the Senate by Senator Clark Jolley last year and passed through the Senate only after the Title had been removed. SB 1133 then went to the House Public Health Committee and only after the Chairman took over authorship of the Bill, passed.

### **SB 1133 Will**

1) Limit the practice of chronic interventional pain management to MDs and DOs only. BUT (and this is important) not just qualified, board certified pain specialists. ANY doctor in the State of Oklahoma can do these injections. Pediatricians, Dermatologists, Family Practice Physicians, any doctor that thinks he can, and wants to, can do these injections (with or without traincing). The author of the Bill, Senator Jolley, stated that he wished that he could restrict these injections to

only Board Certified, Fellowship Trained, Pain Specialists, but he **didn't** think he **"could get the Bill to pass."** So, because of this, any Physician in the state can do these injections if this Bill passes.

- 2) Allow CRNAs to perform Lumbar epidural steroid injections, which yes are the most common spinal injection. BUT again are not the only types of injection used in chronic pain management. They're at least 10 other injection types that are just as safe and are performed by CRNAs across the state every day.
- 3) Cost the State of Oklahoma more money. At present anesthesiologists get pair 10% more for patients who are on Medicaid and Workman's Comp. A majority of the "back Pain' complaints are work related injuries. With the State of Oklahoma facing a Billion (with a "B") dollar deficit, can the State afford to spend any more than it has to??
- 4) Make Oklahoma the first State in the nation to legislate chronic pain management as the practice of Medicine and restrict safe quality care done by CRNAs.

### SB1133 Will NOT:

- 1) Protect Patients. The anesthesiologists would have you believe that CRNAs are hurting patients and the Oklahoma Board of Nursing has some hidden agenda to hide any and all complaints against CRNAs concerning chronic pain management. This is because the Board is following the ruling of the Attorney General. This is a problem???? Also remember, ANY physician in the state can do these pain injections with little or no training. Is that protecting patients???
- 2) Allow CRNAs to do "surgery" A CRNAs practice is limited by the institution in which he or she practices. Privileges have to be granted by the Hospital in which they practice. There are NO hospitals in the State of Oklahoma giving CRNAs surgical privileges.

Chronic interventional pain management is defined by the anesthesiologists e-mail as "sub-acute, persistent and intractable." They go on to say that; "patients may have to wait days or weeks to see a physician for chronic interventional pain management procedures". If a patient is having "persistent and intractable" pain, and qualified CRNA services are available, should they have to wait "days or weeks" to get treatment???

### Problem:

The American Society of Anesthesiologists has made it their mission to restrict and control the practice of anesthesia by Certified Registered Nurse Anesthetists.

(TURF WAR) Chronic pain management is their first step. Oklahoma is set to become the first state in the nation to legislate laws dealing with chronic pain management. Anesthesiologists do NOT own the skills involved in doing and giving anesthesia. 70% of all anesthetics across the country are done by CRNAs either with or without the involvement of an anesthesiologist. The anesthesiologists would also have you believe that only they can and should do aneschesia (let alone chronic pain management. And that there is plenty of specialty trained "Doctors" to provide quality care to the patients of Oklahoma.

Contrary to Representative Trebilcock's statement, rural Oklahomans do not settle for less than quality care when a CRNA does the anesthetic. CRNAs provide quality anesthesia in all 77 counties.

### Solution:

SB 1133 defines chronic pain management as the practice of medicine. Initially the intent of the bill was to restrict all chronic pain management procedures to physicians only. Representative Dr. Doug Cox offered an amendment to "allow" CRNAs to do only one type of epidural injection under "direct supervision" as a way to appease the CRNAs. The statement that CRNAs have refused to discuss a compromise in this Bill is not true. The anesthesiologists' say that they "have negotiated in good faith" is not true. When the anesthesiologists come to the table willing to discuss what they are willing to give up (because the CRNAs are being asked to give up chronic pain management) then we can call this a negotiation.

There are NO studies that show that chronic pain management done by qualified CRNAs is unsafe. The Oklahoma Board of Nursing has no complaints filed against CRNAs related to pain management. If it were unsafe, don't you think there would be complaints?? Think about it.

Voting NO on this Bill changes nothing as far as the practice of chronic pain management in the State of Oklahoma.

### Access

There are CRNAs in 99 of 101 Oklahoma House districts. We are the DNLY Anesthesia provider in 41 of the 77 counties.

SB 1133 will restrict the access to chronic pain management primarily in Rural Oklahoma. Patients will have to drive farther and spend more to get the care they need. Yes this is more of a rural issue than an urban one. But that doesn't mean that because we who live in the Tulsa or Oklahoma City should pass legislation that affects the people and patients of rural Oklahoma.

It would also stop 50-60 CRNAs from providing this quality car and loss of income to the small hospitals in rural Oklahoma struggling to survive. **Think about it.** 

### Education:

### Certified Registered Nurse Anesthetists:

4 year Bachelor Degree in Nursing (required to get into all Nurse Anesthesia programs)

Pass the state licensure exam

At least one year of intensive care nursing (most applicants have more)

24-36 months training in an accredited masters program (taught by both anesthesiologists and CRNAs).

That includes acute and chronic pain management.

= 8 or more years of education, experience and training

### Physicians:

- 4 year Bachelor degree (not required to get into Medical school)
- + 4 years of medical school (No practical experience)
- + 1 year internship (all that is required to practice in Oklahoma)
- + 3-4 years anesthesia residency (Not required to do Pain Management)
- + year for pain medicine specialty (Not required to do Pain Management)
- = 9-13 years

### **eCapitol News**

## Ok-House committee discusses certified registered nurse anesthetists

Author: Shawn Ashley Date: 09/29/2009

http://www.ecapitol.net/email/email 01CK 2RC0G81TR.htm

(OK) Members of the House Public Health and Human Services Committee heard differing views Tuesday on the role of certified registered nurse anesthetists in Oklahoma health care.

Rep. Doug Cox, R-Grove, said two bills considered by the Legislature in 2009 brought the issue to his intention, leading him to request Interim Study 2009H-50, concerning delineating privileges of certified registered nurse anesthetists, or CRNAs, and degrees of oversight required.

According to testimony before the committee, CRNAs are registered nurses who receive two additional years of training related to the administration of anesthesia. Under state law, the committee was told, CRNAs must work under the supervision of a licensed physician. Anesthesiologists, by compar son, must complete a four-year residency in anesthesiology after completing four years of medical school, committee members were told.

Physicians appearing before the committee Tuesday urged lawmakers to keep in place the requirement that nurse anesthetists work under a physician's supervision.

Dr. George Caldwell said properly administered anesthesia is undervalued. "You don't get a second chance when there is botched anesthesia," which could result in death or serious impairment, Caldwell said.

"The practice of anesthesia is far too critical to be provided without a physician's supervision," Dr. Jane Fitch, an anesthesiologist and former CRNA, said in videotaped testimony.

"Knowing what I know now and what I didn't know then," Fitch said, "I am adamantly opposed to nurse anesthetists practicing without physicians' supervision."

Dr. Dennis Carter, a general family practitioner in Poteau, said allowing nurse anesthetists to practice without a physician's supervision would open 'a Pandora's box."

"There is no reason to remove that supervision and increase the risks to the patient," Carter said.

Victor Long, a nurse anesthetist and president of the Oklahoma Association of CRNAs, said the current law requiring a physician's supervision currently is not being met.

"The problem ... is that [the physician's supervision] requirement is not being met and in reality cannot be met," Long said.

Surgeons supervising CRNAs have to give their attention to the surgery being performed and not to monitoring the administration of anesthesia.

"That surgeon has to give his undivided attention to his surgery. That is his art. That's what he does. He can't be providing some form of supervision as far as directing the anesthetic. He doesn't select, order or administer the anesthetic. He can't be responsible to watch the responses to that anesthetic," Long said. Instead, the surgeon and the nurse anesthetist collaborate and work together, Long said. Nurse anesthetists and physicians each bring unique skills to the health care setting, Long added, and one cannot replace the other. Long said removing the supervision requirement would not change the service he and other CRNAs provide.

"Tomorrow if we do not have the word 'supervision' or we had some other word or no other word, I continue to practice as a CRNA only," Long said. According to information presented to the committee, 17 counties have services provided by both CRNAs and anesthesiologists. Thirty-three only have CRNAs available. One county has just an anesthesiologist. Twenty-six counties have neither an anesthesiologist nor a CRNA practicing.

### @2008-09 eCapitol, LLC. All rights reserved.

Information supplied to Client by eCapital is protected by copyright, all rights reserved, and not for resale or redistribution. This restriction is not intended to preclude sharing information as provided within the contractual agreement between Client and eCapital. Excepts may be republished with attribution and proper copyright and trademark notices. The Client agrees that the login and password supplied by eCapital shall be for Client's use only and shall not be provided to any other person, firm, corporation or association. It is the Client's responsibility to maintain the confidentiality of Client's login and password. Client shall be fully liable for any unauthorized use of Client's login and password.



July 22, 2009

Dear Membership:

The time has come to step up to the plate and do your part to fund our legislative efforts.

Next session will be the most important period of state law making to affect our practices in many years. We have fought off efforts to place our practice under the Board of Medicine. We have fought off efforts to remove over 400 CRNAs from Oklahoma practice, due to lack of RX authority. We have successfully stopped, for now, an effort to remove all nonsurgical pain services from our practice. However, we did not receive a hearing on our very important Nurse Practice Act change that would have reflected the true reality of our practice in the state.

The last two mentioned items, SB1133 and HB1394, will be back. The anesthesiologists and some physician bodies want 1133 in law to reflect the AMA's resolution 903 and confirm nonsurgical pain services as the practice of medicine with rules and penalties attached. And we, as Oklahoma CRNAs, need 1394 enacted to reflect our true practice and lead to state opt-out status.

With that said, this association needs your time and monies to defend and protect our practice.

First, we need and expect \$500 one-time from each Oklahoma CRNA in check form or credit card withdrawal. The check needs to be made payable to the OANA PAC or we need a credit card number with expiration date for electronic withdrawal. All checks or credit card withdrawals must come from personal accounts, not business accounts. **There is no tax deduction for donations to our OANA PAC.** We need the PAC donation as soon as possible so as to make the largest impact before the November elections.

We as an association board, decided to ask for PAC money first, as we need to donate to as many legislators funds as possible to insure our voice is heard during the next session. Our database, as of today, shows some 335 active members in the state. If we all give \$500, we will have \$165,500 to use, and this would be huge.

Second, we need monies for the OANA general fund that goes to pay our lobbyists. Our cost for lobbying efforts next year, secondary to the 1133 battle, will double and our general fund is below operating budget. We hired 4 lobbyists to help with 1394 and ended up fighting for our practice rights against 1133. It is apparent to this board, and

I'm sure to this membership, that the next session will be equally as difficult and these same 4 lobbyists will be needed to not only move our legislation along but also to defend ourselves against 1133. With that said, we also need and expect \$500 to the OANA general fund. We can set that up as a one-time check or a credit card donation or split into monthly credit card withdrawals. The check needs to be made payable to the OANA general fund and the credit card withdrawal should be arranged with the OANA office staff. Donations may be from a business account or a personal account and may be tax deductible, **but it is up to your tax professional to advise you on this.** 

This is unprecedented in our history, but as you know, we as non-physician providers, continue to be attacked by physician bodies in their attempt to limit our scopes of practice and further tighten unnecessary supervision requirements. I need all on board as we move into the next session. Money is just one piece of the puzzle; <a href="your advocacy">you radvocacy</a> is also needed. You have all seen my many letters and emails and you know what to do when it comes to building a relationship with your legislator at home, so that your voice and our practice scope is understood when legislators are asked to debate and vote on scope of practice issues.

There is more to come, but for now, included with this letter is a pain survey that must be done and returned no later than August 31, 2009, so as to ready this leadership for the September interim study. Also, we need your donations made to the OANA PAC and OANA general fund as soon as possible. We need the PAC money first and the general fund money second. Also included in this mailing, is a board of directors' nomination form; please consider being a part of this association's leadership. Self nominations are fine and welcome. After the pain surveys start to flow in, I will disseminate the information back to the membership and further brief this membership on the interim study progress and dates. As mentioned in my email, any CRNA of the state with a large or varied nonsurgical pain practice, are welcome and I would encourage you to join me in this interim study. You may email me or contact the office with your desire to participate.

Committed to you and this association,

Victor D. Long, CRNA, MS OANA President 405.834.4952 cell 4sooners1@cox.net

# OANA Demographics and Pain Service Survey Please print legibly! Can be faxed back to 405-364-5379

wazzanii						
Address	:					
City:		State:	Zip:	£	AANA#	
40 1100 110	l (secure) E-mail:				-3.0k33374.7k018.	
	e practice: yes no		e practic	ce: yes no		
	·			, , , , , , , , , , , , , , , , , , , ,		
Facilitie	s: (Please list all facilities at Facility	which you provide services)  County		Facility		County
Select a	I models that apply:					
	olo: yes no	CRNA group: yes	0	CRNA/MD/	A group: yes no	
300000000	Accessores	era ar Browly, Jeo		Citivalia	r group. Jes no	
		PAIN SERV	CES	HDVEV		
Definiti	2222	IAIN SERV	CES	UKVEI		
			CORPO SCORE			areasana 2000-2
		inistration of topical, intr				macologi
agei	its for the anesthetic ma	nagement of surgical and	obstetri	ically induced pain		
		t: The administration of				
nha	macological and psycho	ological techniques and n	odalitie	s, for the managen	nent of acute and cl	ronic pai
pna		· · · · · · · · · · · · · · · · · · ·		include the assessr	ment, planning, imr	lementati
	ide the obstetrical and o	operating room areas. (1	HS IIIav			
outs	ide the obstetrical and o				P	
outs		al approaches in providing			F	
outs and	evaluation of multimod	al approaches in providin	g patien	t care.)	P	
outs and	evaluation of multimod		g patien	t care.)	, , , , , , , , , , , , , , , , , , , ,	
outs and Please 1	evaluation of multimodise the definitions above	al approaches in providing to answer the following	g patien puestion	t care.)		9/.
outs and Please 1	evaluation of multimodise the definitions above	al approaches in providin	g patien puestion	t care.)		_%
outs and Please 1	evaluation of multimode use the definitions above at percentage of your an	al approaches in providing to answer the following nual caseload do you pro	g patien puestion vide <u>Res</u>	t care.) ss: gional Anesthesia S	Services?	
outs and Please v 1. Who 2. Plea	evaluation of multimod- use the definitions above at percentage of your and use mark all techniques of	al approaches in providing to answer the following nual caseload do you pro of Nonsurgical Pain Man	g patien question vide Res	t care.) s: gional Anesthesia S which apply to yo	Services?	
outs and Please v 1. Who 2. Plea	evaluation of multimod- use the definitions above at percentage of your and use mark all techniques of	al approaches in providing to answer the following nual caseload do you pro	g patien question vide Res	t care.) s: gional Anesthesia S which apply to yo	Services?	
outs and Please v 1. Who 2. Plea	evaluation of multimod- use the definitions above at percentage of your an- use mark all techniques of ade the average number	al approaches in providing to answer the following nual caseload do you pro of Nonsurgical Pain Mana of times you provide eac	g patien question vide Res	t care.)  zional Anesthesia S  which apply to yo e annually.	Services? ur annual practice.	Please
outs and Please v 1. Who 2. Plea incl	evaluation of multimod- use the definitions above at percentage of your an- use mark all techniques of ude the average number	al approaches in providin to answer the following nual caseload do you pro of Nonsurgical Pain Mans of times you provide each with steroids	g patien question vide Res gement h service	t care.)  ss:  gional Anesthesia 5  which apply to yo e annually. times per yea	Services? ur annual practice. ur fluro guidance	Please
outs and Please v 1. Who 2. Plea incl	evaluation of multimodesse the definitions above at percentage of your anse mark all techniques of the average number.  Cervical epidural block. Lumbar epidural block	al approaches in providing to answer the following nual caseload do you pro of Nonsurgical Pain Mans of times you provide each with steroids with steroids	g patien  ruestion  ride Reg  gement  n service  yes no	t care.)  ss:  gional Anesthesia S  which apply to yo e annually. times per yettimes per yet	Services?  ur annual practice.  ur fluro guidance ur fluro guidance	Please ? yes no ? yes no
outs and Please 1  Nh:  Please 1  Please 2  Please 2  Leading a. b. c.	evaluation of multimodesse the definitions above at percentage of your anse mark all techniques of the average number.  Cervical epidural block. Lumbar epidural block	al approaches in providing to answer the following nual caseload do you pro of Nonsurgical Pain Man of times you provide each with steroids with steroids	g patien ruestion ride Reg gement h service yes no yes no	t care.)  ss:  gional Anesthesia S  which apply to yo e annually. times per yet times per yet	Services?  ur annual practice.  ur fluro guidance ar fluro guidance	Please ? yes no ? yes no ? yes no
outs and Please 1  Nh:  Please 1  Please 2  Please 2  Leading a. b. c.	evaluation of multimodese the definitions above at percentage of your anse mark all techniques odde the average number.  Cervical epidural block Lumbar epidural block Lumbar facet injections. Lumbar facet/RFTC and the second s	al approaches in providing to answer the following nual caseload do you pro of Nonsurgical Pain Mans of times you provide each with steroids with steroids a dinjections	g patien question ride Reg gement h service yes no yes no yes no	t care.)  ss:  gional Anesthesia S  which apply to yo e annually.  times per yet	Services?  ur annual practice.  ur fluro guidance ar fluro guidance ar fluro guidance	Please ? yes no ? yes no ? yes no ? yes no
outs and Please 1  New 1. White and the conditions and the conditions are the conditions and the conditions are the conditions	evaluation of multimodese the definitions above at percentage of your anse mark all techniques odde the average number.  Cervical epidural block Lumbar epidural block Lumbar facet injections. Lumbar facet/RFTC and the second s	al approaches in providin to answer the following nual caseload do you pro of Nonsurgical Pain Mans of times you provide eac with steroids with steroids is d injections sal root ganglion blocks	g patien  ride Reg  gement h service  yes no yes no yes no yes no	t care.)  s:  gional Anesthesia S  which apply to yo e annually.  times per yet	Services?  ur annual practice.  ur furo guidance ar fluro guidance ar fluro guidance ar fluro guidance ar fluro guidance	Please ? yes no
outs and Please to 1. What 2. Pleas include to c. d. d. e. f.	evaluation of multimodese the definitions above at percentage of your amount and the techniques of the	al approaches in providing to answer the following nual caseload do you proof Nonsurgical Pain Man of times you provide each with steroids with steroids dijections all root ganglion blocks ock	g patien  question  ride Reg  gement h service  yes no	t care.)  S:  gional Anesthesia S  which apply to yo e annually. times per yettimes per yet	Services?  ur annual practice.  ur fluro guidance ar fluro guidance	Please  ? yes no
outs and Please to 1. What 2. Please incl. a. b. c. d. e.	evaluation of multimodese the definitions above at percentage of your anse mark all techniques odde the average number. Cervical epidural block Lumbar epidural block Lumbar facet injections. Lumbar facet/RFTC an Lumbar speeve root/dor Lumbar sympathetic bl. Sacral nerve root/sleeve.	al approaches in providing to answer the following nual caseload do you pro of Nonsurgical Pain Maniof times you provide each with steroids with steroids al root injections al root ganglion blocks ock e root injection	g patien  question  ride Reg  gement h service  yes no	t care.)  ss:  zional Anesthesia S which apply to yo e annually.  times per yet	Services?  ur annual practice.  ur fluro guidance ar fluro guidance	Please ? yes no
outs and Please 1  1. Whi 2. Please incl. a. b. c. d. e. f. f. g. h.	evaluation of multimodese the definitions above at percentage of your anse mark all techniques odde the average number. Cervical epidural block Lumbar facet injections. Lumbar facet (RFTC an Lumbar sympathetic bl. Sacral nerve root/sleev. Sacrolliac joint injectio.	al approaches in providin  to answer the following nual caseload do you pro of Nonsurgical Pain Mans of times you provide eac with steroids with steroids is d injections sal root ganglion blocks ock e root injection n	generation ride Regement h service yes no ye	t care.)  s:  gional Anesthesia S  which apply to yo e annually.  times per yet	Services?  ur annual practice.  ur fluro guidance ar fluro guidance	Please  ? yes no
outs and Please 1  1. Whi  2. Please incl.  a. b. c. d. e. f. g. h. i.	evaluation of multimodese the definitions above at percentage of your amose mark all techniques on the the average number. Cervical epidural block Lumbar facet/RFTC an Lumbar facet/RFTC an Lumbar sleeve root/for Lumbar sympathetic bl Sacral nerve root/sleeves Sacrolitac joint injectio Transforaminal epidural	al approaches in providing to answer the following nual caseload do you pro of Nonsurgical Pain Man of times you provide each with steroids with steroids dijections sal root ganglion blocks ock proof injection in	generation ride Regement h service yes no ye	ss:  gional Anesthesia S which apply to yo e annually.  times per yet	Services?  ur annual practice.  ur fluro guidance  ar fluro guidance	Please  ? yes no
outs and Please 1  Note: The second of the s	evaluation of multimodese the definitions above at percentage of your anse mark all techniques odde the average number. Cervical epidural block Lumbar epidural block Lumbar facet injections. Lumbar sleeve root/dor Lumbar sympathetic bl. Sacral nerve root/sleeve Sacroiliac joint injection. Transforaminal epidura Trigger point injections.	al approaches in providing to answer the following mual caseload do you pro of Nonsurgical Pain Maniof times you provide each with steroids with steroids with steroids dijections saal root ganglion blocks ock e root injection in	gement h service yes no	t care.)  Str.  Zional Anesthesia S which apply to yo e annually.  times per yet	Services?  ur annual practice.  ur fluro guidance ar fluro guidance	Please  ? yes no
outs and Please 1  New 2. Please incl.  a. b. c. d. e. f. g. h. i. j. k.	evaluation of multimodese the definitions above at percentage of your anse mark all techniques odde the average number. Cervical epidural block Lumbar apidural block Lumbar facet injections. Lumbar facet injections. Lumbar speeve root/dor Lumbar sympathetic bl Sacral nerve root/sleeve Sacroiliac joint injection Transforaminal epidura Trigger point injections DCS placement.	al approaches in providin to answer the following nual caseload do you pro of Nonsurgical Pain Mans of times you provide eac with steroids with steroids s d injections sal root ganglion blocks occupantial	gement h service yes no	t care.)  Str.  gional Anesthesia S  which apply to yo e annually.  times per yet	Services?  ur annual practice.  ur fluro guidance ar fluro guidance	Please  ? yes no
outs and Please 1  Note: The second of the s	see the definitions above at percentage of your am seemark all techniques or det the average number. Cervical epidural block Lumbar facet/RFTC an Lumbar facet/RFTC an Lumbar speever off of Compart of the seeman and t	al approaches in providing to answer the following nual caseload do you proof Nonsurgical Pain Man of times you provide each with steroids with steroids dijections all root ganglion blocks ock to root injection in the control of the steroid of th	gement h service yes no	t care.)  SS:  zional Anesthesia S which apply to yo e annually.  times per yet	Services?  ur annual practice.  ur furo guidance  ar furo guidance	Please  ? yes no
outs and Please 1  Note: The second of the s	evaluation of multimodese the definitions above at percentage of your amount and the average number. Cervical epidural block Lumbar facet injections Lumbar facet injections Lumbar spectifications and the second and t	al approaches in providing to answer the following mual caseload do you pro of Nonsurgical Pain Maniof times you provide each with steroids with steroids all root ganglion blocks ock to root injection in the case of the ca	gement h service yes no	t care.)  Six:  Zional Anesthesia S which apply to yo e annually.  times per yet	Services?  ur annual practice.  ur fluro guidance ar fluro guidance	Please  ? yes no
outs and Please 1. White Pleas	evaluation of multimodese the definitions above at percentage of your anse mark all techniques of the average number. Cervical epidural block Lumbar aget injections. Lumbar facet injections. Lumbar sleeve root/dor. Lumbar sleeve root/dor. Lumbar sleeve root/dor. Lumbar facet/RFTC an Lumbar sleeve root/dor. Lumbar sleeve root/dor. Transforaminal epidura Trigger point injections. DCS placement. Hypogastric plexus blo. Lumbar discography. Lumbar sympathetic ne	al approaches in providing to answer the following nual caseload do you pro of Nonsurgical Pain Mans of times you provide each with steroids with steroids and the steroids and the steroids are too tinjection on the steroids and the steroids are too tinjection on the steroids and the steroids are too tinjection on the steroids and the steroids are too tinjection on the steroids and the steroids are too tinjection on the steroids are	gement h service yes no	t care.)  Str.  Zional Anesthesia S  which apply to yo e annually.  times per yet	ur annual practice.  furo guidance	Please  ? yes no
outs and Please t 1. Who 2. Please incl. a. b. c. d. e. f. g. g. h. i. j. j. k. l. m. n. o.	see the definitions above at percentage of your am see mark all techniques o ide the average number Cervical epidural block Lumbar facet injections Lumbar facet/RFTC an Lumbar seeve root/for Lumbar sympathetic bl Sacral nerve root/sleeve Sacrolilac joint injection Triagger point injections DCS placement Hypogastric plexus blo Lumbar discography Lumbar sympathetic ne Median branch block a	al approaches in providing to answer the following nual caseload do you proof Nonsurgical Pain Man of times you provide each with steroids with steroids dijections all root ganglion blocks ock or root injection in the control of the steroids of the control of the steroid of t	gement h service yes no	t care.)  SS:  zional Anesthesia S  which apply to yo e annually.  times per yet	Services?  ur annual practice,  ar furo guidance	Please  ? yes no
outs and Please 1. Wh:  2. Pleas incl.  a. b. c. d. d. e. f. g. g. h. i. j. j. k. l. m. n. o. p.	evaluation of multimodese the definitions above at percentage of your amise mark all techniques of the average number. Cervical epidural block Lumbar facet injections Lumbar facet/RFTC an Lumbar sympathetic bis Sacral nerve root/dor Lumbar sympathetic bis Sacral nerve root/sleev. Sacrolilac joint injection Transforaminal epidura Trigger point injections DCS placement Hypogastre plexus blo. Lumbar discography Lumbar sympathetic ne Median branch block at Spinal cord stimulators.	al approaches in providing to answer the following nual caseload do you pro of Nonsurgical Pain Maniof times you provide each with steroids with steroids with steroids ad injections sal root ganglion blocks ock proof injection in the control of t	gement in service representation of the service representation of	t care.)  Six:  Zional Anesthesia S  which apply to yo e annually.  times per yet	Services?  ur annual practice.  ur fluro guidance ar fluro guidance	Please  ? yes no
outs and outs and outs and outs and outs and outs and outs outs outs outs outs outs outs outs	evaluation of multimodese the definitions above at percentage of your amount of the average number. Cervical epidural block Lumbar epidural block Lumbar facet injections. Lumbar facet/RFTC an Lumbar speeve root/dor Lumbar sympathetic bl. Sacral nerve root/sleeve Sacrolitac joint injection. Transforaminal epidural Trigger point injections. DCS placement. Hypogastric plexus block and Spinal cord stimulators. Vertebroplasty	al approaches in providing to answer the following nual caseload do you pro of Nonsurgical Pain Maniof times you provide each with steroids with steroids with steroids ad injections sal root ganglion blocks ock proof injection in the control of t	gement h service yes no	t care.)  SS:  zional Anesthesia S  which apply to yo e annually.  times per yet	Services?  ur annual practice.  ur fluro guidance  ar fluro guidance	Please  ? yes no
outs and	see the definitions above at percentage of your amose mark all techniques or det the average number. Cervical epidural block Lumbar facet/RFTC an Lumbar facet/RFTC an Lumbar speeve root/dor Lumbar sympathetic bl. Sacral nerve root/sleeve Sacrolilac joint injection Transforaminal epidural Trigger point injections DCS placement. Hypogastric plexus blo. Lumbar discography Lumbar sympathetic ne Median branch block at Spinal cord stimulators Vertebroplasty olysis Techniques:	al approaches in providing to answer the following nual caseload do you pro of Nonsurgical Pain Man of times you provide each with steroids with steroids sal root ganglion blocks ock to tool injection number of the provided in the steroids of the provided in the steroid in the s	ride Regement h services no yes no	t care.)  SS:  zional Anesthesia S  which apply to yo e annually.  times per yet	services?  ar annual practice,  ar furo guidance	Please  ? yes no
outs and and Please v. 1. Who have the control of t	evaluation of multimodese the definitions above at percentage of your amise mark all techniques of ide the average number. Cervical epidural block Lumbar epidural block Lumbar facet/RFTC an Lumbar sleever root/dor Lumbar sympathetic bit Sacral nerve root/sleeve Sacroiliae joint injection Transforaminal epidural Trigger point injections DCS placement Hypogastrie plexus blot. Lumbar discography Lumbar sympathetic nemedian branch block as Spinal cord stimulators Vertebroplasty oblysis Techniques: cryo	al approaches in providing to answer the following mual caseload do you pro of Nonsurgical Pain Man of times you provide each with steroids with steroids of dijections sail root ganglion blocks ock proof injection in the steroid of the steroid ock proof injection in the steroid ock proof injection injection in the steroid ock proof injection injection injection in	muestion ruestion rue	t care.)  Sir:  Zional Anesthesia S  which apply to yo e annually.  times per yet time	Services?  ur annual practice.  ur fluro guidance ar fluro guidance	Please  ? yes no
outs and outs outs outs outs outs outs outs outs	evaluation of multimodese the definitions above at percentage of your amount of the average number. Cervical epidural block Lumbar epidural block Lumbar facet injections. Lumbar facet injections. Lumbar sleeve root/dor Lumbar sympathetic bl. Sacral nerve root/sleeve Sacrolilac joint injection. Transforaminal epidura Trigger point injections. DCS placement. Hypogastric plexus block and Spinal cord stimulators. Vertebroplasty olysis Techniques: cryo heated RF.	al approaches in providing to answer the following mual caseload do you pro of Nonsurgical Pain Maniof times you provide each with steroids with steroids all root ganglion blocks ock to root injection in the case of the ca	ruestion rue	t care.)  It care.)  It care.)  Which apply to yo e annually.  times per yet times per	Services?  ur annual practice.  ur fluro guidance ar fluro guidance	Please  ? yes no
outs and and Please v. 1. Who have the control of t	see the definitions above at percentage of your amose mark all techniques of det the average number. Cervical epidural block Lumbar facet/RFTC an Lumbar facet/RFTC an Lumbar seeve root/for Lumbar sympathetic bl. Sacral nerve root/sleeve Sacrolilac joint nijection Transforaminal epidural Trigger point injections DCS placement. Hypogastric plexus blo. Lumbar discography Lumbar sympathetic ne Median branch block at Spinal cord stimulators Vertebroplasty olysis Techniques: cryoheated RF pulsed RF	al approaches in providing to answer the following nual caseload do you proof Nonsurgical Pain Manof times you provide each with steroids with steroids sal root ganglion blocks ock to the provide each of th	muestion ruestion rue	t care.)  It care.)  It care.)  Which apply to yo e annually.  times per yet times per	Services?  ur annual practice,  ar furo guidance  ar furo guidance	Please  ? yes no



4/21/25, 3:51 PM Bill Information

### BILL INFORMATION FOR SB 1133

### SB 1133 by Jolley and Denney

SELECT SESSION: 2009 Regular Session

Receive Email Updates for this Measure (LENS)

ENTER BILL #:

Search

Professions and occupations; creating the Oklahoma Interventional Pain Management and Treatment Act. Emergency.

Action	Journal Page	Date	Chamber
First Reading	315	02/02/2009	5
Authored by Senator Jolley	315	02/02/2009	s
Second Reading referred to Health and Human Services	379	02/05/2009	s
Reported Do Pass as amended Health and Human Services committee; pending Cl	t	02/05/2009	s
Pending authorship Representative(s) Denney		02/05/2009	5
Reported Do Pass as amended Health and Human Services committee; CR filed	397	02/09/2009	S
Title stricken	397	02/09/2009	S
coauthored by Denney (principal House author)	397	02/09/2009	5
General Order, Considered	626	03/02/2009	s
Advanced to Third Reading	626	03/02/2009	5
Backed up to General Order	626	03/02/2009	S
General Order, considered and deferred	627	03/02/2009	5
General Order, Considered	631	03/02/2009	5
Measure passed: Ayes: 28 Nays: 18	631	03/02/2009	S
Emergency passed: Ayes: 34 Nays: 12	631	03/02/2009	S
Notice served to reconsider vote on measure Jolley	632	03/02/2009	S
Motion expired	850	03/05/2009	S
Referred for engrossment	850	03/05/2009	S
Engrossed to House	851	03/09/2009	S
First Reading	831	03/09/2009	н
Second Reading referred to Public Health	1027	03/18/2009	н
CR; Do Pass, amended by committee substitute Public Health Committee	1197	04/01/2009	н
Coauthored by Representative(s) Derby, Ritze		04/01/2009	н

4/21/25, 3:53 PM Bill Information

### BILL INFORMATION FOR SB 1133

### SB 1133 by Jolley and Trebilcock

SELECT SESSION: 2010 Regular Session

Receive Email Updates for this Measure (LENS)

ENTER BILL #:

Professions and occupations; creating the Oklahoma Interventional Pain Management and Treatment Act.

Action	Journal Page	Date	Chambe
First Reading	315	02/02/2009	5
Authored by Senator Jolley	315	02/02/2009	S
Second Reading referred to Health and Human Services	379	02/05/2009	S .
Reported Do Pass as amended Health and Human Services committee; pending CR	ı.	02/05/2009	s
Pending authorship Representative(s) Denney		02/05/2009	s
Reported Do Pass as amended Health and Human Services committee; CR filed	397	02/09/2009	s
Title stricken	397	02/09/2009	S
coauthored by Denney (principal House author)	397	02/09/2009	5
General Order, Considered	626	03/02/2009	s
Advanced to Third Reading	626	03/02/2009	s
Backed up to General Order	626	03/02/2009	s
General Order, considered and deferred	627	03/02/2009	5
General Order, Considered	631	03/02/2009	5
Measure passed: Ayes: 28 Nays: 18	631	03/02/2009	5
Emergency passed: Ayes: 34 Nays: 12	631	03/02/2009	5
Notice served to reconsider vote on measure Jolley	632	03/02/2009	s
Motion expired	850	03/05/2009	s
Referred for engrossment	850	03/05/2009	5
Engrossed to House	851	03/09/2009	5
First Reading	831	03/09/2009	н
Second Reading referred to Public Health	1027	03/18/2009	н
CR; Do Pass, amended by committee substitute Public Health Committee	1197	04/01/2009	н
Coauthored by Representative(s) Derby, Ritze	1197	04/01/2009	н
Withdrawn from Calendar; rereferred to Public Health Committee	348	02/04/2010	н
CR; Do Pass, amended by committee substitute Public Health Committee	441	02/15/2010	о н
Remove Representative Denney as principal House author and substitute with Representative Trebilcock	441	02/15/2010	н
Title restored	441	02/15/2010	о н

https://www.oklegislature.gov/BillInfo.aspx?Bill=SB 1133&Session=1000

1/2

/25, 3:53 PM	Bill Information			
General Order		568	02/25/2010	
Coauthored by Representative(s) Sullivan		568	02/25/2010	
Third Reading, Measure passed: Ayes: 55 Nays: 33		568	02/25/2010	
Notice served to reconsider vote by Representative Trebilcock		569	02/25/2010	
Emergency failed: Ayes: 45 Nays: 30		569	02/25/2010	
Motion to reconsider tabled		590	03/01/2010	
Motion to rescind vote failed		590	03/01/2010	
Ayes: 46 Nays: 47		590	03/01/2010	
Referred for engrossment		590	03/01/2010	
Engrossed, signed, to Senate		613	03/02/2010	
HAs read		567	03/02/2010	

https://www.oklegislature.gov/BillInfo.aspx?Bill=SB 1133&Session=1000

2/2

4/21/25, 5:53 PM Bill Information

### BILL INFORMATION FOR SB 479

### SB 479 by Jolley and Trebilcock

SELECT SESSION	: 2010 Regular Session	·	Receive Email Updates for this Measure (LENS)
ENTER BILL #:	Search		

Professions and occupations; creating the Oklahoma Interventional Pain Management and Treatment Act. Emergency.

Action	Journal Page	Date	Chambe
First Reading	184	02/02/2009	5
Authored by Senator Lamb	184	02/02/2009	s
Second Reading referred to Appropriations	360	02/03/2009	s
Referred to Appr/Sub-Health and Human Services		02/03/2009	S
Recommendation to the full committee; Do Pass as amended Appr/Sub-Health and Human Services sub-committee		02/04/2009	s
Reported Do Pass as amended Appropriations committee; pending CR		02/12/2009	5
Pending removal author Senator Lamb and replace with Senator Crain		02/12/2009	5
Pending authorship Representative(s) Jackson		02/18/2009	5
Reported Do Pass as amended Appropriations committee; CR filed	463	02/18/2009	s
Title stricken	463	02/18/2009	5
Remove as author Senator Lamb; authored by Senator Crain	463	02/18/2009	s
coauthored by Lamb	463	02/18/2009	s
coauthored by Jackson (principal House author)	463	02/18/2009	s
General Order, Amended	939	03/10/2009	s
Measure passed: Ayes: 33 Nays: 12	940	03/10/2009	s
Referred for engrossment	940	03/10/2009	s
Engrossed to House	953	03/11/2009	s
First Reading	919	03/11/2009	н
Second Reading referred to Public Health	1026	03/18/2009	н
CR; Do Pass, amended by committee substitute Public Health Committee	1258	04/08/2009	н
General Order	1346	04/15/2009	н
Enacting clause stricken	1346	04/15/2009	н
Third Reading, Measure passed: Ayes: 67 Nays: 26	1346	04/15/2009	н
Referred for engrossment	1346	04/15/2009	н
Engrossed, signed, to Senate	1351	04/15/2009	н
HAs read	1284	04/15/2009	s
HAs rejected, conference requested	1480	04/22/2009	) s

1/2

www.oklegislature.gov/BillInfo.aspx?Bill=SB 479&Session=1000

4/21/25, 5:53 PM Bill Information

25, 5:53 PM	ation		
SCs named GCCA	1539	04/30/2009	S
Conference granted, HC's named Jackson, Miller, Jones	1643	05/11/2009	н
Conferees unable to agree	1841	05/21/2009	s
Pending removal author Senator Crain and replace with Senator Jolley		03/08/2010	S
HAs rejected, conference requested, SCs named Jolley, Lamb, Paddack	661	03/08/2010	s
Conference granted, HC's named Trebilcock, Cox, Sullivan, Inman	911	03/11/2010	н
2 CCR read	904	03/11/2010	s
Remove as author Senator Crain; authored by Senator Jolley	904	03/11/2010	S
2 CCR adopted	962	03/24/2010	s
remove as principal author Representative Jackson and substitute with Representative Trebilcock	962	03/24/2010	s
coauthored by Jackson	962	03/24/2010	S
Measure and Emergency passed, to House: Ayes: 40 Nays: 5	962	03/24/2010	s
2 CCR submitted	1048	03/24/2010	н
Considered	1140	04/01/2010	Н
Coauthored by Representative(s) Derby	1140	04/01/2010	н
Laid over	1140	04/01/2010	н
2 CCR adopted	1143	04/01/2010	н
Measure and Emergency Passed: Ayes: 95 Nays: 0	1143	04/01/2010	н
To Senate	1143	04/01/2010	н
Referred for enrollment	1062	04/05/2010	S
Enrolled, to House	1087	04/06/2010	s
Signed, returned to Senate	1175	04/06/2010	н
Sent to Governor	1105	04/06/2010	s
Approved by Governor 04/09/2010	1208	04/12/2010	9

www.cklegislature.gov/BillInfo.aspx?Bill=SB 479&Session=1000

2/2

A contact lens fitting shall be complete and a contact lens prescription may be written when:

- The optometrist has completed all measurements, tests and examinations necessary to satisfy his or her professional judgment that the patient is a viable candidate to wear contact lenses, recognizing that more than one visit between the patient and the optometrist may be required; and
- Contact lenses suitable for the patient's eyes have been evaluated and fitted by the optometrist to the patient's eyes and the optometrist is satisfied with the fitting based on ocular health and the visual needs of the patient.

The patient shall be entitled to receive a copy of the contact lens prescription with the appropriate number of lenses to fulfill the prescription until its expiration date.

Added by Laws 2019, c. 427, § 10, eff. Nov. 1, 2019.

§59-650. Interventional pain management license.

- A. This act shall be known and may be cited as the "Oklahoma Interventional Pain Management and Treatment Act".
  - B. As used in this section:
- "Chronic pain" means a pain state which is subacute, persistent and intractable;
- "Fluoroscope" means a radiologic instrument equipped with a fluorescent screen on which opaque internal structures can be viewed as moving shadow images formed by the differential transmission of X-rays throughout the body; and
- 3. "Interventional pain management" means the practice of medicine devoted to the diagnosis and treatment of chronic pain, through the use of such techniques as:
  - a. ablation of targeted nerves,
  - percutaneous precision needle placement within the spinal column with placement of drugs such as local anesthetics, steroids, analgesics in targeted areas of the spinal column, or
  - c. surgical techniques, such as laser or endoscopic diskectomy, intrathecal infusion pumps and spinal cord stimulators.
- C. It shall be unlawful to practice or offer to practice interventional pain management in this state unless such person has been duly licensed under the provisions of the Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act or the Oklahoma Osteopathic Medicine Act.
- D. Nothing in this section shall be construed to forbid the administration of lumbar intra-laminar epidural steroid injections or peripheral nerve blocks by a certified registered nurse anesthetist when requested to do so by a physician and under the supervision of an allopathic or osteopathic physician licensed in

this state and under conditions in which timely on-site consultation by such allopathic or osteopathic physician is available.

E. A certified registered nurse anesthetist shall not operate a freestanding pain management facility without direct supervision of a physician who is board-certified in interventional pain management or its equivalent.

Added by Laws 2010, c. 67, § 1, emerg. eff. April 9, 2010.

\$59-698.1. Short title.

Chapter 15 of this title shall be known and may be cited as the "Oklahoma Veterinary Practice Act". Added by Laws 1971, c. 126, \$ 1, emerg. eff. May 4, 1971. Amended by Laws 1999, c. 94, \$ 1, eff. Nov. 1, 1999.

### \$59-698.2. Definitions.

As used in the Oklahoma Veterinary Practice Act:

- "Board" means the State Board of Veterinary Medical Examiners;
- "Animal" means any animal other than humans and includes, but is not limited to, fowl, fish, birds and reptiles, wild or domestic, living or dead;
- 3. "Veterinarian" means a person who has received a degree in veterinary medicine or its equivalent from a school of veterinary medicine;
- 4. "Licensed veterinarian" means any veterinarian who holds an active license to practice veterinary medicine in this state:
- 5. "School of veterinary medicine" means any veterinary college or division of a university or college that offers the degree of doctor of veterinary medicine or its equivalent, which conforms to the standards required for accreditation by the American Veterinary Medical Association (AVMA) and which is recognized and approved by the Board;
- 6. "Veterinary technician" means a person who has graduated from a program accredited by the American Veterinary Medical Association, or its equivalent which is recognized and approved by the Board, and who has passed the examination requirements set forth by the Board, and is certified to practice under the direct supervision of a licensed veterinarian. For the purpose of the Oklahoma Veterinary Practice Act, "registered veterinary technician (RVT)" will be used interchangeably with veterinary technician who is certified pursuant to Sections 698.21 through 698.26 of this title;
- 7. "Veterinary technologist" means a person who has successfully graduated from an AVMA-accredited bachelor degree program of veterinary technology, or its AVMA equivalent;

Oklahoma Statutes - Title 59, Professions and Occupations

"Veterinary assistant" means an individual who may perform the duties of a veterinary technician or veterinary technologist;

Oklahoma Statutes - Title 59. Professions and Occupations

Page 615

Page 616

# Nurse Practice Act Scope of Practice Addition

SB1455

1	STATE OF OKLAHOMA
2	2nd Session of the 51st Legislature (2008)
3	SENATE BILL NO By: Johnson (Constance)
4	
5	
6	AS INTRODUCED
7	An Act relating to professions and occupations;
8	amending 59 O.S. 2001, Section 567.3a, which relates to the Oklahoma Nursing Practice Act; modifying definition; and providing an effective date.
9	definition; and providing an effective date.
10	
11	BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:
12	SECTION 1. AMENDATORY 59 O.S. 2001, Section 567.3a, is
13	amended to read as follows:
14	Section 567.3a As used in the Oklahoma Nursing Practice Act:
15	<ol> <li>"Board" means the Oklahoma Board of Nursing;</li> </ol>
16	2. "The practice of nursing" means the performance of services
17	provided for purposes of nursing diagnosis and treatment of human
18	responses to actual or potential health problems consistent with
19	educational preparation. Knowledge and skill are the basis for
20	assessment, analysis, planning, intervention, and evaluation used in
21	the promotion and maintenance of health and nursing management of
22	illness, injury, infirmity, restoration or optimal function, or
23	death with dignity. Practice is based on understanding the human
24	condition across the human lifespan and understanding the

Page 1

Req. No. 3494

1		continues to maintain such recertification by the
2		Council on Recertification of Nurse Anesthetists,
3		(3) administers anesthesia under the supervision of a
4		medical doctor, an osteopathic physician, a
5		podiatric physician or a dentist licensed in this
6		state and under conditions in which timely onsite
7		consultation by such doctor, osteopath, podiatric
8		physician or dentist is available, and
9		(4) has received a certificate of recognition from
10		the Board.
11	b.	The certified registered nurse anesthetist accepts
12		responsibility, accountability, and obligation to
13		practice in accordance with usual and customary
14		advanced practice nursing standards and functions as
15		defined by the scope of practice or role definition
16		statements for the certified registered nurse
17		anesthetist.
18	<u>c.</u>	A certified registered nurse anesthetist, under the
19		supervision of a medical doctor, osteopathic
20		physician, podiatric physician or dentist licensed in
21		this state, and under conditions in which timely, on-
22		site consultation by such medical doctor, osteopathic
23		physician, podiatric physician or dentist is
24		available, shall be authorized, pursuant to rules

Req. No. 3494 Page 11

# HB1394 SB1086 Our first effort to change SUPERVISION language to CONSULTATION

## HAVE YOU CONTACTED YOUR LEGISLATORS??

Do you have your surgeons & administrators support? Oklahoma legislative session starts MONDAY 2/2/09. NOW is the time for all Oklahoma CRNAs to do their part to

# SUPPORT HB 1394!!

It is also vital that we *oppose SB 792 and SB 1133*, which are detrimental to Oklahoma CRNA practices!!

All DANA members should have received tools for writing and calling legislators.

If you have not, please contact the OANA office at 405-329-6262 OR President Victor Long at 405-834-4952 or 4sooners1@cox.net.

Support HB 1394!



Proposed amendments to Title 59. Professions and Occupations, Chapter 12 - Nurses Oklahoma Nursing Practice Act Section 567.3a - Definitions

- 10. a. "Certified registered nurse anesthetist" means any person who holds a license to practice as a registered nurse in this state and who:
- (1) has successfully completed the educational program of a school of nurse enesthetists accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs,
- (2) is certified by the Council on Certification of Nurse Anesthetists as a Certified Registered Nurse Anesthetist within one (1) year following completion of such educational program, and continues to maintain such recertification by the Ccuncil on Recertification of Nurse Anesthetists.
- (3) administers anesthesia under the supervision of in cooperation with a medical doctor, an osteopathic physician, a podiatric physician or dentist licensed in this state, and under conditions in which timely onsite consultation by such doctor, osteopath, podiatric physician or dentist is available, and
- (4) has received a certificate of recognition from the Board.
- b. A certified registered nurse anesthetist, in cooperation with under the supervision of a medical doctor, osteopathic physician, podiatric physician or dentist licensed in this state, and under conditions in which timely, on site consultation by such medical doctor, osteopathic physician or dentist is available shall be authorized, pursuant to rules adopted by the Oklahoma Board of Nursing, to order, select, obtain and administer legend drugs, Schedules II through V controlled substances, devices, and medical gases. only when engaged in the preanesthetic preparation and evaluation; anesthesia induction, maintenance and emergence, and postanesthesia care. A certified registered nurse anesthetist may order, select obtain and administer drugs only during the perioperative or periobstetrical period.
- c. "in cooperation with" means the cooperative working relationship with a medical doctor, osteopathic physician, podiatric physician or dentist, each contributing his or her respective expertise in the provision of patient care, and such collaborative practice includes the discussion of patient treatment and cooperation in the management and delivery of health care.
- d. The certified registered nurse anesthetist accepts responsibility, accountability, and obligation to practice in accordance with usual and customary advanced practice nursing standards and functions as defined by the scope of practice/role definition statements of a certified registered nurse anesthetist.

Proposed amendments to Title 59. Professions and Occupations, Chapter 12 - Nurses Oklahoma Nursing Practice Act Section 567.3a - Definitions

- 10 . a. "Certified registered nurse anesthetist" means any person who holds a license to practice as a registered nurse in this state and who:
- (1) has successfully completed the educational program of a school of nurse anesthetists accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs.
- (2) is certified by the Council on Certification of Nurse Anesthetists as a Certified Registered Nurse Anesthetist within one (1) year following completion of such educational program, and continues to maintain such recertification by the Council on Recertification of Nurse Anesthetists.
- (3) administers anesthesia under the supervision of in collaboration with a medical doctor, an osteopathic physician, a podiatric physician or dentist licensed in this state, and under conditions in which timely onsite consultation by such doctor, osteopath, podiatricphysician or dentist is available, and
- (4) has received a certificate of recognition from the Board.
- b. A certified registered nurse anesthetist, in collaboration with under the supervision of a medical doctor, osteopathic physician, podiatric physician or dentist licensec in this state, and under conditions in which timely, on site consultation by such medical doctor, osteopathic physician or dentist is available shall be authorized, pursuant to rules adopted by the Oklahoma Board of Nursing, to order, select, obtain and administer legend drugs, Schedules II through V controlled substances, devices, and medical gases. only when engaged in the preanesthetic preparation and evaluation; anesthesia induction, maintenance and emergence, and postanesthesia care. A certified registered nurse anesthetist may order, select obtain and administer drugs only during the perioperative or periobstetrical period.
- c. "Collaboration" means the cooperative working relationship with a medical doctor, osteopathic physician, podiatric physician or dentist, each contributing his or her respective expertise in the provision of patient care, and such collaborative practice includes the discussion of patient treatment and cooperation in the management and delivery of health care.
- d. The certified registered nurse anesthetist accepts responsibility, accountability, and obligation to practice in accordance with usual and customary advanced practice nursing standards and functions as defined by the scope of practice/role definition statements of a certified registered nurse anesthetist.

Proposed amendments to Title 59. Professions and Occupations, Chapter 12 - Nurses Oklahoma Nursing Practice Act Section 567.3a - Definitions

- 10. a. "Certified registered nurse anesthetist" means any person who holds a license to practice as a registered nurse in this state and who:
- (1) has successfully completed the educational program of a school of nurse anesthetists accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs,
- (2) is certified by the Council on Certification of Nurse Anesthetists as a Certified Registered Nurse Anesthetist within one (1) year following completion of such educational program, and continues to maintain such recertification by the Council on Recertification of Nurse Anesthetists,
- (3) administers anesthesia under the supervision of upon the request of a medical doctor, an osteopathic physician, a podiatric physician or dentist licensed in this state, and underconditions in which timely onsite consultation by such doctor, osteopath, podiatric physician or dentist is available, and
- (4) has received a certificate of recognition from the Board.
- b. A certified registered nurse anesthetist, <u>upon the request of under the supervision of</u> a medical doctor, osteopathic physician, podiatric physician or dentist licensec in this state, and under conditions in which timely, on site consultation by such medical doctor, osteopathic physician or dentist is available shall be authorized, pursuant to rules adopted by the Oklahoma Board of Nursing, to order, select, obtain and administer legend drugs, Schedules II through V controlled substances, devices, and medical gases. only-when engaged in the preanesthetic preparation and evaluation; anesthesia induction, maintenance and emergence, and postanesthesia care. A certified registered nurse anesthetist may order, select obtain and administer drugs only during the perioperative or periobstetrical period.
- c. "upon the request of " means a medical doctor, osteopathic physician, podiatric physician or dentist practicing within the scope of the healthcare professional's license, requests anesthesia services for a patient."
- d. The certified registered nurse anesthetist accepts responsibility, accountability, and obligation to practice in accordance with usual and customary advanced practice nursing standards and functions as defined by the scope of practice/role definition statements of a certified registered nurse anesthetist.

ı,

### Bill Text For HB1394 - Introduced

```
11
                              STATE OF OKLAHOMA
 21
                1st Session of the 52nd Legislature (2009)
 3 HOUSE BILL 1394
                                        By: Jackson
 4
 51
 61
                               AS INTRODUCED
 71
          An Act relating to professions and occupations;
          amending 59 O.S. 2001, Sections 353.1b and 567.3a,
 81
          which relate to the practice of nursing; requiring
          certified registered nurse anesthetists to consult
 91
          with certain health care practitioners; removing
          certain limitation for the administration of drugs by
10|
          certified registered nurse anesthetists; modifying
          definition; removing requirement for supervision
11|
          under certain circumstances; requiring certified
          registered nurse anesthetists to practice in
12
          accordance with certain scope of practice
          definitions; amending 63 O.S. 2001, Section 2-312,
13
          which relates to controlled dangerous substances:
          removing certain limitation for the administration of
14
          drugs by advanced practice nurses; requiring advanced
          practice nurses to consult with certain health care
15
          practitioners; and providing an effective date.
16
171
18 BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:
191
       SECTION 1.
                      AMENDATORY
                                     59 O.S. 2001, Section 353.1b, is
20|amended to read as follows:
       Section 353.1b Authority to order, select, obtain and
22|administer drugs shall be allowed for a certified registered nurse
23|anesthetist in consultation with a medical doctor, osteopathic
24|physician, podiatric physician, or dentist licensed in this state,
   Req. No. 5698
                                                                    Page 1
```

1|pursuant to rules adopted by the Oklahoma Board of Nursing, only 2 when engaged in the preanesthetic preparation or evaluation; 3 anesthesia induction, maintenance or emergence; or postanesthesia 4 care practice of nurse anosthesia. A certified registered nurse 5|anesthetist may order, select, obtain and administer drugs 6 during the perioperative or periobstetrical period. SECTION 2. 59 O.S. 2001, Section 567.3a, is AMENDATORY 8 amended to read as follows: Section 567.3a As used in the Oklahoma Nursing Practice Act: 1. "Board" means the Oklahoma Board of Nursing; 101 2. "The practice of nursing" means the performance of services 111 12|provided for purposes of nursing diagnosis and treatment of human 13|responses to actual or potential health problems consistent with 14|educational preparation. Knowledge and skill are the basis for 15|assessment, analysis, planning, intervention, and evaluation used in 16|the promotion and maintenance of health and nursing management of 17 | illness, injury, infirmity, restoration or of optimal function, or 18 death with dignity. Practice is based on understanding the human 19|condition across the human lifespan and understanding the 20|relationship of the individual within the environment. This 21|practice includes execution of the medical regime including the 22|administration of medications and treatments prescribed by any 23|person authorized by state law to so prescribe: 241

Req. No. 5698

Page 2

1	and customary advanced practice nursing standards and functions as
2	defined by the scope of practice/role definition statements for the
3	  certified nurse-midwife;
4	9. "Nurse-midwifery practice" means providing management of
5	care of normal newborns and women, antepartally, intrapartally,
6	postpartally and gynecologically, occurring within a health care
7	system which provides for medical consultation, medical management
8	or referral, and is in accord with the standards for nurse-midwifery
9	practice as defined by the American College of Nurse-Midwives;
10	10. a. "Certified registered nurse anesthetist" means any
11	person who holds a license to practice as a registered
12	nurse in this state and who:
13	(1) has successfully completed the educational
14	program of a school of nurse anesthetists
15	accredited by the Council on Accreditation of
16	Nurse Anesthesia Educational Programs,
17	(2) is certified by the Council on Certification of
18	Nurse Anesthetists as a Certified Registered
19	Nurse Anesthetist within one (1) year following
20	completion of such educational program, and
21	continues to maintain such recertification by the
22	Council on Recertification of Nurse Anesthetists,
23	(3) administers anesthesia <del>under the supervision of</del>
24	in consultation with a medical doctor, an

Req. No. 5698

osteopathic physician, a podiatric physician or a
dentist licensed in this state and under
conditions in which timely onsite consultation by
such doctor, osteopath, podiatric physician or
dentist is available, and
has received a certificate of recognition from
the Board.

b. A certified registered nurse anesthetist, under the supervision of a medical doctor, osteopathic physician, podiatric physician or dentist licensed in this state, and under conditions in which timely, on site consultation by such medical doctor, osteopathic physician, podiatric physician or dentist is available, shall be authorized, pursuant to rules adopted by the Oklahoma Board of Nursing, to order, select, obtain and administer legend drugs, Schedules II through V controlled substances, devices, and medical gases only when engaged in the preanesthetic preparation and evaluation; anesthesia induction, maintenance and emergence; and postanesthesia care. A certified registered nurse anesthetist may order, select, obtain and administer drugs only during the

perioperative or periobstetrical period in

Req. No. 5698

1| 2| 1

61

71

81

91

10

11|

13|

14|

16| 17|

18| 19|

201

21|

231

241

Page 11

(4)

Page 12

consultation with a medical doctor, osteopathic 11 21 physician, podiatric physician, or dentist licensed in 31 this state. c. The certified registered nurse anesthetist accepts 4 responsibility, accountability, and obligation to 51 6 practice in accordance with usual and customary 71 advanced practice nursing standards and functions as 8 defined by the scope of practice/role definition 91 statements of the American Association of Nurse Anesthetists for the certified registered nurse 10 11 anesthetist. d. A certified registered nurse anesthetist who applies 12 for authorization to order, select, obtain and 13 administer drugs shall: 14 15 (1) be currently recognized as a certified registered 16 nurse anesthetist in this state, 171 (2) provide evidence of completion, within the 18| two-year period immediately preceding the date of application, of a minimum of fifteen (15) units 19 201 of continuing education in advanced pharmacology related to the administration of anesthesia as 211 22| recognized by the Council on Recertification of 231 Nurse Anesthetists or the Council on Certification of Nurse Anesthetists, 24 Reg. No. 5698 Page 13 Section 2:

Title 59, Pharmacy Act

59 O.S. § 353.1b. Certified registered nurse anesthetist--Prescribing authority

A certified registered nurse anesthetist may be authorized to order, select and obtain drugs after consultation with a treating or operating medical doctor, osteopathic physician, podiatric physician or dentist, pursuant to rules adopted by the Oklahoma Board of Nursing.

Section 3

Title 63, Public Health and Safety

Chapter 2. Uniform Controlled Dangerous Substances Act.

Article III. Regulation of Manufacture, Distribution, Dispensing, Prescribing, Administering and Using for Scientific Purposes of Controlled Dangerous Substances

rescriptions

§ 2-312. Physicians, podiatrists, optometrists, dentists, veterinarians and advanced practice nurses-Authority to prescribe, administer or dispense

A. A physician, podiatrist, optometrist or a dentist who has complied with the registration requirements of the Uniform Controlled Dangerous Substances Act, in good faith and in the course of such person's professional practice only, may prescribe and administer controlled dangerous substances, or may cause the same to be administered by medical or paramedical personnel acting under the direction and supervision of the physician, podiatrist, optometrist or dentist, and only may dispense controlled dangerous substances pursuant to the provisions of Sections 355, 355.1 and 355.2 of Title 59 of the Oklahoma Statutes.

B. A veterinarian who has complied with the registration requirements of the Uniform Controlled Dangerous Substances Act, in good faith and in the course of the professional practice of the veterinarian only, and not for use by a human being, may prescribe, administer, and dispense controlled dangerous substances and may cause them to be administered by an assistant or orderly under the direction and supervision of the veterinarian.

C. An advanced practice nurse who is recognized to prescribe by the Oklahoma Board of Nursing as an advanced registered nurse practitioner, clinical nurse specialist or certified nurse-midwife, who is subject to medical direction by a supervising physician, pursuant to Section 567.3a of Title 59 of the Oklahoma Statutes, and who has complied with the registration requirements of the Uniform Controlled Dangerous Substances Act, in good faith and in the course of professional practice only, may prescribe and administer Schedule III, IV and V controlled dangerous substances.

D. An advanced practice nurse who is recognized to order, select, and obtain drugs by the Oklahoma Board of Nursing as a certified registered nurse anesthetist pursuant to Section 353.1b of Title 59 of the Oklahoma Statutes and who has complied with the registration requirements of the Uniform Controlled Dangerous Substances Act, in good faith and in the course of such practitioner's professional practice only, may order, select, and obtain Schedules II through V controlled dangerous substances.

E. A physician assistant who is recognized to prescribe by the State Board of Medical Licensure and Supervision under the medical direction of a supervising physician, pursuant to subsection D of Section 519.6 of Title 59 of the Oklahoma Statutes, and who has complied with the registration requirements of the Uniform Controlled Dangerous Substances Act, in good faith and in the course of professional practice only, may prescribe and administer Schedule II through V controlled dangerous substances.

### Bill Text For SB1086 -Introduced

1	STATE OF OKLAHOMA
2	1st Session of the 52nd Legislature (2009)
3	  SENATE BILL 1086 By: Marlatt
4	
5	
6	AS INTRODUCED
7	An Act relating to professions and occupations:
8	amending 59 O.S. 2001, Section 567.3a, which relates
	requirement for supervision of certified registered
9	nurse anesthetists; directing certified registered nurse anesthetists to consult with certain health
10	care professionals; deleting requirement for certain
11	<pre>on-site consultation; and providing an effective date.</pre>
12	
13	
14	
15	BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:
16	SECTION 1. AMENDATORY 59 O.S. 2001, Section 567.3a, is
17	amended to read as follows:
18	Section 567.3a As used in the Oklahoma Nursing Practice Act:
19	<ol> <li>"Board" means the Oklahoma Board of Nursing;</li> </ol>
20	2. "The practice of nursing" means the performance of services
21	provided for purposes of nursing diagnosis and treatment of human
22	responses to actual or potential health problems consistent with
23	educational preparation. Knowledge and skill are the basis for
24	assessment, analysis, planning, intervention, and evaluation used in
10	Req. No. 606 Page 1

11	(1) has successfully completed the educational
2	program of a school of nurse anesthetists
3	accredited by the Council on Accreditation of
4	Nurse Anesthesia Educational Programs,
5	(2) is certified by the Council on Certification of
6	Nurse Anesthetists as a Certified Registered
7	Nurse Anesthetist within one (1) year following
8	completion of such educational program, and
9	continues to maintain such recertification by t
ıol	Council on Recertification of Nurse Anesthetist
1	(3) administers anesthesia under the supervision of
.2	medical doctor, an osteopathic physician, a
.3	podiatric physician or a dentist licensed in th
4	state and under conditions in which timely onsi-
5	consultation by such doctor, osteopath, podiatr
6	physician or dentist is available, and
7 [	(4) has received a certificate of recognition from
8	the Board.
9	b. A certified registered nurse anesthetist, under the
o	supervision of in consultation with a medical doctor,
1	osteopathic physician, podiatric physician or dentist
2	licensed in this state, and under conditions in which
3	timely, on site consultation by such medical doctor,
41	OSteopathic physician, podiatric physician or dentist

11 is available, shall be authorized, pursuant to rules 21 adopted by the Oklahoma Board of Nursing, to order, 31 select, obtain and administer legend drugs, Schedules II through V controlled substances, devices, and 51 medical gases only when engaged in the preanesthetic 61 preparation and evaluation; anesthesia induction, 71 maintenance and emergence; and postanesthesia care. A 8 certified registered nurse anesthetist may order, 9 select, obtain and administer drugs only during the 10| perioperative or periobstetrical period. c. A certified registered nurse anesthetist who applies 11 12 for authorization to order, select, obtain and 13 administer drugs shall: 14 (1) be currently recognized as a certified registered 151 nurse anesthetist in this state. 161 (2) provide evidence of completion, within the 171 two-year period immediately preceding the date of 18 application, of a minimum of fifteen (15) units 19 of continuing education in advanced pharmacology 201 related to the administration of anesthesia as 21 recognized by the Council on Recertification of 22 Nurse Anesthetists or the Council on 23 Certification of Nurse Anesthetists, 24 Reg. No. 606 Page 12 Section 1: (10a and 10b)

Title 59, Oklahoma Nursing Practice Act

59 O.S. § 567.3a. Definitions
As used in the Oklahoma Nursing Practice Act:

- 1. "Board" means the Oklahoma Board of Nursing;
- 2. "The practice of nursing" means the performance of services provided for purposes of nursing diagnosis and treatment of human responses to actual or potential health problems consistent with educational preparation. Knowledge and skill are the basis for assessment, analysis, planning, intervention, and evaluation used in the promotion and maintenance of health and nursing management of illness, injury, infirmity, restoration or optimal function, or death with dignity. Practice is based on understanding the human condition across the human lifespan and understanding the relationship of the individual within the environment. This practice includes execution of the medical regime including the administration of medications and treatments prescribed by any person authorized by state law to so prescribe;
- "Registered nursing" means the practice of the full scope of nursing which includes, but is not limited to:
- a. assessing the health status of individuals, families and groups,
- b. analyzing assessment data to determine nursing care needs,
- c. establishing goals to meet identified health care needs,
- d. planning a strategy of care,
- e. establishing priorities of nursing intervention to implement the strategy of care,
- f. implementing the strategy of care,
- g. delegating such tasks as may safely be performed by others, consistent with educational preparation and that do not conflict with the provisions of the Oklahoma Nursing Practice Act,
- h. providing safe and effective nursing care rendered directly or indirectly,
- i. evaluating responses to interventions,
- j. teaching the principles and practice of nursing,
- k. managing and supervising the practice of nursing,
- l. collaborating with other health professionals in the management of health care,
- m. performing additional nursing functions in accordance with knowledge and skills acquired beyond basic nursing preparation, and
- n. delegating those nursing tasks as defined in the rules of the Board that may be performed by an advanced unlicensed assistive person;
- 4. "Licensed practical nursing" means the practice of nursing under the supervision or direction of a registered nurse, licensed physician or dentist. This directed scope of nursing practice

95

- 10. a. "Certified registered nurse anesthetist" means any person who holds a license to practice as a registered nurse in this state and who:
- (1) has successfully completed the educational program of a school of nurse anesthetists accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs,
- (2) is certified by the Council on Certification of Nurse Anesthetists as a Certified Registered Nurse Anesthetist within one (1) year following completion of such educational program, and continues to maintain such recertification by the Council on Recertification of Nurse Anesthetists.
- (3) administers anesthesia, after consultation with the treating or operating medical doctor, osteopathic physician, podiatric physician or dentist licensed in this state, pursuant to rules adopted by the Oklahoma Board of Nursing, and
- (4) who, in addition, may be authorized, pursuant to rules adopted by the Oklahoma Board of Nursing, to order, select and obtain legend drugs, Schedules II through V controlled substances, devices, and medical gases after consultation with the treating or operating medical doctor, osteopathic physician, podiatric physician or dentist licensed in this state and
- (5) has received a certificate of recognition from the Board.
- b. The certified registered nurse anesthetist accepts responsibility, accountability, and obligation to practice in accordance with usual and customary advanced practice nursing standards and functions as defined by the scope of practice/role definition statements for the registered nurse anesthetist [issued by ??? do you want to identify an organization specifically or generically and if so, who/how? Would Council on Recertification of Nurse Anesthetists be appropriate?], pursuant to rules adopted by the Oklahoma Board of Nursing.
- c. A certified registered nurse anesthetist who applies for the additional authorization to order, select, and obtain drugs shall:
- (1) be currently recognized as a certified registered nurse anesthetist in this state,
- (2) provide evidence of completion, within the two-year period immediately preceding the date of application, of a minimum of fifteen (15) units of continuing education in advanced pharmacology related to the administration of anesthesia as recognized by the Council on Recertification of Nurse Anesthetists or the Council on Certification of Nurse Anesthetists,
- (3) provide evidence of professional liability insurance coverage, and
- (4) complete and submit a notarized application, on a form prescribed by the Board, accompanied by the application fee established pursuant to this section.
- d. The authority to order, select and obtain drugs shall be terminated if a certified registered nurse anesthetist has:
- (1) ordered, selected or obtained drugs outside of the certified registered nurse anesthetist scope of practice or ordered, selected, or obtained drugs for other than therapeutic purposes, or
- (2) violated any provision of state laws or rules or federal laws or regulations pertaining to

6

## SB792 Senator Lamb's attempt to require RX Authority to practice Nurse Anesthesia in Oklahoma

### STATE OF OKLAHOMA

1st Session of the 52nd Legislature (2009)

SENATE BILL 792

By: Lamb

### AS INTRODUCED

An Act relating to professions and occupations; amending 59 O.S. 2001. Section 567.3a, which relates to the Oklahoma Nursing Practice Act; modifying definitions; and declaring an emergency.

### BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. AMENDATORY 59 O.S. 2001, Section 567.3a, is amended to read as follows:

Section 567.3a As used in the Oklahoma Nursing Practice Act:

- 1. "Board" means the Oklahoma Board of Nursing;
- 2. "The practice of nursing" means the performance of services provided for purposes of nursing diagnosis and treatment of human responses to actual or potential health problems consistent with educational preparation. Knowledge and skill are the basis for assessment, analysis, planning, intervention, and evaluation used in the promotion and maintenance of health and nursing management of illness, injury, infirmity, restoration or optimal function, or death with dignity. Practice is based on understanding the human condition across the human lifespan and understanding the relationship of the individual within the environment. This practice includes execution of the medical regime including the administration of medications and treatments prescribed by any person authorized by state law to so prescribe:
- "Registered nursing" means the practice of the full scope of nursing which includes, but is not limited to:
  - assessing the health status of individuals, families and groups,
  - analyzing assessment data to determine nursing care needs,
  - establishing goals to meet identified health care needs,
  - planning a strategy of care,
  - e. establishing priorities of nursing intervention to implement the strategy of care.

### Lobbyist Performance Evaluations

### PR Firm hired to battle OSA PR Firm

Date: September 4, 2009

To: Victor Long, President OANA

From: Marvin York, Attorney/Legislative Consultant
Subject: Overview of Lobbyist Activities on Behalf of OANA

Per your request I am submitting for your review an overview which gives in some detail the types of activities I have performed and continue to perform on behalf of Oklahoma's CRNAs over the years as well as the ongoing legislative battle we are currently engaged in with the Oklahoma Society of Anesthesiologists. Please regard this as simply a sampling of the many things I as the OANA lobbyist have done, am currently doing and will continue to do as we address the current attack being waged by the anesthesiologists.

Study issues surrounding the practice of nurse anesthesia in Oklahoma as well as nationally.

Study issues surrounding the practice of physicians engaged in the delivery of anesthesia in Oklahoma.

Review the history of issues regarding problems confronting certified registered nurse anesthetists (CRNAs) in Oklahoma.

Meet with CRNA president and members to discuss possible legislation dealing with issues confronting practice in Oklahoma.

Draft legislation for introduction addressing issues involving but not limited to physician supervision and pain management.

Secure authors and co-authors to introduce bills on behalf of CRNAs.

Make personal contact with members serving on committees wo which CRNA legislation is assigned.

Make personal contact with all members of the legislature to discuss the necessity of enacting legislation of importance to the practice of nurse anesthesia.

Travel to various legislative districts to discuss legislation with legislators.

Conduct strategy sessions with CRNA representatives and members of our lobby team.

Meet with members of committees to which bills introduced by anesthesiologists which CRNAs oppose to discuss reasons for opposition.

Meet with all legislators to discuss reasons for CRNA opposition to bills introduced by anesthesiologists determined to be detrimental to CRNAs.

As a former member of both the House and Senate in Oklahoma, having served in the latter body for fourteen years four of which as President pro tem, I feel that I possess unique capabilities in dealing all aspects of the legislative process in Oklahoma. I also should point out that you have put together a lobby team that is unsurpassed in matters involving legislation in Oklahoma. We all look forward to working for OANA for the remainder of this interim and in the coming session which begins in February, 2010.

Memorandum

To: Pam Dunlap

Re: Proposal

Based on the information we have discussed today, the following are our though;s on the best approaches pertaining to how we should use public relations in a strategic manner to support your legislative agenda for a new law next session "limiting" the practice of certain non-medical, doctor trained/certified personnel from administering anesthesia to patients.

As you know, this is an emotional issue pitting powerful, organized medical groups against each other. On one side we have the nurses and rural hospital groups. These groups view the issue as one of access and costs. Based on our conversation and conversations we had last week with anesthesiologists, we sense the considerable emotional aspect of the issue and the real concern for the unintended consequences if we continue in Oklahoma down the path of expanding who can administer anesthesia to patients in pain management and surgery settings. Regrettably, as is often the case, lost in the center of this furious debate is the patient's best interest, and what is most critical, their safety.

### Goal

 Pass legislation next session limiting the trained medical personnel who can administer certain kinds of anesthesia through tighter definition

Note: We are under the impression it will be legislatively impossible to pass legislation to completely abolish nurses from administering some forms of anesthesia. We need to be better educated on this point and we need to understand what is acceptable and what is not from a legislative standpoint.

### PR's Role

- · Use PR to shape the issue
- . Use PR to educate the public
- · Use PR to garner support for legislative action
- Use PR to engage stakeholders in a dialogue that is timely, consistent, and credible this is what will guide us in what we do here.

The bottom line is that we must create a conversation about this issue to inform and educate as many people and legislators as possible. Let me take this one step further – anesthesiologists have a secret weapon; their patient bases. We need to tap into the patient base and get them engaged in this issue. We need to drive them to a website where they can get the issue framed in a glance and can send their elected friends a note in support on what we desire to accomplish. This kind of grass-root activity is key for us.

As it seems to stand at this point, the legislature would prefer not to address this issue. Perhaps they don't see it as a serious threat to patients. Perhaps they see going against the anesthesiologists as less impactful on them than going against the nurses and hospital interests. That is the way we have to re-frame, re-purpose and re-present the discussion.

### **Keys to Success**

- This is a patient safety issue. Yes, legislators want examples, but an example means
  people have died, and it is this loss of life we want to prevent from ever happening
  through prudent, practical legislation. We know people have died, and we need
  examples.
- Must involve patients and surgeons to carry the message....messengers are important, and we need supporters.
- Positioning and messaging is key ... we must provide contrast to show that this is a live and death issue...you wouldn't want a mechanic piloting your airplane. You'd want a pilot. Don't risk it.
- Consider some paid advertising coordinated with PR.

In order to shape, educate and garner needed support from a number of areas to achieve our goal, the strategy must ensure the issue is not cast as a self-serving move by anesthesiologists. We should re-cast the issue as a genuine, legitimate issue for patients. While this is a challenge, we believe it can be done, but we have to find the right third party messengers and the right message. Furthermore, we believe both must be refined through testing with the public, as public and editorial support will be needed across the state.

We envision a number of well timed tactics to help us shape the issue and garner the support. In addition to editorial board meetings, we also must cultivate other platforms to present and push our message. For example, we must capitalize on the convention in October in New Orleans to tailor messages for consumption at home in order to advance our initiative. We must also create a cause-based platform to show anesthesiologists using their talents to do something good for the community.

### Next Steps

- · Define we still need to define the assignment
- Probe we still need to make sure our team completely understands the issue.
- Strategize we need to strategize
- Plan we will use this memorandum as a baseline, and we will incorporate new thoughts, ideas and insights from our discussion to finalize the plan
- Execute we will develop a planning calendar and other management tools to make sure we execute in an ideal time frame to maximize our opportunity for success
- Evaluate we will establish benchmarks to monitor success

### Budget

We would propose working on a project basis to start. As we proceed, we can see if the assignment has the consistency of scope to warrant the possibility of a different method, such as retainer. Our team will consist of Senior Associate Jennifer Eve working with me, while support is provided by researcher and associate Chris Edison. We will expand the team as required to achieve the objective.

On a project basis our standard hourly rate for senior associates is \$200.00/hr. and associates at \$100/hr. Even though it is a challenge to determine the exact amount of time a project will require, our experience tells us an assignment of this scope will require on average 15 to 25 hours per month with some months higher than others based on the execution plan. We see this as a six-month to eight-month assignment beginning next month. The budget range would be from \$35,000 to \$50,000. We will have a better idea once we complete defining the assignment.

Pam, I trust this proposal will help you. We look forward to supporting you in your efforts.

Best regards,

Brent

From: Scott Mitchell and Associates
Sent: Monday, September 21, 2009
To: Victor D. Long, CRNA, OANA President

Subject: OANA proposal

Vic:

I've completed a thorough review of the political situation, the draft legislation and the background intelligence you provided me in our meeting last week. These are my thoughts and constitute the recommendation for the autumn activity and a foundation for the spring session and beyond.

The opposition will be attempting to frame this debate as a scope of practice issue, but that will be difficult to sell to legislators if the lawmakers are properly 'educated.' As you know, scope of practice issues have primarily focused on optometrists and chiropractors grabbing power for their respective boards in order to perform procedures for which the optometrists and chiropractors are not trained. In these situations, medicine has been virtually united against these efforts, but they failed miserably: there has been no effective third-party advocacy effort because medicine's lobbyists have been effective in derailing these efforts. In effect the insiders have said, "Why win now when we can drag this thing out for a decade."

Further, if they can't defeat radical expansion of optometrist and chiropractor scope, how can they roll-back patient care in the rural areas by well-trained and credentialed professionals with much of their own camp opposing them? They can't, if you beat them to the punch.

In my opinion, there is reason for optimism for your cause simply because you have an opportunity to exploit the opposition's standard game plan (total inside baseball); you have an educated hunch as to how they will play their talking points and history suggests they simply have no basic understanding of how to exploit third party advocacy. But most importantly, like the first cavemen playing with fire, they think they do. In actuality, their intended message carriers (patient groups) as I shall explain are in fact much more accessible to your cause and, secondly, they and their novice 'consultants' have never engaged in this type of a contest.

But most importantly: they don't see you coming. Oklahoma City is a small town, full of so-called political consultants, ad agencies, public relations hacks and hangers-on who possess little talent but get by dealing in political information. Secrecy is the most important element in establishing a winning advocacy campaign: the 'gaggle' of political hacks seldom defeats good advocacy campaigns, but they are often are able to derail good plans by scuttling them by leaking info. Frankly, with the exception of scope of practice advocacy campaigns, I cannot recall when a good advocacy plan has failed, but I can recall several which were internally scuttled. The first step in winning your battle is to circle the wagons, limit the internal discussions and emphasize discipline among your inner circle, and for Heaven's sake: do not let your lobbying team know anything about your advocacy plans.

Why my obsession with secrecy? Because it is critical that corrosive messages which eat away at the opponent's arguments not be traced back to you. That makes the message more believable since the third-party's message does not involve profit, and it allows your group at some point to engage under your flag at a strategic time of your choosing, giving you two message fronts!

You must assume that the opposition will attempt to engage patients. Sadly, they just don't get it: they have nurtured a group called "Patients First" as a front group to assist them in scope of practice issues.

The following is NOT a joke: there are no patients in the Patients First group. In the event they attempt to use this group, and I think they will, you should mercilessly pillory them with this farce. Further, you must, as we spoke about in some detail the other day, bring the necessary positioning to robustly bring forth patients to our side. Once the opposition realizes they have more than dismounted cavalry in front of them in this fight, they will most likely attempt to quickly and recklessly manufacture a phony advocacy group, but you will already have the patient high ground, leaving them to raise funds for a costly ad and PR campaign that won't work because you will possess the targets already.

Now we will have to address that advertising campaign if it comes, but the opportunity is here *right now*. Your opposition is assembling their game plan very slowly. There is some irritation at the OSMA with these splinter groups, and make no mistake consulting fees for those running the groups are at the heart of the rise in these activities. Because you have so many allies in the OSMA, and because of the general dislike of these groups by key OSMA folks, your opposition will be on their own. You can judge your campaign's effectiveness by the amount of discomfort you cause *their* potential targets in the OSMA. *If OSMA and the patients stay out, you win.* 

That is why we must adhere to this principle: build your base fast, fast, fast; get your troops dressed and motivated and build your message delivery and political bludgeoning weapon built right away.

First, build your base. We must target specific allies who can make noise: letters, phone calls, e-mails, press statements. If they lack backbone, we'll have no time to waste on them. I believe very strongly that your group of professionals will be attacked if they can find some authoritative figure with the guts to do so. It's not a difficult prediction to make, since there is no way to logically conclude that your group of professionals poses such a threat to the public that your permissible scope must be rolled back. But people do not think logically when they are scared (think of last September's spectacular and idiotic bailout failure), so your opponents have no choice but to try to scare the public. To counteract, gather anecdotal and study information, build your base and tell that base that lies, lies and more lies are coming. And your base needs to look big and scary to legislators. Building your base beats them at their own game, and that, my friend, is going to come down to wearing out shoe leather, diplomacy and the threat of a big battleship.

Second, start low cost and high tech. The opposition and their consultants, who get fat profits from advertising, will propose glossy TV advertising when they figure out their ill-conceived plans to scare the hell out of ignorant patients have been hi-jacked. I will guarantee you that a \$15K website will be proposed by the oppositions' consultants, and that will take 90 days to get off the ground. The consultants and lobbyists will try to make this a profit center, and they'll try to clear at least \$100K for their time. So hit hard fast: get a cheap blog up and running that can be socially-networked through blogs and talk radio. You need to get attention through electronic mainstream media, which is our specialty. If you strike fast, you'll make their fund-raising very difficult, since potential contributors might think the effort is lost before it begins.

The opposition will rely on print media, specifically the papers in Tulsa and Oklahoma City. By the way, the Tulsa and OKC papers are on life support. What we talk about in your blog needs to be decided, but we want to attract patients. We'll have to define that internally, but you must hit hard, hit often and hit fast. Setting and sticking to a timetable is critical in defeating a powerful and well-funded opponent.

Those two goals may seem simple, but the fundamentals must be emphasized right now. Building your base, building a delivery weapon and a media tool to distribute the message should occupy your time until the end of the year. Your 'weapon' can be utilized in either an offensive mode (advancing your NPA language) or as the primary tool for engaging in the event legislation is offered that limits your present scope.

As previously mentioned, my fee will be \$10k for the autumn campaign, commencing September 1st. We will deliver to you the base for an effective advocacy campaign, strategic advice for the campaign and a fully-functioning and integrated to social and mainstream media blog or website for message delivery. With the successful first phase, you would be able to assume control of the campaign or we could discuss further involvement on my part if your organization would see utility to that arrangement.

There would be a fee of course for the blog, but my experience that expense to be in the \$2K range.

I hope this memo encompasses the scope of what we discussed, and I'd of course be delighted to fill in any details not addresses herein.

# Strategic Fund App



### American Association of Nurse Anesthetists

### Agreement for a Grant from the Strategic Reserve Fund

This Grant Agreement is made this 20th day of November, 2009 by and between the American Association of Nurse Anesthetists, an Illinois not-for-profit corporation ("AANA"), and the Oklahoma Association of Nurse Anesthetists, a not-for-profit corporation.

In consideration of granting said funds by the AANA from the Strategic Reserve Fund (SRF) to the Oklahoma Association of Nurse Anesthetists, the parties hereto agree as follows:

The funding provides for a grant to be used to assist the Oklahoma Association of Nurse Anesthetists to fund lobbying and PR advocacy efforts. These efforts are designed to repeal legislation to be introduced by the Oklahoma Society of Anesthesiologists in an attempt to control and further restrict the practice of nurse anesthesia practice particularly in the area of pain management (i.e., interventional pain management).

Furthermore, the grant from the SRF to the Oklahoma Association of Nurse Anesthetists will be for an amount not to exceed \$137,000.00 to be disbursed subject to each and all of the following conditions:

- Funds will be disbursed only when requested in writing by the Oklahoma Association of Nurse Anesthetists as expenses are incurred. Each such request shall be accompanied by invoices at least equal to the amount requested for legal services performed or costs incurred. AANA may require such additional documentation as AANA deems necessary.
- The Oklahoma Association of Nurse Anesthetists shall provide quarterly updates (or more frequent updates if necessary) as the situation progresses;
- The amount of this financial assistance to the Oklahoma Association of Nurse Anesthetists should be kept strictly confidential and should not be discussed with any members outside of the Oklahoma Association of Nurse Anesthetists Board of Directors.
- The Oklahoma Association of Nurse Anesthetists may disclose the financial assistance received (without the specific amount) from the Strategic Reserve Fund to its members as appropriate.
- 5. The existence and amount of financial assistance received from the Strategic Reserve Fund should NOT be disclosed to any non-members, including but not limited to: attorneys, iobbyists, other professional organizations, other consultants, etc. If the Oklahoma Association of Nurse Anesthetists believes that disclosure of the existence and/or amount of this financial assistance is required, it agrees to notify the AANA at least five (5) days prior to any such disclosure and to advise and consult with the AANA prior to any such disclosure.
- The grant will be available to the Oklahoma Association of Nurse Anesthetists through November 20, 2010. Funds that are not used after that date will revert back to the SRF fund.

IN WITNESS, WHEREOF, this Grant Agreement regarding the Strategic Reserve Fund is signed and sealed by the President and Secretary of the Oklahoma Association of Nurse Anesthetists for and on behalf of the Oklahoma Association of Nurse Anesthetists and by the Executive Director of the AANA for and on behalf of the AANA all on the day and year first stated above.

Oklahoma Association of Nurse Anesthetists  BY: James APM ordercu	(Seal) ATTEST:	
State Association President		State Association Secretary
American Association of Nurse Anesthetists		
BY:		
Executive Director		

## Increased Grass Roots Activity SB544



Members,

My letter on September 17<sup>th,</sup> 2010 brought to your attention two very important studies that should change the way we advocate for our profession at the capitol. These studies you know by name as the RTI study and Lewin study, both contain valuable information/research that prove we are not only the most cost effective anesthesia provider but also point out through sound methodology our safe practice whether supervised or unsupervised.

The RTI study, by taking into account all opt-out states along with non opt-out states, has firmly provided us with the information we needed in Oklahoma to push forward with changing the outdated and unrealistic language of supervision in our NPA. Organized medicine in Oklahoma believes we need physician oversight to ensure the citizens of Oklahoma have safe anesthesia care. Well, the study not only shows anesthesia is safer than ever, but it is clear there is no difference in mortality, morbidity and/or complication rates if a CRNA is supervised or unsupervised in a opt out or non-opt out state. All indications are there is a shift in provider services to the solo CRNA in opt-out states and these states are enjoying a safe and more cost effective delivery of service.

The Lewin study unfolds the mystery of cost delivery like no other study in modern times. The methodology is sound, the data is vast, and the conclusions are: the independently acting CRNA is the most cost effective model for not only facility and net revenues but also most cost effective to the private payer under the widest range of conditions.

So with this simple analysis from me, one that should only ignite your curiosity to read both studies, I hope you will begin the education process of your CEOs, surgeors, and legislators. I believe they deserve to know the truth and direction of our changing health care delivery models. Financially it is a must in today's economy and safety of the Oklahoma citizen, concerning anesthesia delivery, is protected.

I need you to start today and work until you are satisfied your education has influenced your particular players in each setting. We must start with the CEOs, and then move to surgeons and then to legislators. You must make that first visit and then you will feel the power of lobby and the best thing about it you are selling the truth, no lies no deception. I will help in any way I can. I will meet with CEOs, surgeons, legislators, and supervising anesthesiologists at their and your request, to discuss any questions or comments they may have. I will make myself available at all times that my professional schedule allows.

We deserve this positive change and our surgeons and facilities are overdue. Let's get started and moving today, Saturday the 9th of October 2010. More to come from the GRC desk...

Committed to you and this effort, Victor Long, OANA GRC

### U.S. HEALTH CARE WORKFORCE

By Brian Dulisse and Jerry Cromwell

### No Harm Found When Nurse Anesthetists **Work Without Supervision** By Physicians

DDG: 10.1327 Admin 2008 0066 HEALTH AFFAIRS 29, NO. B (2010): 1469-1475 62010 Project HOPE-The People to People Health

ABSTRACT In 2001 the Centers for Medicare and Medicaid Services (CMS) allowed states to opt out of the requirement for reimbursement that a surgeon or anesthesiologist oversee the provision of anesthesia by certified registered nurse anesthetists. By 2005, fourteen states had exercised this option. An analysis of Medicare data for 1999-2005 finds no evidence that opting out of the oversight requirement resulted in increased inpatient deaths or complications. Based on our findings, we recommend that CMS allow certified registered nurse anesthetists in every state to work without the supervision of a surgeon or anesthesiologist.

Brian Dolisse is a health economist at the Research Friangle Institute, in Waltham Massachusotts

Jerry Cromwell (jcromweligarti. org) is a senior fellow in health economics at the Research Triangle Institute.

urgical anesthesia in the United States is administered by both anesthesiologists and certified registered nurse anesthetists (CRNAs). For almost 150 years, these nurses were the dominant providers of anesthesia services. but by 1986 the rapid influx of physicians into the specialty resulted in a greater number of anesthesiologists who practiced alone or in a team arrangement with nurse anesthetists.1,2 Even so, 37,000 certified registered nurse anesthetists provide thirty million anesthetics annually in the United States and represent two-thirds of anesthetists in rural hospitals.3

### Background On The Issue

Until recently, the Centers for Medicare and Medicaid Services (CMS) reimbursement rules for anesthesia providers prohibited payments to certified registered nurse anesthetists who administered anesthesia in the absence of physician supervision. This supervision could be provided by either an anesthesiologist or the surgeon,4 although surgeons now largely defer to anesthetists at the operating table during the administration of anesthesia and immediately after surgery

In December 1997, CMS published a proposed rule to, in the words of the final version, "let State law determine which professionals would be permitted to administer anesthetics, and the level of supervision required for practitioners [seeing Medicare patients] in each category."5 The agency later reported basing its decision on a "lack of evidence to support...[the] requirement for Isurgeon or anesthesiologist! supervision of Certified Registered Nurse Anesthetists 24

It should be noted that except for the extra training that anesthesiologists receive in medical school and residency in specialties other than the direct provision of anesthesia, both certified registered nurse anesthetists and anesthesiologists undergo similar classroom and clinical training in anesthesia care.3

Anesthesiologists opposed the proposed rule, arguing that they provide anesthesia care superior to that of certified registered nurse anesthetists,2,8 even though adverse events related to anesthesia are rare regardless of the provider.59-11 The final CMS rule of November 2001 maintained physician supervision of nurse anesthetists "unless the governor of a State, in consultation with the State's Boards of Medicine & Nursing, exercises the option of exemption from this requirement\* through a written request

As the demand for health care continues to grow, increasing the number of CRNAs, and permitting them to practice in the most efficient delivery models,

N THE UNITED STATES, anesthesia services are administered predominately by two types of providers. Anesthesiologists are physicians who have completed medical school, a clinical base year residency, and 3 years as a resident in an anesthesia program. Certified registered nurse anesthetists (CRNAs) are advanced practice nurses who have earned a baccalaureate degree, practiced at least 1 year as an acute care nurse, and have successfully completed a graduate-level nurse anesthetist program. These graduate programs have an average duration of 28 months and may be as long as 36 months. Currently, there are approximately 40,000 practicing anesthesiologists in the United States (Health Resources and Services Administration, 2007) and over 36,000 CRNAs (American

Association of Nurse Anesthetists [AANA], 2009). Both types of providers are critical to the safe, efficient provision of anesthesia services.

Anesthesia services are provided by CRNAs and by anesthesiologists in a variety of different delivery models. The delivery models vary by the degree of autonomy in which CRNAs may deliver anesthesia, as well as economic considerations. At one end of the spectrum, the CRNA may provide and bill for anesthesia services. At the other end, anesthesiologists may be the only providers administering and billing for anesthesia services in a particular practice setting. Between the two end points, CRNAs may work under varying degrees of supervision or medical direction. Delivery models may vary by

PAUL F. HOGAN, MS, is an Economist and Vice President, The Lewin Group, Falls Church, VA.

RITA FURST SEIFERT, PhD. is a Managing Consultant, The Lewin Group, Falls Church, VA.

CAROL S. MOORE, PhD, is a Managing Consultant, The Lewin Group, Falls Church, VA.

BRIAN E. SIMONSON, MS, is a Managing Consultant, The Lewin Group, Falls Church, VA.

ACKNOWLEDGMENTS: This research was funded by the American Association of Nurse Anesthetists. The views

AUGUST 2010 29:8 HEALTH AFFAIRS 1469

Paul F. Hogan Rita Furst Seifert Carol S. Moore Prian E. Simonson

### **Cost Effectiveness Analysis of Anesthesia Providers**

### EXECUTIVE SUMMARY

- Anesthesiologists and certified registered nurse anesthetists provide high-quality, efficacious anesthesia care to the U.S. population.
- This research and analyses indicate that CRNAs are less costly to train than anesthesiologists and have the potential for providing anesthesia care efficlently
- Anesthesiologists and CRNAs can perform the same set of anesthesia services, including relatively rare and difficult procedures such as open heart surgeries and organ transplantations, pediatric procedures, and others
- CRNAs are generally salaried. their compensation lags behind anesthesiologists, and they generally receive no overtime
- will be a key to containing costs while maintaining quality care.

expressed here are those of the authors.

NURSING ECONOMICS/May-June 2010/Vol. 28/No. 3

### Oklahoma



### FYI-VL 12-5-2008

----Original Message----

From: Victor & Lisa Long [mailto:4sooners1@cox.net]

Sent: Thursday, December 04, 2008 9:36 PM

To: Annette Mills; David Mullins; Kaori Donohue; Lavonna Sanders; Norman Cantrell; Tina Smith; Tysha King; Edward Sommerhauser; Jack Kirk; Lee Goodman; Randall Brady; Ronald Sturgeon; Stephanie Trussler; Angel Mae Rosenberger; Ann Farrar; Greg Farrar; Justin Endersby; Maria Van Bebber; Marisa Endersby; Patsy Bynum; Bill Brasher; John Silvy; Mike Huff; Travis Thompson; Andrew Flesher; Janice Palovik; Mathew Roberson; Steven Hallford; Timothy Shields; Cheryl Shadden; Dennis Dodd; Jessica Poe; Jon Brown; Mark Vacney; Dale Denton; Donald Desalvo; Sherl Salver; Teresa Tobey

Cc: Benny Vanatta; John Bryant; Marvin York; Steve Edwards

Subject: House authors

Dear CRNAs, This is the first group effort to reduce my mailing and begin to groove a path for our legislative effort. All of you share a common thread and that is the leadership of this association and the lobbyist' team has identified the key points of beginning and that beginning is to recruit authors for our legislation and that begins in your area. All areas carry the same importance because the more authors you have the more strength you carry when it comes to staying the course against all odds. You and I both know that the misinformation will begin to fly and there will be a lo-. We must stay the course and with honesty and integrity bring the truth to the front and never relent on our message. Now as groups the effort is to recruit authors for our legislation and as we do that educate all these legislators to the practice of nurse anesthesia in this state and the reality of our work models. Many of you have begun this effort already, as potential authors were identified and contacted, and some of you are getting started for the first time. We want to begin this legislation in the house so we want you to start with your state representative. Mike Jackson-Enid, Gus Blackwell-Guymon, Kris Steele-Shawnee, Tad Jones -Claremore, Doug Cox -Grove, Dennis Johnson- Duncan, Charles Ortega-Altus and then any and all contacts you may have with other representatives through family, past ties from prior work locations and all other situations you can think of. Attached you will find a very coherent set of talking points and then a down sized bullet document. Read them carefully and begin to formulate your message from the points provided. Remember to stay honest and do not forget to pound the message hard that this is not a scope of practice change, that we will continue to work within our scope as adopted by the AANA and our certifying body and by rules promulgated by the BON. We will do no more or no less than the practice of nurse anesthesic, but true up the statutes to reflect the reality of our Oklahoma practice. Also attached you will find a letter for our surgeon friends to use in contacting these representatives and encouraging their support of our important legislation. You can use it as is or change it around to suit each situation that presents itself. I can not express in words the importance of surgeons getting behind this. They will make all the difference in the world and if they understand the reasons as stated in the talking points they will also realize it the right thing to do in this changing delivery of health care, They should not

be responsible for supervising something they know very little about and also providing their art. Simply said the science of anesthesia and the technical practice is not in their skill set. Work in groups and teams as you set up meetings. Have them at the hospital and invite your surgeons and CEO, I will say now we have an author in Mike Jackson from Enid who is holding a bill for us in Title 59 but as the process is very early that is not a done deal. We meet with Mike on Tuesday of next week and hope to solidify the deal with some honest education through discussion. Although we have a soft commitment we do not want to stop, but to keep recruiting as many authors and supporters as possible and then lead with just one and co-author the rest. That will be the ideal scenario and that is the effort I hope you will make a commitment towards. Call me with any questions you have at 1-405-834-4952. The rest of the membership will see these points and more instruction tomorrow in a blast e-mail then a hard copy to all so stay tuned and let's get to work and use this time before the holidays to make a difference. Most of my focus after tomorrow's membership mail will be back in touch with you either group by group, or in a similar mail like this one. Thanks in advance! Committed to you and this effort Victor Long, OANA President

### SB 544 and its passage is Pro-Business

SB 544 and its passage will allow CRNAs to do what they are trained and highly qualified to do, and it will encourage a more cost effective mix of anesthetists, which will in turn increase access and reduce cost. (Pro- business)

SB 544 and its passage will free up hospitals to develop their own anesthesia departments that best fit the region and clients they serve. (Pro business)

SB 544 and its passage will free a hospital to recruit physicians and be able to tell them they do not need to supervise CRNAs, now it becomes easier to recruit and retain physicians to more underserved areas and I would also argue urban. More physicians, more delivery, more services offered and more citizens served. (Probusiness)

SB 544 and its passage will place Oklahoma one step closer to opt-out, which would not impact state licensure laws or the training requirements of CRNAS but would reduce the compliance cost a facility must incur to ensure supervision. CMS Part A facility money would flow unfettered and at reduced cost to ensure its delivery. (Pro-business)

SB 544 and its passage will ensure Oklahoma nurses that leave for training in anesthesia are more likely to return to a state with less restriction to practice. Oklahoma nurses returning as CRNAs to practice their profession in all areas of Oklahoma, even though they were trained outside the state is (pro-business)

SB 544 and its passage eliminate the borrowed servant liability, which is felt and carried as a burden by the surgeon working with an independent contractor. Additionally, you eliminate the vicarious liability a hospital has if you are employed by the hospital or vicarious liability an anesthesiologist feels if you are an employee. Financial relief, better working relationships is (pro-business)

### CSW&P

Jack G. "Chip" Clark, Jr. Ronald E. Staken 101 Park Ave, Sulte 400 Oktahoma City, OK 73102 405) 232-4271 phone (405) 232-4275 fax

Clark, Stakem, Wood & Patten, P.C. Attorneys & Counselors at Law www.cswp-law.com

Of Counsel Rebecos J. Patten 765 Asp Ave., Suite 202 Norman, OK 73069 [405] 321-0616 phone [405] 321-7571 fax

Betty Gerrett Wood 512 N.W. 12<sup>th</sup> St. Oklahoma City, OK 73103 (405) 839-3081 phone (405) 232-6358 fax

March 10, 2011

Members of the Oklahoma Senate Oklahoma State Capitol Oklahoma City, Ok. 73102

Re: SB 544; effect on physician's medical liability; PLICO letter of 2/28/2011

### Dear Senator:

Don Mordecai, CRNA and President of the Oklahoma Association of Nurse Anesthetists asked me to review a letter of 2/28/2011, by the PLICO CEO contending that passage of SB 544 would, "In no way ... decrease the medical liability" of affected physicians, either surgeons or OBGYNs. He asked if I agree with that legal conclusion.

No, I do not agree. Medical liability requires three indispensable elements: 1) a duty to the patient; 2) a breach of that duty (here the duty to "supervise" a CRNA under current law); and 3) injury to the patient legally caused by that breach. Whenever a duty is supplied by a statute, any breach of that statute is negligence per se.

Under the existing statute, both a physician's failure to supervise a CRNA or a physician's negligent supervision of a CRNA are viable claims. SB 544 would eliminate the physician's statutory duty to supervise a CRNA (and replace it with a modern model of collaboration between highly trained professionals). Consequently, after the passage of SB 544, there could be no viable claim for either a physician's failure to supervise or negligent supervision of a CRNA. All other appropriate available claims including primary negligence could still be asserted against a physician, just as such claims may be asserted now whenever either a CRNA or anesthesiologist works with the physician in a surgery or delivery.

Because SB 544 will limit the number and type of claims that may be asserted against a physician, SB544 will, in my opinion, decrease a physician's medical liability risk and exposure.

For The Firm

### YOUR LEGISLATOR CAN IMPROVE RURAL HEALTH CARE

### Why are doctors reluctant to move to rural Oklahoma?

When you need surgery, you also need a person certified to deliver anesthesia. Surgeons generally have no training or interest in anesthesiology. Yet, state law requires a doctor who has **no training** to supervise certified registered nurse anesthetists (CRNAs) who have all of the necessary training. Doctors don't want the liability of supervising CRNAs.

Senate Billi 544 by Senator Anthony Sykes fixes this problem.

- · SB 544 allows doctors to "collaborate" with CRNAs instead of "supervise" them.
- SB 544 will save supervision compliance cost to the hospital.
- SB 544 will improve anesthesia department flexibility to a more cost effective model.
- SB 544 passes these savings on to the consumer.
- · Forty states have made this change.

Oklahoma should join the states that have removed "supervision" and adopt a "collaborative" model. CRNAs were around before Oklahoma was a state and have been providing safe, evidence-based care to Oklahomans for more than 100 years!

Call your State Senator now at (405) 524-0126 Call your State Rep. now at (405) 521-2711

### **VOTE YES on SB 544**

Paid for by the Oklahoma Association of Nurse Anesthelists (CANA), Don Mordecal, President, 419 W. Grzy, P.O. Box 6516, Norman, OK 73070.

1	STATE OF OKLAHOMA
2	1st Session of the 53rd Legislature (2011)
3	SENATE BILL 544 By: Sykes
4	
5	
6	AS INTRODUCED
7	An Act relating to the practice of certified registered nurse anesthetists; amending 59 O.S. 2001,
8	Sections 353.1b, as amended by Section 2, Chapter 321, O.S.L. 2009 and 567.3a (59 O.S. Supp. 2010,
9	Section 353.1b), which relate to nursing; modifying authority and duties of certified registered nurse
10	anesthetists; modifying definitions; defining term; amending 63 O.S. 2001, Section 2-312, which relates
11	to the Uniform Controlled Dangerous Substances Act; modifying the authority of certain nurses to
12	administer controlled dangerous substances; and providing an effective date.
13	## Note that the state of the s
14	
15	BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:
16	SECTION 1. AMENDATORY 59 O.S. 2001, Section 353.1b, as
17	amended by Section 2, Chapter 321, O.S.L. 2009 (59 O.S. Supp. 2010,
18	Section 353.lb), is amended to read as follows:
19	Section 353.1b A certified registered nurse anestherist has
20	authority, in collaboration with a medical doctor, an osteopathic
21	physician, a podiatric physician or a dentist licensed in this
22	state, shall be authorized to order, select, obtain and administer
23	<pre>legend drugs, Schedules II through V controlled substances, devices,</pre>
24	and medical gases pursuant to rules adopted by the Oklahoma Board of

Req. No. 528 Page 1

4/25/25, 10:01 AM Bill Information

### BILL INFORMATION FOR SB 544

### SB 544 by Sykes and Blackwell

SELECT SESSION: 2011 Regular Session

Receive Email Updates for this Measure (LENS)

ENTER BILL #:

Search

Certified registered nurse anesthetists; modifying authority and duties of certified registered nurse anesthetists.

History	Amendments	Bill Summaries	Versions	Votes	Authors/Co Authors		
Action					Journal Page	Date	Chamber
First Read	ling				175	02/07/2011	s
Authored by Senator Sykes					175	02/07/2011	s
Second Reading referred to Judiciary					286	02/08/2011	s
Reported	Do Pass as amen	ided Judiciary com	nittee; CR fi	led	404	02/28/2011	s
Title strici	ken					02/28/2011	5
coauthored by Johnson (Constance)					404	02/28/2011	5
coauthore	d by Blackwell (	principal House aut	hor)		404	02/28/2011	s

https://www.oklegislature.gov/BillInfo.aspx?Bill=Sb 544&Session=1100

1/2

1	STATE OF OKLAHOMA
2	1st Session of the 53rd Legislature (2011)
3	HOUSE BILL 1351 By: Blackwell
4	
5	
6	AS INTRODUCED
7 8 9 10 11 12	An Act relating to certified nurse anesthetists; amending 59 O.S. 2001, Sections 353.1b, as amended by Section 2, Chapter 321, O.S.L. 2009 and 567.3a (59 O.S. Supp. 2010, Section 353.1b), which relate to nursing; modifying authority and duties of certified registered nurse anesthetists; modifying definitions; defining term; amending 63 O.S. 2001, Section 2-312, which relates to the Uniform Controlled Dangerous Substances Act; modifying the authority of certain nurses to administer controlled dangerous substances; and providing an effective date.
.5	BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:
6	SECTION 1. AMENDATORY 59 O.S. 2001, Section 353.1b, as
7	amended by Section 2, Chapter 321, O.S.L. 2009 (59 O.S. Supp. 2010,
8	Section 353.1b), is amended to read as follows:
9	Section 353.1b A certified registered nurse anesthetist has
0.0	authority, in collaboration with a medical doctor, an osteopathic
1	physician, a podiatric physician or a dentist licensed in this
22	state, shall be authorized to order, select, obtain and administer
3	<u>legend</u> drugs, Schedules II through V controlled substances, devices,
4	and medical gases pursuant to rules adopted by the Oklahcma Board of

1

Req. No. 5484 Page 1 4/24/25, 11:40 AM

Bill Information

### BILL INFORMATION FOR HB 1351

### HB 1351 by Blackwell

SELECT SESSION: 2011 Regular Session

Receive Email Updates for this Measure (LENS)

ENTER BILL #:

Certified nurse anesthetists; modifying authority and duties of certified registered nurse anesthetists; effective date.

History	Amendments	Bill Summaries	Versions	Votes	Authors/Co Aut	hors	
Action					Journal Page	Date	Chamber
First Read	ling				111	02/07/2011	н
Authored	by Representativ	e Blackwell			111	02/07/2011	н
Second Re	eading referred to	Public Health			300	02/08/2011	н

https://www.oklegistature.gov/BillInfo.aspx?Bill=HB1351&Session=1100

1/2

## Executive Director of Board of Nursing asked for AG Opinion on "timely onsite consultation" language in Nurse Practice Act



### OKLAHOMA BOARD OF NURSING

2915 CLASSEN BOULEVARD • SUITE 524 • OKLAHOMA CITY, OKLAHOMA 73106-5437 • (405) 962-1800 www.ok.gov/nursing • Fax (405) 962-1821

April 26, 2012 Via Hand Delivery

RECEIVED RECEPTIONIST

APR 2 0 2012

The Honorable Scott Pruitt
Attorney General of the State of Oklahoma
Office of the Attorney General

313 NE 21<sup>st</sup> Street Oklahoma City OK 73105

Dear Attorney General Pruitt:

As Executive Director of the Oklahoma Board of Nursing, I am asking that you issue a formal Attorney General Opinion addressing the meaning of "timely onsite consultation" as that phrase is used in the statute concerning Certified Registered Nurse Anesthetists in Oklahoma.

The phrase refers to the conditions under which Certified Registered Nurse Anesthetists (CRNA's) may administer, and if authorized may select, order, obtain and administer anesthesia. It is found in two places in the relevant statute, Title 59 Section 567.3a. (10). That definitional statute is quoted below with the phrase underlined.

a. "Certified Registered Nurse Anesthetist" is an Advanced Practice Registered Nurse who:

- (1) is certified by the Council on Certification of Nurse Anesthetists as a Certified Registered Nurse Anesthetist within one (1) year following completion of an approved certified registered nurse anesthetist education program, and continues to maintain such recertification by the Council on Recertification of Nurse Anesthetists, and
- (2) <u>administers anesthesia</u> under the supervision of a medical doctor, an osteopathic physician, a podiatric physician or a dentist licensed in this state and <u>under conditions in which timely onsite consultation</u> by such doctor, osteopath, podiatric physician or dentist is available.
- b. A Certified Registered Nurse Anesthetist, under the supervision of a medical doctor, osteopathic physician, podiatric physician or dentist licensed in this state, and <u>under conditions in which timely, on-site consultation</u> by such medical doctor, osteopathic physician, podiatric physician or dentist <u>is available</u>, shall be authorized, pursuant to neadopted by the Oklahoma Board of Nursing, to order, select, obtain and administer legend drugs, Schedules II through V controlled substances, devices, and medical gases only when engaged in the preanesthetic preparation and evaluation; anesthesia induction,

1

maintenance and emergence; and postanesthesia care. A Certified Registered Nurse Anesthetist may order, select, obtain and administer drugs only during the perioperative or periobstetrical period.

59 O.S. §567.3a(10).

Thus, CRNA's may <u>administer</u> anesthesia under the supervision of one of the enumerated practitioners in a situation in which timely onsite consultation with a supervising practitioner is available. They may also, if authorized pursuant to Rules established by the Board of Nursing, <u>select, order obtain and administer</u> anesthesia under the supervision of one of the enumerated practitioners in a situation in which timely, on-site consultation with a supervising practitioner is available **provided**, this additional authority to select, order, and obtain the anesthesia may be exercised only in the perioperative or periobstetrical period.

This was the opinion of your office as expressed in Attorney General Opinion 08-26, in which your office answered three questions concerning the scope of practice of Certified Registered Nurse Anesthetists in Oklahoma. That Opinion, however, was not asked to and did not address the meaning of the phrase "timely onsite consultation" as it is used in the statute.

Questions have recently been asked suggesting that "timely onsite consultation" requires that the supervising practitioner be in the facility at all times the CRNA is engaged in providing anesthesia services. Opposing points of view suggest that what constitutes "timely onsite consultation" is a medical judgment, to be left to the supervising practitioner.

Still others suggest that the Board of Nursing should distinguish between anesthesia and analgesia, and declare that administration of analgesia does not require supervision or timely onsite consultation; similar to the latest Interpretive Guidelines to the Conditions of Participation for Hospitals participating in Medicare and Medicaid. However, even that new Interpretive Guideline recognizes, "Anesthesia exists along a continuum. For some medications there is no bright line that distinguishes when their pharmacological properties bring about the physiologic transition from the analgesic to the anesthetic effects. Furthermore, each individual patient may respond differently to different types of medications...[t]here is often no bright line, i.e., no clear boundary, between anesthesia and analgesia. This is particularly the case with moderate versus deep sedation, but also with respect to labor epidurals." (See 42 CFR Section 482.52 and CMS Manual Services Pub. 100-07 transmittal date Jan. 14, 2011.)

The Interpretive Guidelines define six separate levels of anesthesia ranging from general anesthesia at the deepest end to topical or local anesthesia at the shallowest end. (Id.) By contrast, the Oklahoma Nursing Practice Act simply speaks of "anesthesia" as one broad category and it does not define the term anesthesia at all. The common dictionary definition is "local or general insensibility to pain with or without the loss of consciousness, induced by anesthetic". American Heritage Dictionary of the English Language, 3rd Edition

The questions on which I seek a formal Attorney General Opinion are:

(1) does the phrase "timely onsite consultation" as used in Section 567.3a (10) of the Oklahoma Nursing Practice Act mean that the supervising practitioner must be onsite

2

in the facility during the administration of anesthesia, or does it mean that the supervising practitioner must be capable of being onsite at the facility in a timely manner?

- (2) if the answer to question (1) is that the practitioner supervising the Certified Registered Nurse Anesthetist must be onsite in the facility during the administration of anesthesia, then must the supervising practitioner be present throughout the provision of anesthetic services: i.e. from "anesthesia induction" through "maintenance", "emergence" and "postanesthesia care"?
- (3) does the Oklahoma Nursing Practice Act permit a Certified Registered Nurse Anesthetist to draw a distinction between analgesia and anesthesia in terms of the level of supervision required?

I will be happy to answer any questions you may have and to provide you any assistance I can in answering the questions I have posed or in issuing your Opinion.

Respectfully,

Executive Director



### Office of Attorney General State of Oklahoma

### ATTORNEY GENERAL OPINION 2012-21

Executive Director, Kim Glazier, RN, M.Ed. Oklahoma Board of Nursing 2915 Classen Blvd., Suite 524 Oklahoma City, Oklahoma 73106 December 13, 2012

Dear Ms. Glazier:

This office has received your request for an official Attorney General Opinion in which you ask, in effect, the following questions:

- 1. What does the phrase "timely onsite consultation" as used in 59 O.S.2011, § 567.3a(10) of the Oklahoma Nursing Practice Act mean with regard to the actual physical presence of the supervising practitioner of a Certified Registered Nurse Anesthetist ("CRNA"), i.e must he or she be onsite in the facility during the administration of anesthesia, or is it enough that the supervising practitioner be capable of being onsite in the facility in a timely manner?
- 2. Must the supervising practitioner of a CRNA be available for timely onsite consultation throughout all stages of the administration of anesthesia?
- 3. Does the Oklahoma Nursing Practice Act permit the Board of Nursing to draw a distinction between analgesia and anesthesia in terms of the level of supervision of the CRNA required by the supervising practitioner?

### I. BACKGROUND

The Oklahoma Nursing Practice Act ("Act"), 59 O.S.2011, §§ 567.1 – 567.19, creates the Oklahoma Board of Nursing ("Board") and establishes the scope of practice for nurses. The Board is charged generally with:

A. 1. The education, certification and licensure of registered and licensed practical nurses or advanced unlicensed assistive persons, and the practice of registered or practical nursing or advanced unlicensed assistance in this state is hereby declared to affect the public health, safety and welfare and, in the

313 N.E. 215T STREET \* OKLAHOMA CITY, OK 73105 \* (405) 521-3921 \* FAX: (405) 521-6246



Executive Director, Kirn Glazier, RN, M.Ed. Oklahoma Board of Nursing

A.G. Opin. 2012-21 Page 11

The Board is authorized by its enabling act "to adopt and revise rules, not inconsistent with the provisions of the Oklahoma Nursing Practice Act, as may be necessary to enable it to carry into effect the provisions of the act." 59 O.S.2011, § 567.4(F). Further, 59 O.S.2011, § 567.2(A)(3), states "[t]he Board shall promulgate rules to identify the essential elements of education and practice necessary to protect the public." However, this "does not include authority to make rules which extend their powers beyond those granted by statutes." See Adams, 524 P.2d at 934. It is, therefore, not within the Board's power to adopt an interpretation, definition, or rules relating to what constitutes "anesthesia" and/or "analgesia," in such a way so as to allow less supervision than is required by statute.

### It is, therefore, the official Opinion of the Attorney General that:

- Title 59 O.S.2011, § 567.3a(10) of the Oklahoma Nursing Practice Act
  requires that the supervising practitioner must be available for "timely
  onsite consultation" with the Certified Registered Nurse Anesthetist
  ("CRNA") during the administration of anesthesia. Section 567.3a(10)
  does not require that the supervising practitioner in all instances be
  onsite in order to be "available" for timely onsite consultation; it just
  requires that the supervising practitioner be available to provide a
  consultation that is both timely and onsite.
- 2. The determination of what constitutes "timely onsite consultation" as used in 59 O.S.2011, 567.3a(10) of the Oklahoma Nursing Practice Act, is left to the sound medical judgment of the supervising practitioner. These medical professionals, in the exercise of their professional judgment, may establish requirements to be applied in given medical situations for what constitutes timely onsite consultation. Based on the particular facts and circumstances of any particular medical situation, this may mean that the supervising practitioner must be onsite at all times during the supervision in order to be available to provide the required timely and onsite consultation, while at other times particular facts and circumstances may dictate that the supervising practitioner is available for the required timely and onsite consultation even though supervising from offsite.
- Under 59 O.S.2011, § 567.3a(10), the supervising practitioner of a CRNA must be available for timely onsite consultation at all recognized stages of the administration of anesthetic services.

4. Because the Oklahoma Nursing Practices Act requires the availability of timely onsite consultation at all recognized stages of the administration of anesthetic services, the Oklahoma Board of Nursing may not promulgate rules defining analgesia and anesthesia in such a way so at to allow less supervision than is required by statute. See Adams v. Prof'l Practices Comm'n, 524 P.2d 932, 934 (Okla. 1974).

E. SCOTT PRUITT

ATTORNEY GENERAL OF OKLAHOMA

REGINA SWITZER

ASSISTANT ATTORNEY GENERAL

0-26



### **SB634** An effort to link our **Nurse Practice Act Language** to CMS 42 C.F.R.482.52

T.	9	law. Provided further, nothing in this paragraph
2	3	shall limit the authority of the Board of Dentistry to
3	18	establish the qualifications for dentists who direct
4	8	the administration of anesthesia.
5	<u>h.</u> <u>i</u>	Notwithstanding the foregoing, a Certified Registered
6	į	Nurse Anesthetist practicing in a hospital licensed
7	1	pursuant to Section 1-701 et seq. of Title 63 of the
8	9	Oklahoma Statutes, including all facilities covered
9	Ĩ	under such license, upon the request of a medical
.0		doctor, osteopathic physician, podiatric physician or
1	<u> </u>	dentist licensed in this state, shall be authorized,
.2	I	pursuant to rules adopted by the Oklahoma Board of
.3	1	Nursing:
4	71	(1) to order, select and obtain legend drugs,
.5		Schedules II through V controlled substances,
.6		devices, and medical gases during the
.7		perioperative or periobstetrical period if he or
8		she has completed the requirements of
9		subparagraph c of this paragraph, and
0	(-	(2) consistent with the standards set forth by the
1		Centers for Medicare and Medicaid Services in 42
2		C.F.R. § 482.52 and the interpretation thereof,
:3		to administer anesthesia and/or analgesia when
4		engaged in preanesthetic preparation and

Reg. No. 93

	3	
Page 14	Req. No. 93	Page 15

1

2

3

5

6

7

8

9

10

11

12

13

14

15

16

17

19

21

23

evaluation; anesthesia induction, maintenance and

emergence; and postanesthesia care.

Nothing herein shall affect the limitations set forth in the Oklahoma Interventional Pain Management and

Treatment Act, except that Certified Registered Nurse

peripheral nerve blocks in a licensed hospital facility

as permitted in this subsection. In order to provide

Registered Nurse Anesthetist must obtain authorization

from the Oklahoma Board of Nursing to order, select and

obtain legend drugs, Schedules II through V controlled

substances, devices and medical gases on or before

11. "Supervising physician" means an individual holding a current license to practice as a physician from the State Board of

Medical Licensure and Supervision or the State Board of Osteopathic

Examiners, who supervises a Certified Nurse Practitioner, a Clinical Nurse Specialist, or a Certified Nurse-Midwife, and who is not in training as an intern, resident, or fellow. To be eligible to

supervise such Advanced Practice Registered Nurse, such physician shall remain in compliance with the rules promulgated by the State

January 1, 2016;

such services in a licensed hospital, a Certified

Anesthetists shall be permitted to provide lumbar

intra-laminar epidural steroid injections and

### BILL INFORMATION FOR SB 634

### SB 634 by Schulz and Ownbey

SELECT SESSION: 2013 Regular Session

Receive Email Updates for this Neasure (LENS)

ENTER BILL #:

ER BILL #: Sear

Professions and occupations; allowing certified registered nurse anesthetists to order, select, and obtain legend drugs. Effective date.

History	Amendments RV FOR SB 634	Bill Summaries	Versions	Votes	Authors/Co Authors		
Action			Journal Page	Date	Chambei		
First Reading Authored by Senator Schulz					161	02/04/2013 02/04/2013	s s
					161		
Second Re	ading referred to	285	02/05/2013	s			
coauthored by Ownbey (principal House author)				304	02/05/2013	s	

## **Continued Grass Roots Efforts to Educate Legislators Statewide**



### Are You the Captain of the Ship?

by Kevin Driskill, Driskill Law Firm

In my practice, I have often seen plaintiff's attorneys argue that a physician is the "captain of the ship" in an effort to hold a physician liable for a nurse's or other hospital staff member's negligence. This argument is usually raised by plaintiff's attorneys in the context of a claim arising from a surgery, although the argument has been raised in other instances, such as a physician's management of a woman in labor. Plaintiff's attorneys argue that under the captain of the ship doctrine, a physician is responsible for the negligence of a nurse or staff member solely because the physician is present in the operating room or involved in the management of the patient when the negligence occurred. However, the Supreme Court of Oklahoma has never upheld the captain of the ship doctrine. Thus, a physician cannot be held liable for a nurse's or staff member's negligence merely because the physician was in the operating room or managing the patient's care when the negligence occurred. However, there are fact specific situations where a physician may be deemed as a matter of law to be "supervising" ancillary medical personnel including a physician's assistant or a certified registered nurse anesthetist.

Even though the captain of the ship doctrine is not in force in Oldahoma, a physician may still be held liable for the negligence of a nurse or staff member under two other legal doctrines. The first doctrine is the doctrine of vicarious liability. The doctrine of vicarious liability. The doctrine of vicarious liability states that an employer is responsible for the negligent acts of the employee when those negligent acts are committed in furtherance of the employer's business. As an example, say that an employee of a grocery store injured a customer while negligently restocking a shelf. In that case, the grocery store would be liable to the customer for the employee's

acts because the employee's acts were done in furtherance of the grocery store's business. In applying the doctrine of vicarious liability to the practice of medicine, the Supreme Court of Oklahoma has held that a physician was liable for his nurse-employee's failure to keep an accurate count of the surgical sponges placed in the patient during surgery, thus causing the patient to retain a surgical sponge after surgery. Aderhold v. Stewart, 1935 OK 479, 46 P.2d 1301. In modern practice, it is relatively uncommon for the operating room personnel to be employees of the surgeon. Therefore, physicians will not have vicarious liability for the acts of the purses or staff members in the operating room for such things as sponge counts, transferring of a patient into and out of the operating room, sterility of equipment, and the like. However, should a physician have an employed physician's assistant, nurse practitioner, or scrub tech with the physician at surgery, the physician would be responsible for the acts of that employee. The second doctrine for which a physi-

In escond doctrine for which a physician can be held liable for a nurse's or staff member's negligence is the loaned servant doctrine. Under the loaned servant doctrine, the loaned servant is not the employee of the physician. Instead, courts look to the amount of control, direction, and supervision the physician exercises over the nurse or staff member. If the physician exercises a sufficient amount of control, direction, and supervision over the nurse or staff member, the nurse or staff member is deemed to be the employee of the physician for the time that the control, direction, and supervision is exercised over the nurse or staff member. The determination of whether a nurse or staff member is

Continued on page 2



### Insurance Corner: PLICO Introduces the 360° Exposure Review (ER) to Ohlahoma Doctors

Some have described it as a risk check up. When was the last time you had yours? By utilizing the 360° ER, many physicians are discovering that they have uninsured exposures involving risks not associated with their medical professional liability.

Since it's introduction in early 2008, the 360° ER has revealed uninsured medical offices, under insured medical equipment, overlapping coverage, inadequate limits, expired policies, and more.

Your 360° ER begins with reviewing your current coverage and the risks associated with your practice or organization. Lawsuits, unraid claims and loss of your assets is a difficult way to learn about your coverage.

Your review includes: Medical Professional Liability, General Liability, Workers' Compensation, Employee Benefits, Business Personal Property, Building Coverage, Employment Practices Liability, Business Income Interruption, Directors and Officers Liability, and more.

Join other Oklahoma physicians who have closed gaps in coverage and discovered cost effective risk management strategies.

To schedule your 360° Exposure Review, contact Scott Fikes at (405) 443-2024. page 2

### Stability Integrity



the loaned servant of the physician depends on the facts of each case. Therefore, there are no safe harbor rules which, if followed, would prevent the physician from having the nurse or staff member deemed a loaned servant. As for an example of what constitutes a loaned servant, the Supreme Court of Oklahoma found that a physician was liable for burns to a patient from heated water bottles where the physician personally placed the water bottles next to the patient, ordered that the bottles be at a certain temperature, ordered that the nurses leave the bottles until otherwise instructed, and was present during the time the bottles were on the patient. Randolph v. Okla. City Gen. Hosp., 1937 OK 313, 71 P2d 607.

### ...the Supreme Court of Oklahoma has never upheld the captain of the ship doctrine,

However, a surgeon was not liable for any negligence that resulted after the surgeon left the operating room, Flower Hospital v. Hart, 1936 OK 459, 62 P2d 1248, or for the negligent acts of nurses in preparing the patient for surgery, McCowen v. Sisters of the Most Precious Blood of Enid, 1953 OK 37, 253 P2d 830. Basically, in determining whether a nurse or staff member is a loaned servant of the physician, courts look to whether the physician directed the actions and supervised the conduct of the nurse or staff member to such an extent that the physician should have been capable of preventing the negligent conduct.

Plaintiff's attorneys have also sought to

hold physicians liable for the negligence of a certified registered nurse anesthetist ("CRNA") regardless of whether any relationship existed between the physician and the CRNA. The licensing statutes for CRNA's require that a CRNA practice under the direction of a "supervising physician." "A certified registered nurse anesthetist, under the supervision of a medical doctor, osteopathic physician, pediatric physician or dentist licensed in this state, and under conditions in which timely, on-site consultation by such medical doctor, osteopathic physician or dentist is available, shall be authorized, pursuant to rules adopted by the Oklahoma Board of Nursing, to order, select, obtain and administer legend drugs, Schedules II through V controlled substances, devices, and medical gases only when engaged in pre-anesthetic preparation and evaluation; anesthesia induction, maintenance and emergence; and post-anesthesia care. A certified registered nurse anesthetist may order, select, obtain and administer drugs only during the peri-operative or peri-obstetrical period." 59 O.S. § 567.13a (10)(b). Plaintiff's attorneys argue that the surgeon present at the time of surgery is the supervising physician. The term "supervising physician" is a defined term in the Oklahoma statutes. A "supervising physician\* is the licensed physician who has formally accepted the responsibility for the health care services rendered by the CRNA. See 59 O.S. § 567.3a(11)(12). A surgeon's mere presence in the operating room, without more, should not make the surgeon the CRNA's "supervising physician" under the statute since the surgeon has not agreed to accept this role for the CRNA. Therefore, the surgeon should not have responsibility for the

actions of the CRNA. I would note that the Supreme Court of Oklahoma has not decided this issue. Thus, whether the Supreme Court of Oklahoma would agree with this position is an open question and the recent decisions of the Court on medical malpractice cases have not been particularly favorable.

As a matter of professional practice, it makes little sense to hold a surgeon responsible for the acts of a CRNA when that surgeon is not the CRNA's supervising physician.

Since the surgeon is focused on the patient's surgery, the surgeon is not in a position to supervise the act one of the CRNA or monitor the patient's response to the anesthetic medications. More importantly, the surgeon lacks the requisite training and expertise to address anesthesia issues and supervise a CRNA. However, there is a concern that the Court may, as a matter of law, deem the physician in the operating room to be the CRNA's "supervising physician."

In my opinion, the public policy should be that a physician not be held liable for a nurse's or other staff member's negligence merely because the physician was in the room when the negligence occurred. The 'bright line' rule should be that in order for the physician to be held responsible for the acts of a nurse or staff member, such staff member must be found to be the employee or baned servant of the physician. Without such a showing, the physician should not liable for the negligent acts of such others. Whether that reasoning will be adopted by the Court has vet to be decided.

### Our Vision

OANA is a vibrant, cohesive and motivated community focused on advancing the cause of cost-effective, quality patient care.

### Our Mission

OANA helps CRNAs succeed by:

- Advancing and protecting CRNA practice through professional advocacy and education
- · Promoting practice excellence
- Supporting members in personal wellness
- Providing professional growth opportunities

### Our Desired Brand

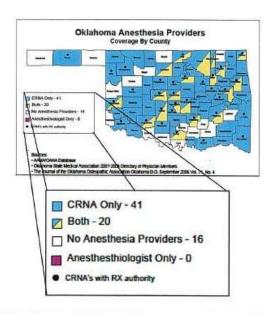
High Quality with Responsive, Caring Member Service. We recognize that incorporating innovation is the key to a strengthening the brand.

### **Our Over-Arching Goal**

Nurses to practice to the fullest extent of their education so that Oklahomans enjoy access to quality, affordable healthcare.

### Statistics

Over 500 CRNAs working in 61 Oklahoma Counties





### Oklahoma Association of Nurse Anesthetists

### Oklahoma Association of Nurse Anesthetists

PO Box 6616 Norman, Oklahoma 73070-6616

Telephone: (405) 329-OANA(6262) Fax: (405) 364-5379



### WHO WE ARE

### Certified Registered Nurse Anesthetists (CRNAs) at a Glance

Nurse anesthetists have been providing anesthesia care to patients in the United States for 150 years.

The credential CRNA (Certified Registered Nurse Anesthetist) came into existence in 1956. CRNAs are anesthesia professionals who safely administer more than 34 million anesthetics to patients each year in the United States, according to the American Association of Nurse Anesthetists (AANA) 2012 Practice Profile Survey.

CRNAs are the primary providers of anesthesia care in rural America, enabling healthcare facilities in these medically underserved areas to offer obstetrical, surgical, pain management and trauma stabilization services. In some states, CRNAs are the sole providers in nearly 100 percent of the rural hospitals.

CRNAs provide anesthesia in collaboration with surgeons, anesthesiologists, dentists, podiatrists, and other qualified healthcare professionals. When anesthesia is administered by a nurse anesthetist, it is recognized as the practice of nursing; when administered by an anesthesiologist, it is recognized as the practice of medicine. Regardless of whether their educational background is in nursing or medicine, all anesthesia professionals give anesthesia the same way.

CRNAs practice in every setting in which anesthesia is delivered: traditional hospital surgical suites and obstetrical delivery rooms; critical access hospitals; ambulatory surgical centers; the offices of dentists, podiatrists, ophthalmologists, plastic surgeons, and pain management specialists; and U.S. military, Public Health Services, and Department of Veterans Affairs healthcare facilities.

Nurse anesthetists have been the main providers of anesthesia care to U.S. military personnel on the front lines since WWI, including current conflicts in the Middle East. Nurses first provided anesthesia to wounded soldiers during the Civil War.

Managed care plans recognize CRNAs for providing high-quality anesthesia care with reduced expense to patients and insurance companies. The cost-efficiency of CRNAs helps control escalating healthcare costs.

In 2001, the Centers for Medicare & Medicaid Services (CMS) changed the federal physician supervision rule for nurse anesthetists to allow state governors to opt out of this facility reimbursement requirement (which applies to hospitals and ambulatory surgical centers) by meeting three criteria: 1) consult the state boards of medicine and nursing about issues related to access to and the quality of anesthesia

services in the state, 2) determine that opting out is consistent with state law, and 3) determine that opting out is in the best interests of the state's citizens. To date, 17 states have opted out of the federal supervision requirement, most recently Kentucky (April 2012). 39 states do not have supervision requirements in state law and are eligible to opt out should the governors elect to do so.

### Education and experience

required to become a CRNA include:

- A Bachelor of Science in Nursing (BSN) or other appropriate baccalaureate degree.
- · A current license as a registered nurse.
- At least one year of experience as a registered nurse in an acute care setting.
- Graduation with a minimum of a master's degree from an accredited nurse anesthesia educational program.
   As of Aug. 1, 2013, there are 16 programs that award a doctoral degree for entry into practice.
- Pass the national certification examination following graduation.
- Starting January 1, 2016 recertification will require testing every 8 years.

A Nurse Practitioner (NP) is a registered nurse who is prepared, through advanced education and clinical training, to provide a wide range of preventive and health care services to individuals of all ages. NPs provide physical examinations, diagnose and treat many common acute and chronic problems, interpret laboratory results and X-rays, prescribe and manage medications and other therapies, provide training and supportive counseling with an emphasis on prevention of illness and health maintenance, and refer patients to other health professionals as needed.

For more information, visit www.npofoklahoma.com

Midwives are primary health care providers to women throughout the lifespan. This means that midwives perform physical exams, prescribe medications including contraceptive methods, order laboratory tests as needed, provide prenatal care, gynecological care, labor and birth care, as well as health education and counseling to women of all ages. Women, children, and families have better lives because of the work of Certified Nurse-Midwives (CNMs) and certified midwives (CMs). The American College of Nurse-Midwives is the professional association that represents CNMs and CMs.

For more information, visit www.midwife.org

Clinical Nurse Specialists (CNS) are expert clinicians in a specialized area of nursing practice. The specialty may be identified in terms of:

- Population (e.g. pediatrics, geriatrics, women's health)
- · Setting (e.g. critical care, emergency room)
- Disease or Medical Subspecialty (e.g. diabetes, oncology)
- Type of Care (e.g. psychiatric, rehabilitation)
- · Type of Problem (e.g. pain, wounds, stress)
- CNSs practice in a wide variety of health care settings.
   In addition to providing direct patient care, CNSs influence care outcomes by providing expert consultation for nursing staffs and by implementing improvements in health care delivery systems.

For more information, visit www.nacns.org

Certified Registered Nurse Anesthetists (CRNA) are highly educated anesthesia experts who provide every type of anesthesia for patients of all ages, for any kind of procedure and in every healthcare setting where anesthesia is required. There is 0% difference in safety between CRNAs and anesthesiologists (Research Triangle Institute). CRNAs are the primary anesthesia providers in the military, the VA healthcare system, rural America and medically-underserved inner-city areas. Like all anesthesia professionals, CRNAs collaborate with other members of a patient's healthcare team.

For more information, visit www.oana.org

### **CRNAs: Ensuring Sate Anesthesia Care**

### WHY SURGEONS AND OTHER HEALTHCARE PROVIDERS RELY ON CRNAS

Certified Registered Nurse Anesthetists (CRNAs) are advance practice registered nurses who collaborate with surgeons, obstetricians, anesthesiologists, dentists and other healthcare providers to deliver safe, high-quality and cost-effective anesthesia care to patients in virtually every healthcare setting.

Access to Care



CRNAs practice in all 50 states and in the military, safely providing more than 38 million anesthetics each year.

### Patient Safety



A landmark study confirms that anesthesia care is equally safe regardless of whether it is provided by a CRNA working alone, an anesthesiologist working alone or a CRNA working with an anesthesiologist.\*



Anesthesia care is nearly 50x safer than it was in the 1980s.

This is due to advancements in monitoring technology, anesthetic drugs, provider education, and standards of care.

There is 0% difference in safety between CRNAs and anesthesiologists.

Research Triangle Institute (RTI) \*

### Risk Management





CRNAs are educated, trained and experienced in providing anesthesia care for complicated medical procedures and handling emergency situations.



As licensed professionals, CRNAs are responsible and accountable for decisions made and actions taken in their professional practice.



Case law shows that surgeons and other healthcare providers face no increase in liability when working with a CRNA versus an anesthesiologist.

### Cost Savings

Healthcare facilities that hire anesthesiologists to supervise CRNAs in an effort to manage risk may more than triple the costs of anesthesia delivery without improving patient outcomes, lowering risk or reducing liability coverage costs.



\*\*Institute of Medicine





### **CRNA Education and Training**



By 2025, all anesthesia

program graduates will earn doctoral degrees

CRNAs have a minimum of 7 to 8 years of education and training specific to nursing and anesthesiology before they are licensed to practice anesthesia.





Critical care nursing experience



Classroom and clinical



CRNAs obtain an average of







of critical care nursing experience before

entering a nurse anesthesia program.<sup>2</sup> They are the only anesthesia professionals with this level

of critical care experience prior to entering an





Constant Learners

Minimum 40 hours of approved continuing education



Examination and be recertified every 2 years so they

are-current on the latest anesthesia techniques and technologies. Anasthasiologists are recertified every 10 years.

CRNAs must pass a National Certification

of substantial anesthesia practice



of current state licensure

CRNAs are qualified to administer every type of anesthesia in any healthcare setting, including pain management for acute or chronic pain



educational program.











less costly to educate and train than anesthesiologists.3



of employers report high satisfaction levels with the preparedness of recently araduated CRNAs.4

As the demand for healthcare continues to grow, increasing the number of CRNAs will be key to containing costs while maintaining quality care.

**CRNAs** 

- 2. National Board of Certification and Recertification for Norse Anasthetists 2012 NBCRNA Annual Report of NICE Performance Data
- 3. Cost Effectiveness Analysis of Anesthesia Providers, Nursing Economics, June 2019
- 4. Assessment of Recent Graduates Preparedness for Entry into Practice, AAMA Journal, November 2013

For more information, visit www.future-of-anesthesia-care-today.com American Association of Nurse Anesthetists 2014





# Oklahoma is in a fiscal and health care crisis. CRNAs are part of the answer to Oklahoma's biggest problems.

Oklahoma is running out of money and Medicaid will likely have huge cuts again in 2017.

Medical staff shortages are becoming an epidemic in Oklahoma.

Hospitals are closing or laying off staff, especially in rural areas.

Oklahoma has decades old mandates that prevent the expansion in health care delivery. An example is the requirement that doctors supervise CRNAs.

# Physicians per capita in Oklahoma, by county Physicians per 1,000 people, by county 0 to 1 1 to 2 2 to 3 3 to 4 4 to 5 Source A Tulsa World analysis of data from the Oklahoma State Board of Osteopathic Examiners DAVID HOUSH/Tulsa World

### Consider the facts:

CRNAs provide all the anesthesia services in 41 Oklahoma counties

CRNAs save the state 20% in Medicaid dollars versus anesthesiologists for the same services.

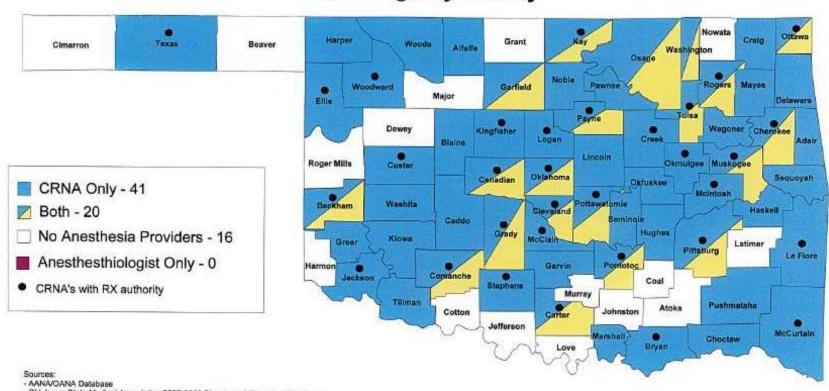
Studies show Oklahoma CRNAs working without physician supervision is the most cost effective model and is as safe as the more expensive supervised model.

When an Oklahoma CRNA works in collaboration with a physician there are cost savings for the state and medical facilities and patient safety is the



Produced by the Oklahoma Association of Nurse Anesthetists

# Oklahoma Anesthesia Providers Coverage By County



- Oklahoma State Medical Association 2007-2008 Directory of Physician Members
- The Journal of the Oklahoma Ostoopathic Association Oklahoma D.O. September 2008 Vol. 71, No. 4

# OKLAHOMA is in a fiscal and HEALTHCARE CRISIS. CRNAs are part of the ANSWER to Oklahoma's biggest problems.

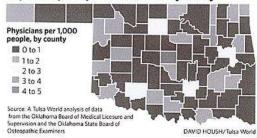
Oklahoma is running out of money & Medicaid will likely have huge cuts again in 2017.

Medical staff shortages are becoming an epidemic in Oklahoma.

Hospitals are closing or laying off staff, especially in rural areas.

Oklahoma has decades-old mandates that prevent the expansion in health care delivery. An example is the requirement that doctors supervise CRNAs.

# Physicians per capita in Oklahoma, by county



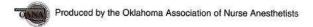
### Consider the facts:

CRNAs provide ALL ANESTHESIA SERVICES in 41 Oklahoma counties

CRNAs SAVE the state 20% in  $Medicald\ dollars\ versus\ an esthesiologists\ for$  the same services.

Studies show Oklahoma CRNAs working without physician supervision is the MOST COST EFFECTIVE model and is AS SAFE as the more expensive supervised model.

When an Oklahoma CRNA works in COLLABORATION with a physician, there are cost savings for the state and medical facilities and patient safety is the same!



Re: Quality health care requires amendment to 59 O.S. §567.3(10)(a)
Dear [Representative or Senator]:
I am a physician in active private practice in your legislative district. My specialty is I ["frequently" or some other descriptor of the situation, like "often", "daily", "routinely", "always"] use the professional services of a certified registered nurse anesthetist ("CRNA") to administer essential anesthesia to my patients. In the course of a year, I will work with CRNAs approximately [add the number,]times. As a constituent, I am especially interested in sharing with you my views of a need to clarify 59 O.S. §567.3(10)(a). Without a clarification, that part of the Nursing Practices Act could be too restrictively interpreted and applied to my practice and to that of the CRNAs with whom I work.
Specifically, there is no medical necessity for the level of immediacy and on-site supervision of CRNAs working with me in my practice as might be the interpretation of the current statute, 59 O.S. §567.3(10)(a). There is no medical necessity for the law to require that the CRNA administering anesthesia must "administer anesthesia under the [my] supervision" or that administration of anesthesia always must be "under conditions in which timely onsite consultation by [me] is available." CRNA's currently consult with all specialists as needed for patient continuity of care.
Public interest is not well served by current restrictions on CRNA practice. The best approach is to empower competent professionals to do what they do best as a 'earn in the exercise of their best judgment. The public interest is best served by a health care delivery model that consists of me consulting with a CRNA and each doing our respective specialties. The statute should be amended to clearly authorize that consultation without unnecessary restrictions such as "under my supervision" or "under conditions where timely onsite consultation by a [physician] is available." A suggested amendment to that part of the Nursing Practices Act is attached, along with conforming changes in the Pharmacy Act and the Controlled Dangerous Substances Act that would also be needed to implement this important clarification.
Your support for this needed clarification would improve health care delivery in Oklahoma. I would appreciate your consideration of this important issue. I would be happy to speak to you about this and to answer any questions you might have. Thank you.
Sincerely,
Dr.

Date

# **SB781 Attempting to Authorize Dental Assistants in** providing IV Sedation and **Local Anesthesia**

1 | ENGROSSED SENATE BILL NO. 781 By: Jolley, Crain, David, 2 Paddack, Loveless, Sykes, and Shortey of the Senate 3 and 4 Cox of the House 5 6 7 An Act relating to the State Dental Act; amending 59 O.S. 2011, Section 328.2, as amended by Section 1, 8 Chapter 405, O.S.L. 2013 (59 O.S. Supp. 2014, Section 328.2), which relates to declarations; clarifying 9 language; amending 59 O.S. 2011, Section 328.3, as amended by Section 2, Chapter 405, O.S.L. 2013 (59 10 O.S. Supp. 2014, Section 328.3), which relates to definitions; adding, deleting, and amending certain 11 definitions; amending 59 O.S. 2011, Section 328.10, which relates to the Board of Dentistry; permitting 12 Board to hold certain meetings; deleting language referring to certain personnel; permitting certain 13 reimbursement; amending 59 O.S. 2011, Section 328.15, as last amended by Section 3, Chapter 405, O.S.L. 14 2013 (59 O.S. Supp. 2014, Section 328.15), which relates to powers of the Board; modifying powers; 15 amending 59 O.S. 2011, Section 328.17, which relates to certain appointments; deleting certain power of 16 appointment; creating certain committees; providing for membership; providing standards for meetings; providing jurisdiction of committees; providing 17 appointing authority; amending 59 O.S. 2011, Section 18 328.19, as amended by Section 4, Chapter 405, O.S.L. 2013 (59 O.S. Supp. 2014, Section 328.19), which 19 relates to the practice of dentistry; expanding certain acts constituting practice of dentistry; 20 amending 59 O.S. 2011, Section 328.21, as amended by Section 5, Chapter 405, O.S.L. 2013 (59 O.S. Supp. 21 2014, Section 328.21), which relates to licensure and examinations; removing certain exception; requiring 22 certain examinations and standards for licensure; deleting certain requirement; permitting certain 23 persons to submit licenses under certain circumstances; removing certain required 24 documentation; providing for reexaminations under

4/24/25, 11:21 AM

Bill Information

### BILL INFORMATION FOR SB 781

### SB 781 by Jolley and Cox

SELECT SESSION: 2015 Regular Session

Receive Email Updates for this Measure (LENS)

ENTER BILL #:

Search

State Dental Act; modifying definitions; amending provisions relating to licensure of dentists. Effective date. Emergency.

HISTORY FOR SB 781			
Action	Journal Page	Date	Chambe
First Reading	214	02/02/2015	s
Authored by Senator Jolley		02/02/2015	5 5
coauthored by Cox (principal House author)		02/02/2015	s
Second Reading referred to Health and Human Services	268	02/04/2015	s
coauthored by Crain	286	02/09/2015	S
coauthored by David	286	02/09/2015	s
coauthored by Paddack	311	02/12/2015	s
coauthored by Loveless	322	02/16/2015	s
Reported Do Pass, amended by committee substitute Health and Human Services committee; CR filed	392	02/23/2015	s
General Order, Considered	473	03/03/2015	s
Measure and Emergency passed: Ayes: 40 Nays: 5	474	03/03/2015	s
Referred for engrossment		03/03/2015	s
coauthored by Sykes, Shortey	613	03/03/2015	5
Engrossed to House		03/04/2015	s
First Reading		03/04/2015	н
Second Reading referred to Appropriations and Budget		03/10/2015	н
Referred to Appropriations and Budget Health Subcommittee		03/11/2015	н
Recommendation to the full committee; Do Pass Appropriations and Budget Health Subcommittee sub-committee		03/31/2015	н
CR; Do Pass Appropriations and Budget Committee	849	04/09/2015	н
Coauthored by Representative(s) Roberts (Sean), Montgomery	849	04/09/2015	н
General Order	1038	04/23/2015	н
Coauthored by Representative(s) Ownbey, Proctor, Cockroft, Calvey	1038	04/23/2015	н
Third Roading, Measure and Emergency passed: Ayes: 80 Nays: 11	1038	04/23/2015	н
Signed, returned to Senate	1038	04/23/2015	н
Referred for enrollment	1067	04/27/2015	s
Enrolled, to House	1077	04/28/2015	s

https://www.oklegislature.gov/BillInfo.aspx?Bill=SB 781&Session=1500

 4/24/25, 11:21 AM
 Bill Information
 04/28/2015
 H

 Signed, returned to Senate
 1071
 04/28/2015
 H

 Sent to Governor
 1079
 04/28/2015
 S

 Approved by Governor 05/01/2015
 1119
 05/04/2015
 S

https://www.oklegislature.gov/BillInfo.aspx?Bill=S8 781&Session=1500

1/2

2/2



### Patty Wadsack

From: Sent: To: Subject: Cheryl Nimmo, DNP, MSHSA, CRNA [elart@aana.com]

Tuesday, December 13, 2016 4:12 PM

Patty Wadsack

Member Alert: Watch for VA Call-to-Action Email on Dec. 14



Dear Colleagues,

The battle may have been lost, but the war is definitely not over!

With this morning's publication of the VA final rule granting full practice authority to all APRNs except CRNAs, not only am I angry, I am more resolved and determined than ever to convince the VA it is making a huge mistake! Hanging in the balance are the best interests of our nation's veterans, who have more than earned the right to receive safe, high-quality anesthesia care when and where they need it. Veterans Health Administration (VHA) CRNAs are ready, willing, and highly qualified to ensure veterans access to the timely care they deserve.

### So get ready to take action!

Tomorrow you will receive a blast email from the AANA requesting you to write to the VA and let it be known that the final rule is unacceptable to you as a highly educated and qualified healthcare professional and as an American who is deeply concerned about the best interests of our nation's veterans. In a strong yet professional way, tell the VA that the rule simply must be changed to grant full practice authority to CRNAs along with the other APRN specialties.

The issues and arguments to be included in your comments will be outlined for you in the blast email coming your way, but it is important that you write your comments in your own words. Thousands of individualized letters from CRNAs and SRNAs will be far more compelling than thousands of form letters.

I challenge every member of the AANA to participate in this call to action. We only have 30 days to submit comments, so don't delay! The hour you devote to writing and sending your comment letter could help propel our profession forward and improve the quality of care for veterans.

Knowing that the holidays are upon us and our time is precious, I thank you in advance for keeping up the fight on behalf of our beloved profession and for veterans across the United States.

Sincerely,

Cheryl Nimmo, DNP, MSHSA, CRNA AANA President

1

PAL TALL

FALL/WINTER ISSUE

DECEMBER 15, 2016

# **OANA Newsletter**

Oklahoma Association of Nurse Anesthetists



# Welcome to the new 2016-2017 Board of Directors

The Oklahoma Association of Nurse Anesthetists would like to welcome our newest board members Rebecca Donnell, Kate Feeley, and Ashley Craig. Also elections were held for the board of the directors and we are pleased to announce that Brenda Toland will serve one additional year as OANA President, Maria Roberson Vice President, Jenny Schmitt Secretary, and Kate Feely Treasurer. Missing from the picture above is board members Quentin Sukut.

PAGE 3

EBECCA DONNELL
PAGE 6

ASHLEY CRAIG
PAGE 8



In This Issue:

President's Message

Meet your new OANA Board of Directors

AANA in DC Highlights

Social Media and GRC Update

Spring Meeting 2017 News

OANA Day at the Capital

Student Spotlight



1

# **SB570 February 6, 2017** By the Dark of Night

4/9/25, 12:39 PM Bill Information

# BILL INFORMATION FOR SB 570

## SB 570 by Griffin and Cockroft

SELECT SESSION: 2018 Regular Session

Receive Email Updates for this Measure (LENS)

ENTER BILL #;

Cosmetology and barbering; State Board of Cosmetology and Barbering; recreating Board. Effective date.

History   Amendments   Bill Summaries   Versions   Votes   Au  HISTORY FOR SB 570	thors/Co Authors
Action	Journal Page Date Chambe
First Reading	171 02/06/2017 S
Authored by Senator Griffin	171 02/06/2017 S
Second Reading referred to Business, Commerce and Tourism	250 02/07/2017 5
Coauthored by Representative Jordan (principal House author)	322 02/20/2017 S
Reported Do Pass, amended by committee substitute Business, Commer Tourism committee; CR filed	rce and 356 02/23/2017 S
General Order, Considered	455 03/07/2017 S
Measure passed: Ayes: 35 Nays: 8	456 03/07/2017 S
Referred for engrossment	456 03/07/2017 S
Engrossed to House	467 03/08/2017 S
First Reading	539 03/08/2017 H
Second Reading referred to Administrative Rules	798 03/27/2017 H
CR; Do Pass Administrative Rules Committee	875 04/12/2017 H
General Order	997 04/24/2017 H
Remove Representative Jordan as principal House author and substitute Representative Biggs	e with 997 04/24/2017 H
Amended	998 04/24/2017 H
Third Reading, Measure passed: Ayes: 87 Nays: 4	998 04/24/2017 H
Referred for engrossment	998 04/24/2017 H
Engrossed, signed, to Senate	1023 04/25/2017 H
HAs read	981 04/25/2017 S
HAs rejected, conference requested	1087 05/04/2017 5
Conference granted, naming Conference Committee on Administrative R	tules 1194 05/10/2017 H
SCs named Griffin, Newberry, Leewright, Daniels, Bergstrom, Pittman, B	Bass 1141 05/11/2017 S
Conferees unable to agree	1256 05/25/2017 5
remove as principal author Representative Biggs and substitute with Representative Cockroft	193 02/05/2018 S
HAs rejected, conference requested	904 04/24/2018 5
SCs named Griffin, Leewright, Daniels, Bergstrom, Scott, Pittman, Brook	s 906 04/24/2018 S

https://www.oklegislature.gov/BillInfo.aspx?Bill=SB570&Session=1800

4/9/25, 12:39 PM Bill Information Conference granted, naming Conference Committee on Rules 04/24/2018 H 828 coauthored by Babinec 04/26/2018 S Died in conference 05/09/2018 S

https://www.oklegislature.gov/BillInfo.aspx?Bill=SB570&Session=1800

1/2

# SB801 An Act to Remember

# An Act

ENROLLED SENATE BILL NO. 801

By: Rosino, Scott, Dahm and Sharp of the Senate

and

McEntire, McDugle, Davis, Cornwell, Mize and Kerbs of the House

An Act relating to Advanced Practice Registered Nurses; amending 59 O.S. 2011, Section 567.3a, as amended by Section 1, Chapter 281, O.S.L. 2017 (59 O.S. Supp. 2019, Section 567.3a), which relates to definitions used in the Oklahoma Nursing Practice Act; modifying definition; updating statutory reference; and declaring an emergency.

SUBJECT: Certified Registered Nurse Anesthetists

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. AMENDATORY 59 O.S. 2011, Section 567.3a, as amended by Section 1, Chapter 281, O.S.L. 2017 (59 O.S. Supp. 2019, Section 567.3a), is amended to read as follows:

Section 567.3a. As used in the Oklahoma Nursing Practice Act:

- 1. "Board" means the Oklahoma Board of Nursing;
- 2. "The practice of nursing" means the performance of services provided for purposes of nursing diagnosis and treatment of human responses to actual or potential health problems consistent with educational preparation. Knowledge and skill are the basis for assessment, analysis, planning, intervention, and evaluation used in

functions as defined by the scope of practice/role definition statements for the Certified Nurse-Midwife;

- 9. "Nurse-midwifery practice" means providing management of care of normal newborns and women, antepartally, intrapartally, postpartally and gynecologically, occurring within a health care system which provides for medical consultation, medical management or referral, and is in accord with the standards for nurse-midwifery practice as defined by the American College of Nurse-Midwives;
  - 10. a. "Certified Registered Nurse Anesthetist" is an Advanced Practice Registered Nurse who:
    - (1) is certified by the National Board of Certification and Recertification for Nurse Anesthetists as a Certified Registered Nurse Anesthetist within one (1) year following completion of an approved certified registered nurse anesthetist education program, and continues to maintain such recertification by the National Board of Certification and Recertification for Nurse Anesthetists, and
    - (2) administers anesthesia under the supervision of in collaboration with a medical doctor, an osteopathic physician, a podiatric physician or a dentist licensed in this state and under conditions in which timely onsite consultation by such doctor, osteopath, podiatric physician or dentist is available.
    - b. A Certified Registered Nurse Anesthetist, under the supervision of in collaboration with a medical doctor, osteopathic physician, podiatric physician or dentist licensed in this state, and under conditions in which timely, on-site consultation by such medical doctor, osteopathic physician, podiatric physician or dentist is available, shall be authorized, pursuant to rules adopted by the Oklahoma Board of Nursing, to order, select, obtain and administer legend drugs, Schedules II through V controlled substances, devices, and medical gases only when engaged in the preanesthetic

ENR. S. B. NO. 801 Page 8

- e. The Oklahoma Board of Nursing shall notify the Board of Pharmacy after termination of or a change in the authority to order, select, obtain and administer drugs for a Certified Registered Nurse Anesthetist.
- f. The Board shall provide by rule for biennial application renewal and reauthorization of authority to order, select, obtain and administer drugs for Certified Registered Nurse Anesthetists. At the time of application renewal, a Certified Registered Nurse Anesthetist shall submit documentation of a minimum of eight (8) units of continuing education, completed during the previous two (2) years, in advanced pharmacology relating to the administration of anesthesia, as recognized by the Council on Recertification of Nurse Anesthetists or the Council on Certification of Nurse Anesthetists.
- g. This paragraph shall not prohibit the administration of local or topical anesthetics as now permitted by law. Provided further, nothing in this paragraph shall limit the authority of the Board of Dentistry to establish the qualifications for dentists who direct the administration of anesthesia.
  - As used in this paragraph, "collaboration" means an agreement between a medical doctor, osteopathic physician, podiatric physician or dentist performing the procedure or directly involved with the procedure and the Certified Registered Nurse Anesthetist working jointly toward a common goal providing services for the same patient. This collaboration involves the joint formulation, discussion and agreement of the anesthesia plan by both parties, and the collaborating medical doctor, osteopathic physician, podiatric physician or dentist performing the procedure or directly involved with the procedure and that collaborating physician shall remain available for timely onsite consultation during the delivery of anesthesia for diagnosis, consultation, and treatment of medical conditions;

ENR. S. B. NO. 801 Page 10

4/24/25, 6:11 PM Bill Information

### BILL INFORMATION FOR SB 801

# SELECT SESSION: 2019 Regular Session Receive Email Updates for this Measure (LENS)

Oklahoma Nursing Practice Act; modifying authority of Certified Registered Nurse Anesthetists to administer anesthesia and controlled substances. Effective date.

Utrania American Bulletinia Victoria Victoria de La

Action	Journal Page	Date	Chambe
First Reading	239	02/04/2019	s
Authored by Senator Smalley	239	02/04/2019	s
Second Reading referred to Health and Human Services	334	02/07/2019	s
Reported Do Pass, amended by committee substitute Health and Human Services committee; CR filed	345	02/11/2019	) s
Coauthored by Representative McEntire (principal House author)	417	02/19/2019	s
Coauthored by Senator Scott	501	02/25/2019	s
Coauthored by Representative McDugle	517	02/26/2019	s
Coauthored by Representative Davis	561	03/04/2019	s
Coauthored by Representative Cornwell	650	03/06/2019	s
Coauthored by Representative Mize	670	03/07/2019	s
Coauthored by Representative Kerbs	739	03/11/2019	s

https://www.oklegislature.gov/Billinfo.aspx?Bill=Sb801&Session=1900

1/2

## BILL INFORMATION FOR SB 801

SB 801 by Smalley	and McEntire		
SELECT SESSION:	2019 Regular Session	•	

Receive Email Updates for this Measure (LENS)

ENTER BILL #:

Oklahoma Nursing Practice Act; modifying authority of Certified Registered Nurse Anesthetists to administer anesthesia

BOLL SUMMARIES/FISCAL IMPACT FOR SB 801 (SENATE)	
Committee Substitute	3/7/2019
Floor Amendment 1	2/25/2019
Floor Amendment 4	2/14/2020
ntroduced	2/11/2019
OPLAA ACTUARIAL STATEMENTS FOR SB 801 (HOUSE)	
None	
OPLAA ACTUARIAL STATEMENTS FOR SB 801 (SENATE)	
None	
FISCAL IMPACT STATEMENTS FOR SB 801 (House)	
None	
FISCALIMPACT STATEMENTS FOR SH 801 (SENATE)	
BB01 FA4 FLPDF	Fiscal (Senate)

Senate Votes 4/24/25, 6:03 PM

Please click on a link below to go directly to that vote:

Committee Vote THIRD READING (RCS# 0007)

Top of Page

THE OKLAHOMA STATE SENATE 2nd Session of the 57th Legislature

SENATE BILL 801 Oklahoma Nursing Practice Act; modifying authority of Certified Registered Nurse Rosino Anesthetists to administer anesthesia and

controlled substances. Effective date.

Emergency.

THIRD READING

NAYS: 2/17/2020 EXC : N/V : 1:59 PM

VAC :

YEAS: 44 Allen

Bice

Dugger Matthews Scott Floyd Hall Sharp Shaw Bergstrom McCortney Montgomery Haste Murdock Silk

Boggs Brooks Simpson Standridge Stanislawski Bullard Howard Pederson Ikley-Freeman Coleman Pemberton Stanley Pugh Dahm Jech Daniels Kidd Quinn Treat

David Rader Weaver Dossett Leewright Rosino Young

NAYS:

EXCUSED:

Newhouse Thompson Boren

N/V : 0

VACANT: 1

1/2

SENATE BILL 801

4/24/25, 6:03 PM Senate Votes

THE OKLAHOMA STATE SENATE

2nd Regular Session of the 57th Legislature

February 11, 2019

COMMITTEE ON HEALTH AND HUMAN SERVICES

SB 801

By: Smalley of the Senate

Oklahoma Nursing Practice Act; modifying authority of Certified Registered Nurse Anesthetists to administer anesthesia and controlled substances. Title:

Effective date.

DO PASS AS AMENDED Recommendation:

Coleman, Hicks, Ikley-Freeman, Rosino, Scott, Silk, Simpson, Young, Aye:

Daniels, Pugh, Standridge, McCortney Nay:

Constitutional Privilege:

https://www.oklegislature.gov/cf/2019-20 SUPPORT DOCUMENTS/votes/Senate/S8801\_VOTES.HTM

4/24/25, 6:02 PM House Votes

Please click on a link below to go directly to that vote:

THIRD READING (RCS# 1430)

Ion of Page

OKLAHOMA HOUSE OF REPRESENTATIVES 57th Oklahona Legislature Second Regular Session

SB901By McEntire of Oklahoma Nursing Practice Act PASSED

THIRD READING RCS# 1430 05/04/2020 02:19 PM YEAS: 100 NAYS: EXC : C/P :

YEAS: 100

Albright Fugate Rosecrants Meredith Miller Mize Moore Munson Newton Nichols Baker Bell Bennett Blancett Russ Sanders Sims Smith Goodwin Grego Hardin (D) Boatman Boles Branham Hardin (T) Hasenbeck Bilbert Sneed Stark Steagall Bill Humphrey Johns Kannady Brever Nollan GDonnell Olsen Sterling Strom Tadlock Burns Bush Caldwell (C) Caldwell (T) Conley Cornwell Talley Taylor Townley Vancuren Ortega Osburn Pae Patzkowsky Kerbs Kiger Lawson Perryman Pfeiffer Phillips Pittman Virgin Waldron Walke Crosswhite Hader Lepak Davis Dills Luttrell Rellace Dollens Hest (J) Hest (R) Hest (T) Horthen Hright Mr. Speaker Dunnington Echols Fatgatter Manger Marti Provensano Randleman Martinez Ranson Roberts (D) Roberts (S) Roe Fincher Ford Prix May McBride McDugle

NAYS:

EXCUSED: 0

2/2

CONSTITUTIONAL PRIVILEGE: 0



J. Kevin Stitt Office of the Governor State of Oklahoma

November 20, 2020

Electronic Delivery: Seema Verma@cms.hhs.gov

The Honorable Seema Verma, Administrator Centers For Medicare and Medicaid Services 200 Independence Ave., S.W. Washington, DC 20201

Dear Ms. Verma,

Please rescind the letter I sent you on July 29, 2020 and accept this letter that I believe is clearer regarding my stance on the matter.

Pursuant to the final rule in the November 13, 2001, Federal Register Volume 66, Number 219, I hereby notify you of the state of Oklahoma's election for state exemption from federally directed physician supervision of Certified Registered Nurse Anesthetists (CRNAs). Please consider this official notice of Oklahoma's election for state exemption.

This exemption is consistent with recent Oklahoma Law changes made during the Second Regular Session of the 57th Legislature through Senate Bill 801. Senate Bill 801 amended a requirement that a CRNA be supervised by a physician and instead implemented a requirement that a CRNA must collaborate with a physician. This is the law that will apply under this election for state exemption, and this action will not change the current delivery of health care in Oklahoma.

As you are aware, 18 other states have exercised this option prior to CMS suspending this requirement for all 50 states during the COVID-19 pandemic. We know this will enhance and improve access to care throughout Oklahoma, particularly in the rural areas. Moreover, at this time of heightened demands on our healthcare system, this will provide our physicians with more time for other critical medical services.

My office has consulted with the Executive Director of the Oklahoma Nursing Board, the Executive Director of the Oklahoma State Board of Medical Licensure and Supervision as well as other interested parties regarding this matter. I have concluded this exemption to be in the best interests of all Oklahomans, rural communities and our hospitals across the state.

Sincerely,

J. Kevin Stitt

Governor of Oklahoma

STATE CAPITOL BUILDING - 2300 N. LINCOLN BOULEVARD, SUITE 212 - OKLAHOMA CITY, OKLAHOMA 73105 + (405) 521-2342 - (405) 521-3353



State of Oklahoma

July 29, 2020

The Honorable Seema Verma, Administrator Centers For Medicare and Medicaid Services Hubert Humphrey Building 200 Independence Ave., S.W. Washington, DC 20201

Dear Ms. Verma.

Pursuant to the final rule in the November 13, 2001, Federal Register Volume 22, Number 219, I am exercising the option available to states and exempting the State of Oklahoma from the regulation requiring the Certified Registered Nurse Anesthetists (CRNA's) be supervised by a physician. As you are aware 18 other states have exercised this option prior to CMS suspending this requirement for all 50 states during the COVID-19 pandemic. Similar to President Trump, the Oklahoma Standard is responding to this crisis by ensuring that red tape is removed that precludes Oklahomans from receiving quality health care that Oklahomans deserve.

This exemption is consistent with Oklahoma Law ( Session Law 11 (S8 801) 2020 ). We know this will enhance and improve access to care throughout Oklahoma, particularly in the rural areas. Moreover, at this time of heightened demands on our healthcare system, this will provide our physicians with more time for other critical medical services.

My office has consulted with the Executive Director of the Oklahoma Nursing Board and other interested parties regarding this matter. I have concluded this exemption to be consistent with Oklahoma law and it to be in the best interests of all Oklahomans, rural communities and our hospital's statewide.

Please consider this letter to be the official notification of Oklahoma's election for state exemption from the regulation requiring CRNA's to be supervised.

Sincerely,

Governor of Oklahoma

STATE CAPITOL BUILDING . 2300 N. LINCOLN BOULEVARD, SUITE 212 . OKLAHOMA CITY, OKLAHOMA 73105 . 405-521-2342

