Oral Testimony of Christina Cowgill, CRNA

for the Oregon Association of Nurse Anesthetists (ORANA)

Before the Senate Health Care and Human Services Committee

March 25, 2013

In support of SB 136

Chair Monnes Anderson and Members of the Committee:

My name is Christina Cowgill, and I am a nurse anesthetist (CRNA) and The Director of Government Relations for ORANA. I appreciate the opportunity to appear before you in support of SB 136 with the amendments you have before you.

I wanted to share with you the experience of the Washington State Experience of Prescribing Practices. As you may know, all advanced practice nurses including CRNAs have the opportunity to obtain prescriptive authority for schedule II through IV controlled substances since the law was passed in 2005. A six year study was concluded by Louise Kaplan (this study is attached for your reference) to look at the prescribing practices of Washington State CRNAs. Of note, at the conclusion of 6 years after the law was implemented only 30% of CRNAs held prescriptive authority. The remainder of CRNAs practice using the Nurse Practice Act Provision to "select, order, and administer" as the foundation of their practice. The drugs that were commonly prescribed were largely anesthetics, 94.7%. NSAIDS, such as ibuprofen or naproxen, were the second most common prescribed drug at 60%. Narcotics made up about only 53.3% of drugs CRNAs were prescribing. Other commonly prescribed drugs categories were benzodiazepines (44%), such as xanax; hypotics like ambien (26.7%); and non-narcotic analgesics, like Ultram (24%). I thought this background would help Oregon rest assured that, due to the similarities in regional practice, Oregon CRNAs would likely trend near those practice habits of Washington. In addition, it is important to note that according to a review of disciplinary actions by the Board of Nursing against a CRNA in Washington State (3 disciplinary actions during the 6 year study time); not one have had to do with prescriptive authority issues and the CRNA.

ORANA over the past 4 years has queried our own membership about the use of prescriptive authority or the continued practice of "select, order, and administer" and it is likely that in 6 years would not have greater than 30% of CRNAs in Oregon that utilized

this feature that SB 136 would authorize; therefore we predict a very similar experience as that of Washington State. (This however would change if the practice landscape changed; for example a large employer like Providence or OSHU created bylaws within that institution that required all CRNAs to hold prescriptive authority).

I also, included in your testimony packet for today, a letter from a Board Certified Anesthesiologist highlighting the impact that passing Senate Bill 136 would have on the benefit of patient care in Oregon. He states...

"While writing prescriptions for patients receiving anesthesia care does not occur with great frequency, there are several circumstances under which being able coordinate care and provide needed medicines to patients both before and after surgery is highly beneficial to Oregonians. For example, a patient arrives for their preoperative visit and they need antibiotics, anti-anxiety medication or anti-nausea medication before their surgery. Anesthesia providers regardless of their academic credentials are the experts in this area of perioperative patient care. SB 136 would allow CRNAs to work at the level of their education and training for the good of our shrinking health care dollars and the citizens of Oregon. This would also put them on the same level as the other advanced practice nurses in our state."

Included in the packet provided, is also a letter from a surgeon providing examples of how SB 136 would improve his practice and the patient experience in his health care setting.

We, as a membership of over 320 CRNAs, serving a large portion of rural Oregon including critical access hospitals; have carefully considered bringing this issue to the level of the legislature because of the historical challenges by anesthesiologists and restraints on CRNA practice by medicine. However, we believe wholeheartedly that lifting barriers or potential barriers to serving Oregon patients in the best, most fluid way possible far outweighs the turf battle and politics between the practice of medicine and nursing.

In conclusion, if one understands the way CRNAs are educated and currently practice in Oregon; one could conclude that this is not a scope of practice issue, it is a practice barrier that if removed is the best way to offer outstanding care to the patient. And that is what health care is all about.

Thank you for your time and I respectfully request that SB 136 is passed.

CRNA Prescribing Practices: The Washington State Experience

Louise Kaplan, PhD, ARNP, FNP-BC, FAANP
Marie-Annette Brown, PhD, ARNP, FNP-BC, FAAN
Dan Simonson, CRNA, MHPA

One year after implementation of a 2005 Washington State law that granted Certified Registered Nurse Anesthetists (CRNAs) authority to prescribe schedule II through IV controlled substances, only 30% of CRNAs held prescriptive authority. The purpose of this study was to describe Washington State CRNA prescribing practices and workforce and practice characteristics.

A questionnaire was mailed in 2006 to CRNAs licensed in Washington with addresses in Washington, Oregon, and Idaho. A typical respondent was 51 years old, white, and equally likely to be male or female, with 19 years of experience. More than half (52.2%) of the CRNAs were employed by hospitals, and 22% were in solo practice. Forty-one percent of the sample had prescriptive authority; however, 11% had prescriptive authority without Drug Enforcement Administration (DEA) registration. Respondents without prescriptive authority used the Nurse Practice Act provision to "select, order and administer" as the foundation for practice. Of CRNAs with prescriptive authority, 94.7% prescribed anesthetics, 60% prescribed nonsteroidal anti-inflammatory medications, and just 53.3% prescribed narcotic analgesics.

Professional and policy controversies about autonomous prescribing for CRNAs are discussed. Further research is needed to determine the factors that limit CRNA prescribing and the transition to a new scope of practice.

Keywords: Controlled substances, CRNA workforce, nurse anesthetists, prescribing practices, prescriptive authority.

A 2005 Washington State law completed Certified Registered Nurse Anesthetist (CRNA) prescriptive authority by adding schedule II through IV controlled substances to their fully autonomous scope of practice. In contrast, most other states do not authorize CRNA autonomous prescriptive authority. Prescriptive authority is based on state legislation that grants prescription writing as a part of CRNA scope of practice.

Adoption of changes in scope of practice among advanced practice nurses is often slow and uneven.[1] Many CRNAs choose not to prescribe medications despite the option to do so. For example, in December 2008, only 1 of 1,282 CRNAs in Louisiana had applied for prescriptive authority (P. Greiner, Louisiana State Board of Nursing, oral communication, December 2008). To date, no research was found on how CRNAs who, limited by law, adapt their practice to prescribing constraints, and then transition to a new scope of practice when the law changes. In addition, few studies have been published about the CRNA workforce.

There is little in the literature regarding CRNAs and prescriptive authority. No research about prescriptive authority for CRNAs was located in PubMed, CINAHL, the Cochrane Library, Clinical Evidence, the National Guideline Clearinghouse, and the American Association of Nurse Anesthetists (AANA) website. Three articles on CRNA prescribing were written by attorneys for the AANA between 1988 and 1993.[2-4] These articles addressed 2 questions.

The first question was whether CRNA practice involves prescribing rather than selecting and administering anesthetic agents during the perianesthesia period. According to a review of court cases and federal law, AANA attorneys concluded that an anesthetic agent administered in the perianesthesia period is dispensed, not prescribed. This is part of CRNA scope of practice and serves as the basis for CRNA practice with or without prescriptive privileges.

The second question addressed whether individual registration with the Drug Enforcement Administration (DEA) was required for a CRNA employed by or acting as an agent of an institution. Adopted in 1993, DEA regulations have allowed CRNAs to "dispense" controlled substances without obtaining an individual DEA registration. These rules define "dispense" as the administration or prescribing of a controlled substance. In states without CRNA prescriptive authority, CRNAs who are agents or employees of a DEA registrant are exempt from DEA registration. In states where CRNA practice includes prescriptive authority as the legal basis for administering anesthetic agents, DEA registration is required.

CRNA Prescriptive Authority

There is wide variability in prescriptive authority for

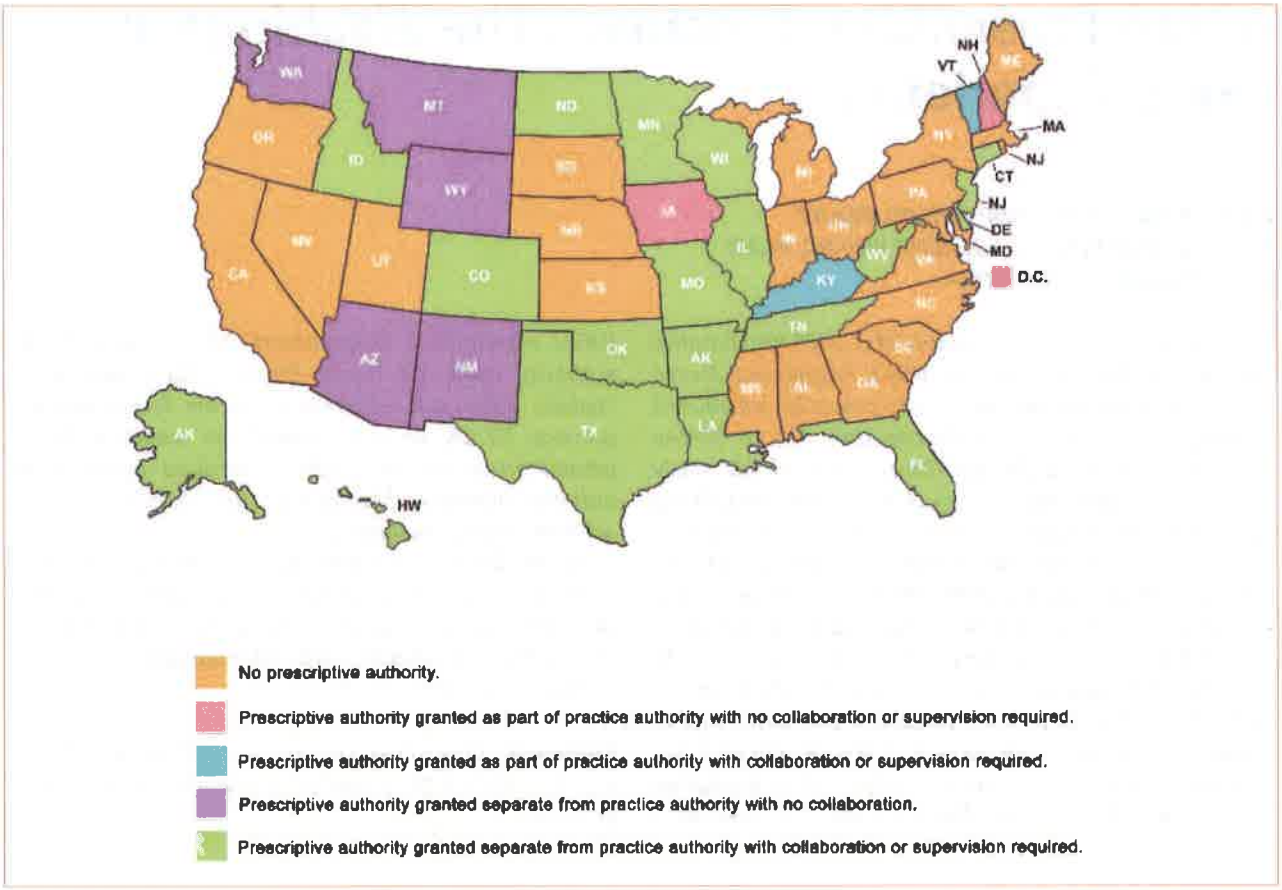

Figure. Prescriptive Authority by State for Certified Registered Nurse Anesthetists
Source: Review of the statutes and rules of each state and consultation with boards of nursing staff when needed.

CRNAs. The Figure summarizes the status of CRNA prescribing across the nation. This figure is the result of a review of the statutes and rules of each state, consultation with boards of nursing staff when clarification was necessary, and review by interested participants in several CRNA electronic mailing lists.

Twenty-two states have no prescriptive authority for CRNAs. In 2 states and the District of Columbia, prescriptive authority is granted as part of practice authority and *does not require* collaboration with or supervision by a physician. In 2 states prescriptive authority is granted with practice authority but *requires* collaboration with or supervision by a physician. Five states offer prescriptive authority separate from practice authority and have *no requirement* for physician collaboration or supervision. Nineteen states grant prescriptive authority separate from practice authority and *require* physician collaboration or supervision.

Examples of restrictive CRNA prescribing laws include prescribing only in the perioperative period in Arizona and prescribing as a delegated responsibility that requires a written agreement with a physician in Minnesota and Georgia. In contrast, CRNAs in the District of Columbia receive completely independent prescriptive authority as part of licensure. In some states, both with and without prescriptive authority, a section of the Nurse Practice Act or the administrative rules allow a CRNA to "select, order and administer" medications in the perianesthesia period. In states that do not recognize CRNAs, use of medications in the perianesthesia period is controlled by the institution.

Limitations in CRNA prescriptive authority are in part a result of interprofessional challenges between CRNAs and anesthesiologists.[5-7] To confront practice barriers, nurse anesthetists and others need data about CRNA prescribing practices.

Prescribing Medications

The definition of a prescription that results from the act of prescribing varies from state to state. A prescription may be written, verbal, or electronically submitted. Washington State law, for example, defines a prescription as "an order for drugs or devices issued by a practitioner duly authorized by law or rule in the state of Washington to prescribe drugs or devices in the course of his or her professional practice for a legitimate medical purpose."[8] Prescribing is often viewed as the act of ordering a medication for use in the outpatient setting. Prescribing may also include writing an order in a hospital (T. Fuller,

pharmacist consultant, Washington State Board of Pharmacy, written communication, January 2009).

Study Purpose

The purpose of this study was to describe Washington State CRNA prescribing practices and workforce and practice characteristics. A secondary purpose of the study was to analyze factors related to Washington State CRNAs' adoption of prescriptive authority for controlled substances II through IV.

Background of Prescriptive Authority in Washington State

Since 1973, CRNAs in Washington State have been authorized as independent advanced registered nurse practitioners (ARNPs). Beginning in 1979, ARNPs, including CRNAs, became eligible to apply for prescriptive authority for legend drugs (all prescribed medications) with the exception of controlled substances. Prescribing schedule V drugs was authorized by rule in 1982. As an alternative to prescriptive authority, a 1993 amendment to the nurse practice act codified CRNA practice that had occurred for decades. The amendment allowed CRNAs "subject to facility-specific protocols ... to select, order, or administer Schedule II through IV controlled substances being limited to those drugs that are to be directly administered to patients who require anesthesia for diagnostic, operative, obstetrical, or therapeutic procedures in a hospital, clinic, ambulatory surgical facility, or the office of a practitioner."[9]

A 2005 law authorized CRNAs to prescribe schedule II through IV controlled drugs.[10] This completed fully autonomous practice for CRNAs in Washington. In December 2004, before passage of this law, 26% of CRNAs (157 of 601) had prescriptive authority (V. Zandell, Washington State Department of Health, written communication, December 2004). At the time of this study, approximately 1½ years after passage of the law, 30.5% of CRNAs (194 of 635) had prescriptive authority, an increase of 4.5% (T. Stair, Washington State Department of Health, written communication, December 2006).

Methods

This descriptive study used survey methodology. Investigators refined and expanded an earlier questionnaire of CRNAs to create the 55-item 2006 Washington State CRNA Questionnaire. The instrument included questions about a wide range of CRNA practices. Specific sections of the questionnaire were demographic data, characteristics of CRNA practice, prescriptive authority, and prescribing practices. Validity of the instrument occurred through a process based on consultation with leaders of the Washington Association of Nurse Anesthetists who were content and clinical experts, staff from the University of Washington Center for Health Workforce studies who were content experts, and evaluation of results from earlier Washington State surveys.

After receiving institutional review board approval, the questionnaire was first mailed in late 2006 to CRNAs licensed in Washington with addresses in Washington, Oregon, and Idaho (n = 436). As a result of 3 mailings, a response rate of 65% was achieved. Analysis included descriptive statistics for all variables. Comparisons between those practicing inside and outside of Washington revealed only 1 significant difference. Respondents practicing in Washington, on average, billed fewer clinical hours compared with those who practiced outside of Washington: 28 hours for those in state and 38 for those out of state. Results are presented only for respondents who were both licensed and practicing in Washington State (n = 203).

Results

• *Demographic Characteristics.* A typical respondent was 51 years of age, white, and equally likely to be male or female. Only 6% (n = 12) were from communities of color. Approximately 50% of the sample (n = 97) responded that they were educated before 1985, and half of the sample (n = 104) reported they had plans to retire within 10 years. Demographic characteristics of the sample of 203 CRNAs are detailed in Table 1.

• *Practice Setting Characteristics.* Most respondents, 65.7% (n = 132), practiced in urban settings, whereas 17.4% (n = 35) practiced in rural areas and 16.9% (n = 34) practiced in both rural and urban settings. Slightly more than one-third of the CRNAs (34.3%) practiced full time or part time in rural areas. Respondents often worked in multiple practice settings. Approximately three-fourths (76.8%, n = 156) were in a hospital operating room; 42.4% (n = 86), in a hospital obstetrical unit; and 41.9% (n = 85), in an ambulatory surgical center. Other practice settings included dental offices, pain centers, and specialty ambulatory clinics.

Respondents were asked to report all of their practice arrangements. More than half (52.2%, n = 106) of the CRNAs were employees of a hospital, 13.3% (n = 27) were in a group practice with CRNA colleagues, and 12.3% (n = 25) were in a group practice with anesthesiologists. Solo practices were reported by 22.6% (n = 46), while 28.1% (n = 57) had "other" arrangements.

Respondents were highly experienced, with an average of 19 years as a CRNA (range, less than 1 year to 45 years). Half (n = 105) had practiced 20 or more years, and only 12.5% (n = 25) had practiced 5 or fewer years. Three-fourths of the CRNAs (75.5%, n = 162) worked full time, defined as 35 or more hours per week, and 40.8% (n = 78) reported 20 or more cases per week. Most respondents had some type of hospital privileges (87.6%, n = 177), and 57.1% (n = 116) took call.

The CRNAs were asked to indicate their 2005 CRNA-related gross income. The average salary for CRNAs working full time was $157,470. The average hourly wage

Demographic	Number	Percent
Gender		
Male	105	52
Female	97	48
Initial CRNA education		
Certificate	70	34.7
Baccalaureate program	31	15.3
Master's degree	112	55.4
On-the-job training/other	8	4
Highest educational attainment		
Associate degree	7	3.5
Diploma	16	8
Baccalaureate degree	43	21.4
Master's degree	134	66.7
Doctorate	1	< 0.01
Age, y		
Range	28-75	
Average	51	
Quartile 1: ages 28-45	48	
Quartile 2: ages 46-52	56	
Quartile 3: ages 53-57	53	
Quartile 4: ages 58-75	43	

Table 1. Demographic Profile of the Sample
Some data do not total to 203 because of unanswered questions or duplicate responses.
CRNA indicates Certified Registered Nurse Anesthetist.

was $69. Of the CRNAs, 53.7% (n = 109) were salaried. Billing mechanisms for CRNA services included the following: 26.6% (n = 54) billed by the hour, 19.7% (n = 40) billed by the unit, 10.3% billed by the case; and another 11.3% (n = 23) reported some other type of billing.

• *Prescriptive Authority.* Respondents were asked if they were aware that Washington law changed in 2005 to allow CRNAs with prescriptive authority to prescribe schedule II through IV medications. Thirteen percent of the respondents (n = 27) were not aware of the change in law. Only 30% of the sample (n = 60) had both prescriptive authority and DEA registration, which is required to prescribe controlled substances. Another 11% (n = 22) had prescriptive authority but no DEA registration and could not prescribe controlled substances.

Almost two-thirds (61%, n = 120) of the CRNAs chose not to obtain prescriptive authority. These respondents were asked to explain their reason or reasons for not obtaining prescriptive authority (Table 2). The most frequently reported reason was that the Nurse Practice Act provision to "select, order and administer medications" provided the necessary support for their practice (44.4%, n = 52). Approximately one-third (35%, n = 41) noted that they did not want to prescribe medications. Eleven percent (n = 12) relied on other providers to write prescriptions for their patients. Several of the respondents who chose "other reasons" noted they had "no need" for prescriptive authority in their practice.

Reason	Number	Percent
Use the "select, order and administer" provision of the Nurse Practice Act	52	44.4
Do not want to prescribe medications	41	35.0
Other	29	24.8
MD writes all my prescriptions	11	9.5
In process of meeting requirements for prescriptive authority	2	1.7
In process of applying for prescriptive authority	1	0.9
CRNA or other ARNP writes all my prescriptions	1	0.9

Table 2. Reasons for No Prescriptive Authority
Respondents were asked to check all that apply so cumulative percentage is >100%.
CRNA indicates Certified Registered Nurse Anesthetist; ARNP, advanced registered nurse practitioner.

Study participants were then asked: "How much do you need prescriptive authority for Schedule II-IV drugs in your clinical practice?" While most anesthetics are not controlled substances, most adjuvant medications are. The majority (52.5%, n = 106) who responded to the question indicated they had "no need" to prescribe controlled substances. Another 22.8% (n = 48) responded that they had very little need. In contrast, 8.9% (n = 18) had some or a moderate amount of need, and only 5.4% (n = 11) reported a great deal of need to prescribe schedule II through IV controlled substances. Another 10.4% (n = 21) were uncertain.

This survey also provided an opportunity to describe the medications prescribed by those CRNAs who had prescriptive authority (Table 3). Nearly all of the respondents (94.7%, n = 71) prescribed anesthetics, 60% (n = 45) prescribed nonsteroidal anti-inflammatory drugs (NSAIDs), and 53.3% (n = 40) prescribed narcotic analgesics.

Those CRNAs without prescriptive authority provide anesthesia under the Nurse Practice Act provision to select, order, and administer anesthesia under facility protocols. Two-thirds (65.3%, n = 128) reported practicing under facility protocols, and nearly one-fourth (23%, n = 45) did not know whether they had facility protocols. One-third (n = 57) of the respondents considered the potential for malpractice liability as a compelling reason to continue with facility protocols rather than using independent prescriptive authority.

Some of the respondents (11.2%, n = 19) experienced institutional barriers that prevented them from providing anesthesia and analgesia care using prescriptive authority

Medication class[a]	Number	Percent
Anesthetics	71	94.7
NSAIDs (eg, ibuprofen or naproxen)	45	60.0
Narcotic analgesics (eg, Vicodin or Percocet)	40	53.3
Benzodiazepines (eg, Xanax or Dalmane)	33	44.0
Hypnotics (eg, Ambien or Lunesta)	20	26.7
Non-narcotic analgesics (eg, Ultram or Fioricet)	18	24.0
Muscle relaxants (eg, Robaxin or Soma)	15	20.0
Other	8	8.1
Neurologics (eg, Neurontin)	4	5.3
Tricyclic antidepressants (eg, amitriptyline)	3	4.0

Table 3. Types of Medications Typically Prescribed
NSAIDs indicate nonsteroidal anti-inflammatory drugs.
[a] Generic names for brands listed are as follows: Vicodin, hydrocodone-acetaminophen; Percocet, oxycodone-acetaminophen; Xanax, alprazolam; Dalmane, flurazepam; Ambien, zolpidem; Lunesta, eszopiclone; Ultram, tramadol; Fioricet, butalbital-acetaminophen-caffeine; Robaxin, methocarbamol; Soma, carisoprodol; and Neurontin, gabapentin.

for scheduled drugs. These included hospital bylaws and malpractice insurance that did not cover CRNA prescribing. The survey also asked whether full prescriptive authority had changed the participants' practices; only 8% (n = 14) responded that it had. Benefits included enhanced independence and increased ability to meet the needs of their patients related to pain management.

Participants were asked in what ways they expected full prescriptive authority to change their future practice. Of the 120 who responded to the question, 65% (n = 78) anticipated no effect on their practice and 13.3% (n = 16) were uncertain. The CRNAs (12.7%, n = 26) who expected change envisioned benefits such as a pain management practice, independent practice, enhanced flexibility, prescribing when the surgeon was unavailable, and improvements in patient care and career mobility.

Discussion

This study contributes rich data that enhances our understanding of Washington State CRNA demographics, practice characteristics, and prescriptive authority. The analysis of CRNA prescribing (as distinct from "select, order and administer") is believed to be the first of its kind published about prescribing practices of CRNAs.

• *Workforce and Practice Characteristics.* The typical Washington State CRNA who responded to this survey was age 51 years, had an average of 19 years of experience, was employed by a hospital, took call, and performed 20 or more cases a week. More than 25% of responding CRNAs in Washington State reported a solo practice arrangement. In the state of Washington, CRNAs make a substantial contribution to access to care, particularly as 34% work full time or part time in rural areas. Half of the respondents (n = 104) indicated they planned to retire in the next 10 years. The 1 CRNA program in Washington enrolls 8 students per year, with the potential for 80 graduates in the next 10 years.[11] Careful monitoring of retirements is needed to evaluate whether current recruitment and retention continue to provide access to anesthesia care by CRNAs.

• *Prescribing Practices.* Most CRNAs were aware of the new option for full prescriptive authority with schedule II through IV medications. However, only 30% took advantage of this option and obtained prescriptive authority and a DEA number. Most respondents without prescriptive authority considered the Nurse Practice Act provision to "select, order and administer" as the foundation for their practice. In addition, respondents who "do not want to prescribe medications" seem to perceive that their current practice does not involve "prescribing." These data are consistent with the finding that three-fourths of the CRNAs perceived "no need" for prescriptive authority.

Study findings contribute new knowledge regarding the classes of medications *prescribed* by CRNAs. As expected, almost all of the respondents with prescriptive authority prescribed anesthetics. More than half of the respondents prescribed NSAIDs and narcotic analgesics. The fact that NSAIDs were prescribed slightly more often than narcotic analgesics may be attributable to a lack of DEA registration among some respondents. Alternately, NSAIDs may be a preferred drug category or the most appropriate medication for specific types of pain management. Benzodiazepines were prescribed more commonly than nonnarcotic analgesics and hypnotics. The infrequent prescribing of neurologic agents or tricyclic antidepressants, often used for chronic pain, suggests that few CRNAs may be involved in this area of practice.

• *Professional and Policy Issues in CRNA Prescribing.* Study findings about CRNA prescribing provide a basis from which to address a sensitive and potentially controversial professional issue for some CRNAs. Some CRNAs may not view autonomous prescribing as a benefit with the potential of strengthening the profession's control over itself and professional autonomy. This attitude is similar to the perspective of other advanced practice nurses who were comfortable with the status quo before legal changes.[1]

Study results suggest that many CRNAs perceive "select, order and administer" as sufficient for practice. This may result from historical challenges by anesthesiologists and restraints on CRNA practice. In many states CRNA prescriptive authority requires supervision, collaboration, or a written agreement with a physician. Possibly, CRNAs are reluctant to promote prescribing legislation

because of a concern that physicians might respond by withdrawing from collaborative arrangements.

Any CRNAs interested in autonomous prescribing could consider a variety of strategies for change, particularly collaboration with other advanced practice nurses. One example is the Washington State experience, where CRNAs obtained autonomous prescribing for controlled substances as part of a law written to benefit all advanced practice nurses.

Changing the legal environment is only one step in the process of fully autonomous prescribing. Internal barriers to adoption of autonomous prescriptive authority also need to be overcome.[1] "It is not just in action but in thought that we create autonomy for ourselves."[12] Despite the option for fully autonomous prescribing, only a small percentage of Washington State CRNAs made the transition to this new scope of practice. One contributing factor could be that some Washington State facilities have policies that are more restrictive than the law. Another contributing factor may be that CRNAs with many years of experience may be less motivated to adopt a new scope of practice that included prescribing schedule II through IV controlled substances. Analysis of CRNA socialization and education could contribute to a deeper understanding about perspectives on CRNA autonomous practice.

• *Implications for Further Research.* Research is needed to determine what barriers limit CRNAs from practicing to the full scope of their ability. Studies might seek to understand the experiences of CRNAs who are subject to Nurse Practice Act language to "select, order and administer." In addition, information about physician supervision of CRNA prescribing could provide the basis for recommendations for change in professional and public policy. Any time transition to a new scope of practice occurs, it is key to follow the implications of the changes.

Conclusion

The transition of CRNAs to a new scope of practice will take time. A study of Washington State nurse practitioners' (NPs') transition to fully autonomous prescribing identified that "NPs had to adapt their practice and use creative strategies...for providing their patients with controlled substances. This normalization process contributed to the use of old ways despite a new law."[1(p190)] The phenomenon of transition is complex and often invisible. As CRNAs face ongoing challenges to independent practice, a paradigm shift may be necessary for them to fully embrace autonomous prescriptive authority.

REFERENCES

1. Kaplan L, Brown MA. The transition of nurse practitioners to changes in prescriptive authority. *J Nurs Scholarsh.* 2007;39(2):184-190.
2. Blumenreich GA. Nurse anesthetists and prescriptive authority. *AANA J.* 1988;56(2):91-93.
3. Blumenreich GA, Stallone DR, Tobin MH. Federal drug laws and CRNAs. *AANA J.* 1990;58(4):253-254.
4. Blumenreich GA, Tobin MH. Drug Enforcement Administration midlevel practitioner regulation. *AANA J.* 1993;61(5):480-484.
5. American Society of Anesthesiologists. Recommended Scope of Practice of Nurse Anesthetists and Anesthesiologist Assistants. March 2009. http://www.asahq.org/For-Members/Advocacy/Federal-Legislative-and-Regulatory-Activities/Position-Papers/Recommended-Scope-of-Practice-of-Nurse-Anesthetists-and-Anesthesiologist-Assistants.aspx. Accessed October 29, 2010.
6. American Society of Anesthesiologists. Opposing Opt-Outs from the Medicare Supervision Requirement. March 2009. http://www.asahq.org/For-Members/Advocacy/Federal-Legislative-and-Regulatory-Activities/Position-Papers/Opposing-Opt-Outs-from-the-Medicare-Supervision-Requirement.aspx. Accessed October 29, 2010.
7. Gunn IP. Issues and perspectives affecting CRNA practice: professional identity and historical roots. *CRNA.* 1999;10(1):41-47.
8. Revised Code of Washington. Definitions. 18.64.011 (8). http://apps.leg.wa.gov/RCW/default.aspx?cite=18.64.011. Accessed February 12, 2009.
9. Revised Code of Washington. Construction. 1993 RCW 18.88.280. 1994 18.79.240 section 1(r). http://apps.leg.wa.gov/RCW/default.aspx?cite=18.79.240. Accessed February 12, 2009.
10. State of Washington. House Bill 1479. Advanced Registered Nurse Practitioners—prescription authority. http://apps.leg.wa.gov/documents/billdocs/2005-06/Pdf/Bills/Session%20Law%202005/1479.SL.pdf. Accessed February 12, 2009.
11. Gonzaga University. Master of Anesthesiology Education website. http://www.gonzaga.edu/Academics/Colleges-and-Schools/School-of-Education/Educational-Leadership-and-Administration/Master-of-Anesthesiology-Education/default.asp. Accessed June 14, 2009.
12. Kaplan L, Brown MA. What is true professional autonomy? *Nurse Pract.* 2006;31(3):37.

AUTHORS

Louise Kaplan, PhD, ARNP, FNP-BC, FAANP, is senor policy fellow in the Department of Nursing Practice and Policy at the American Nurses Association, Silver Spring, Maryland. Email: louise.kaplan@ana.org.

Marie-Annette Brown, PhD, ARNP, FNP-BC, FAAN, is a professor in the School of Nursing, University of Washington (UW), Seattle, Washington, where she is the Group Health Endowed Professor in Chronic Illness Care. She is a family nurse practitioner at the UW Medical Center Women's Health Care Clinic. Email: mabrown@u.washington.edu.

Dan Simonson, CRNA, MHPA, is a nurse anesthetist with The Spokane Eye Surgery Center, Spokane, Washington. Email: dsimonson@mac.com.

ACKNOWLEDGMENT

This research received funding through grant 672710 from the American Association of Nurse Anesthetists Foundation, Park Ridge, Illinois.

Senator Monnes-Anderson and Health Care Committee

I am writing in support of SB 136, which upon passage would provide prescriptive authority for Certified Registered Nurse Anesthetists (CRNAs). As an Anesthesiologist I have spent a good deal of my professional career working with and around CRNAs. My experience as well as modern research has shown CRNAs to be very safe, cost-effective providers of anesthesia services. Independent CRNA practice in Oregon has allowed many areas of the state to have top notch anesthesia delivery systems especially in very rural settings. This allows for a great number of routine to extremely complex surgeries to occur in Oregonians home communities, which eases the financial and social burdens for patients needing surgical intervention.

While writing prescriptions for patients receiving anesthesia care does not occur with great frequency, there are several circumstances under which being able coordinate care and provide needed medicines to patients both before and after surgery is highly beneficial to Oregonians. For example, a patient arrives for their preoperative visit and they need antibiotics, anti-anxiety medication or anti-nausea medication before their surgery. Anesthesia providers regardless of their academic credentials are the experts in this area of perioperative patient care. SB 136 would allow CRNAs to work at the level of their education and training for the good of our shrinking health care dollars and the citizens of Oregon. This would also put them on the same level as the other advanced practice nurses in our state.

In closing, I urge you to support SB 136.

Robert Montgomery MD
Board certified anesthesiologist

Senator Monnes-Anderson and Senate Health Committee,

I am writing this letter in support of SB 136. As a surgeon who continuously works closely with Certified Registered Nurse Anesthetists (CRNAs), I am very aware of their clinical skills through direct observation during the provision of anesthesia care for my surgical patients. In my opinion, CRNAs possess both the depth of skill and knowledge to prescribe needed medications before and after surgery. There are times where patients who are visiting the preoperative clinic may benefit from anti-anxiety, anti-nausea or antibiotic medicines as recommended by my CRNA colleagues. Taking care of surgical patients is a team effort and allowing prescribing authority for CRNAs makes sense for Oregonians.

Here is a recent example of how CRNA prescribing authority may improve patient care. My practice is very busy, the workday involves coordinating patients in my office, in the operating room schedule, responding to urgent and emergent surgical candidates as they enter the system. After completing a surgery, visiting with the patient and family, I returned to my office to see patients. About an hour later one of my CRNA colleagues recognized a potential corneal abrasion in our patient. (FYI: a corneal abrasion is a scratch on the surface layer of the eye which can cause severe burning pain and watery eye. Corneal abrasions have many causes, but generally occur after sleepy patients rub there eyes when emerging from anesthesia). Potential corneal abrasion recognition and conservative treatment is well established. This particular instance caused me to return to the post operative area, assess the patient and confirm the same observations of my CRNA colleague. This instance highlights the need for prescribing authority for Nurse Anesthetists.

In reality, my surgical patient would have been well served with the treatment recommendations of the CRNA in the postoperative area and my clinic patients would have been expeditiously moved through my clinic and not delayed if the CRNAs were allowed to consult with me, prescribe the needed medicines and keep the system flowing. While rare occurrences, I feel these types of patient presentations are well within the CRNA knowledge base, skill and clinical expertise.

I feel that prescribing authority for CRNAs is good for Oregonians and more specifically the patient population I care for. I urge the committee to approve SB 136.

Aaron Martin, D.O.
Asante Physician Partners
Three Rivers Medical Center
Department of Surgery