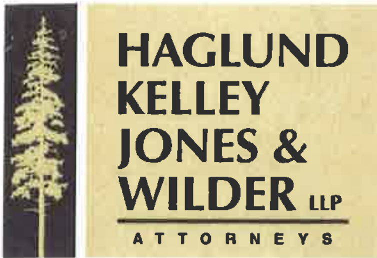

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Testimony of Julie Weis

for the Oregon Association of Nurse Anesthetists

Before the House Committee on Health Care

April 22, 2013

In support of SB 210

Chair Greenlick and Members of the Committee:

My name is Julie Weis, and I am an attorney representing the Oregon Association of Nurse Anesthetists (ORANA). ORANA has been representing Oregon nurse anesthetists for more than 70 years, and my firm Haglund Kelley has been working with ORANA since shortly after passage of the current Oregon statutes relating to the practice of nurse anesthetists 15 years ago. I urge you to support SB 210, which codifies the existing office practice of certified registered nurse anesthetists (CRNAs) throughout the state and clarifies an apparent ambiguity in the existing statutory scheme regulating CRNAs. Those statutory provisions are found at ORS §§ 678.245-.285 and referred to in this testimony as "the CRNA Statute."

SB 210 codifies CRNA office practice in Oregon. The legislation is needed because the CRNA Statute does not explicitly address office practice. Although ORANA has never viewed the CRNA Statute as being ambiguous with respect to office practice, we learned in late 2012 that some have questioned whether CRNAs should be practicing in offices in light of the CRNA Statute's silence on the issue. This is no small matter for CRNAs and the Oregonians they serve, particularly in rural communities where many practitioners rely solely on CRNAs.

Oregon nurse anesthetists have long practiced in the office setting. Oregon CRNAs practiced in the office setting before the passage of the CRNA Statute. And today, CRNAs practice in all medical care settings, including the offices of dentists, podiatrists, ophthalmologists, plastic surgeons and women's care providers. This is in addition to the hospital and ambulatory surgical center care settings.

You may wonder how we ended up with an ambiguous statutory scheme (in the eyes of some). Prior to the 1997 passage of the CRNA Statute, nurse anesthetists practiced in all settings in Oregon without any governing statute. The lack of a governing statute became

an issue in 1996 after a legal opinion (that originated from competitors) was circulated among a number of hospitals that employed independent CRNAs. The testimony from 1997 indicates the legal opinion threatened that hospitals using independent CRNAs were at risk of losing their national accreditation, and at risk of being sued over their use of independent CRNAs. Because of that cloud of legal risk, ORANA was forced to pursue legislation in 1997 to codify existing practice.

The final form of the 1997 legislation was a compromise bill endorsed by the Oregon Medical Association, the Oregon Society of Anesthesiologists, the Oregon Association of Hospitals and Health Systems and ORANA. From ORANA's perspective, the compromise bill was designed to do two main things: (1) authorize the Oregon State Board of Nursing to adopt a scope of practice for nurse anesthetists working in any setting and to promulgate rules for certifying nurse anesthetists; and (2) explicitly authorize hospitals and ambulatory surgical centers to establish at the facility level how nurse anesthetists would be employed.

Because the compromise bill singled out hospitals and ambulatory surgical centers, shortly after the legislation passed, the Assistant Attorney General advising the Oregon State Board of Nursing was asked to advise the Board of Nursing whether the CRNA Statute in some way limited the settings in which CRNAs could practice. The resulting 1998 legal opinion, which accompanies my written testimony, concluded that the compromise bill was <u>not</u> intended to limit the settings in which CRNAs may practice. Rather, the CRNA Statute authorized the Board of Nursing to establish the CRNA scope of practice, which subsequently was tied to the skill, knowledge and experience levels of individual CRNAs regardless of setting. Also accompanying my written testimony are two 1997 letters from legislators involved in the passage of the CRNA Statute confirming that the CRNA Statute was not intended to limit the settings in which CRNAs practice.

After passage of the CRNA Statute, CRNAs continued to practice in all settings, including the office setting, within the scope of their skills, knowledge and experience. It was not until late 2012 that ORANA was notified that the CRNA Statute's silence as to office practice was troublesome to some. The perceived ambiguity puts at risk Oregonians' continued access to healthcare services, particularly in rural areas served only by CRNAs. ORANA determined that the best and most expeditious way to resolve the ambiguity was to come back to you, 15-plus years after passage of the CRNA Statute, for explicit codification of CRNA office practice.

We urge you to support SB 210. Passage of SB 210 is particularly important in this era of healthcare reform, where it is essential than advanced practice registered nurses like CRNAs be able to practice to the full extent of their education and training. CRNAs are doing so now in all practice settings, and SB 210 will make clear that they can continue to serve us in the office setting.

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DEPARTMENT OF JUSTICE
GENERAL COUNSEL DIVISION

MEMORANDUM

DATE: January 28, 1998

TO: Members of the Oregon State Board of Nursing

FROM: Kimberly R. Cobrain
Assistant Attorney General

SUBJECT: Nurse Anesthetists, ORS 678.245 to 678.285 (SB 412)

During the last Board meeting, the question arose as to whether the new legislation concerning nurse anesthetists, ORS 678.245 to 678.285 ("the Act"), in some way limited the settings in which certified registered nurse anesthetists (CRNAs) may practice. This question relates to the rulemaking process currently underway to enable the Board to carry out its statutory duty under ORS 678.285(1) to establish a CRNA scope of practice. Conflicting viewpoints were expressed to the Board by members of the Advisory Committee which the Board has established to aid in the development of the rules. In response, the Board directed me to review SB 412 and provide an interpretation of the statute on this issue.

In short, both the legislative history and language of the Act reflects a codification of existing practice. The Act neither limits nor enlarges the settings in which CRNAs may practice. As is made clear in the legislative history of the bill, the purpose of the Act was to codify existing CRNA practice. Testimony presented to and relied upon by the Legislature demonstrated that existing CRNA practice encompasses a wide variety of settings and services.

As was expressed to the Legislature, different facilities, such as hospitals, clinics, and ambulatory surgical centers, use CRNAs in a variety of manners. Some hospitals, particularly rural hospitals, rely exclusively on CRNAs to provide anesthesia care. Other hospitals utilize both CRNAs and anesthesiologists. The Legislature made clear that it did not want to change the status quo with regard to the use of CRNAs and consequently left how CRNAs were to be utilized up to the individual facility as long as such use was consistent with the scope of practice established by the Board. The wording of the Act reflects this intent.

ORS 678.285 requires the Board of Nursing to adopt rules establishing, among other things, the scope of practice of CRNAs. Although this provision appears last in the Act it is in fact the starting point of understanding how the Act works..

A scope of practice is an all encompassing expression of what functions may be performed by one who has the sufficient knowledge and experience to undertake it. Not every CRNA will be able to perform every function. The individual CRNA will be limited by their own unique level of knowledge and experience. As is discussed below, individual facilities may then determine what services CRNAs provide in the facility consistent with the scope established by the Board. They may not enlarge upon the scope the Board has established. Only the Board may determine the scope. As such, the Board should develop a CRNA scope of practice that is sufficient to capture the full range of services that CRNAs provide.

The scope of practice must also be consistent with the other provisions in the Act. Of particular interest are the provisions relating to ambulatory surgical centers (ASC) and hospitals. For example, ORS 678.255(2)(d) permits CRNAs to provide necessary or routine post-anesthesia care services in ASCs without medical collaboration if no anesthesiologist is readily available. The Board may not establish a scope of practice that would preclude such services.

As stated above, both ASCs and hospitals are granted the ability to determine how CRNAs may be utilized in their particular facility. With respect to ASCs, the Act first requires that anesthesia care be provided by anesthesiologists or by CRNAs acting in medical collaboration with an anesthesiologist. ORS 678.255(1). However, if no anesthesiologist is readily available, the Act outlines the services a CRNA may provide without medical collaboration. ORS 678.255(2) and (3). Significantly, the ASC may determine what constitutes the ready availability of an anesthesiologist. ORS 678.265. By making such a determination, the ASC is actually establishing the instances in which a CRNA may provide services in its facility without medical collaboration. Again, this is left to the province of the ASC and the Board may not develop rules which would curtail that ability. The ASC, on the other hand, may not permit services which would be inconsistent with or the enlarge scope of practice established by the Board. ORS 678.265.

Hospitals are given similar latitude with regard to utilization of CRNAs. ORS 678.275 states that CRNAs may perform a variety of services outlined in subsection (1) without medical collaboration. As with ASCs, hospitals are also given the ability to define, viz a viz their own facility's rules, regulations and medical staff bylaws, whether CRNA services will be deemed independent or require the supervision or medical collaboration of an anesthesiologist. ORS 678.275(2).

It is important to remember that although the Act does grant ASCs and hospitals autonomy in its use of CRNAs, such autonomy is limited by the scope of practice established by the Board and the outline of services prescribed in the Act. Both types of facilities must make their use of CRNAs consistent with the scope established by the Board. ORS 678.265, 678.275(2). In other words, a hospital or ASC cannot authorize a CRNA to provide a service that is outside the scope set by the Board.

In summary, the Act was designed to codify existing CRNA practice. There is no evidence of legislative intent to tie the CRNA scope of practice to a limitation on the settings in which CRNAs may practice. To the contrary, the Act purposely sets up a scheme whereby ASCs and hospitals determine what services may be provided in their own facility. To achieve such flexibility, the Board should not constrict the scope of practice to a particular setting but rather to the skill, knowledge, and experience levels needed to perform the full range of functions provided by CRNAs.

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SENATOR MARYLIN SHANNON
DISTRICT 15
REPRESENTING THE HEART OF
THE WILLAMETTE VALLEY

1997-1999 COMMITTEES
Transportation, Chair
Education, Vice-Chair
Health and Human
Services

December 2, 1997

Ms. Louise Shores, RN E & D
Oregon State Board of Nursing
800 NE. Oregon St. Suite 465
Portland, Or. 97232-2162

Re : Legislative History of SB412

Dear Ms. Shores :

I understand there has been conflicting information presented to the Oregon Board of Nursing concerning the underlying intent of SB412, and the ultimate compromise that was agreed to by all concerned parties. This letter represents an effort to clarify the intent of SB412; and hopefully eliminate any misunderstandings or confusion that still exist.

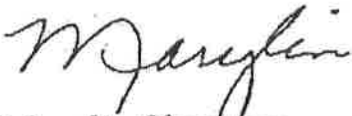
By way of brief background, I was the chief sponsor of SB412 in the '97 legislature. I was also a member of the Senate Health & Human Services Committee, that not only reviewed this bill, but also participated in the compromise which resulted in SB412-A. My fundamental goal (and that of the Committee's) throughout this entire process was to ensure that SB412 properly recognized the practice of CRNA's in Oregon; and also defined their scope of work consistent with CRNA practices that have occurred in Oregon for years. In other words, the underlying intent of SB412 was to preserve the status quo in connection with CRNA's practicing in Oregon.

During this process, the Committee intended to allow CRNA's to continue to practice independently, but also to allow hospitals, surgical centers, or other health care settings to define for themselves, how they intended to utilize CRNA's. During testimony offered in connection with both the original version of SB412, and the compromise bill; it was frequently represented that physicians or other entities--in any setting--could continue to employ CRNA's as independent practitioners, or require them to be supervised. In essence, we were attempting to simply recognize the very practices that has been employed by CRNA's for years.

Let me conclude by simply saying that a claim stating that the intent of SB412 was to somehow restrict or limit the practice of any CRNA in a manner inconsistent from how that person practiced in the past, is inaccurate.

Should you have any questions, or require any other information, please don't hesitate in contacting my office. Thank you for your time and consideration of this letter.

Sincerely yours,



Marylin Shannon
Oregon State Senator, Dist. 15

mls:jel

SUSAN CASTILLO
State Senator
DISTRICT 20

REPLY TO ADDRESS INDICATED:

☐ Oregon State Senate
Salem, OR 97310

☐ PO Box 5309
Eugene, OR 97405

Committees:
Member:
Education
Health and Human Services

OREGON STATE SENATE
SALEM, OREGON
97310

November 25, 1997

Louise Shores, RN, EdD
Oregon State Board of Nursing
800 NE Oregon Street, Suite 465
Portland, OR 97232-2162

Dear Ms. Shores and Members of the State Board of Nursing:

As a member of the Senate Health and Human Services Committee which reviewed Senate Bill 412 in the 1997 Legislative Session, I am sincerely interested in its outcome and implementation.

The intent behind SB 412 and the compromise that finally passed, was to allow nurse anesthetists to continue to practice in Oregon – in hospitals, surgical centers and physician offices - in the same manner they practice today.

The purpose of the bill was to give the Board of Nursing the authority to develop an independent scope of practice for CRNAs, but to allow hospitals and surgical centers to determine how they wanted to employ them. Today, some health care centers use CRNAs as independent providers, others require physician supervision, and others have some type of collaboration. Allowing this kind of flexibility among providers in the provision of anesthesia care has worked well in Oregon for over sixty years, and SB 412 was intended to maintain the status quo.

I would be happy to discuss the bill further with you or the Board if you have any questions.

Sincerely,

Susan Castillo
State Senator, District 20

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