Why did we go to medical school? The answer is easy: so that we could help patients from a clinical, education or research position. Sadly, government actions, and in some cases inaction, have made caring for patients a much more difficult job for each of us. Caring for patients is no longer limited to what we do in the perioperative environment; it now includes advocating on behalf of our patients and our specialty on legislative, regulatory and scope-of-practice issues.

The secret to a robust and successful advocacy program is legislators hearing the voices of physicians from home – the voices of anesthesiologists from the local office, clinic or hospital. ASA is blessed with extremely talented professionals who work in our Washington, D.C. office. They do a wonderful job advocating for our interests before the U.S. House of Representatives, U.S. Senate and federal agencies, but the most effective form of advocacy is the one-on-one communication between you and your elected official.

One of the missions of the Committee on Governmental Affairs (CGA) is to increase the involvement of individual ASA members in advocacy. We have seen tremendous growth in the number of ASA members involved in our advocacy efforts, but there is still much work to do. The “Engage 2010” grassroots campaign focused on assisting candidates and elected officials in their roles as candidates for office. ASA member participation in campaigns reached unprecedented levels, resulting in more elected officials being receptive to issues related to anesthesiology than at any point in recent memory. While this success is laudable, the dangers facing our specialty are great and we all must do more.

The 2011 “All Politics Is Local” campaign is focusing on the “official” role of a legislator. Here, we are working with a lawmaker – a government employee sworn to “preserve, protect and defend” the Constitution. The most obvious place to start is an in-district meeting because you do not have to travel to Washington, D.C. There are many ways to have this meeting. You can meet with them at their office, at your office, and you can even host them for a site visit to your hospital or surgical center.

Before you meet with your elected official, it is crucial to be prepared. ASA’s website and Washington staff can provide you with a wide range of resources. Please remember our Key Issues card with a focus on our four “Es.” Ensure fair payment, Empower patients, Expand access and Ease drug shortages. Part of being prepared is identifying what issues you want...
to address and staying on message. Lawmakers have busy schedules and generally they will spend time talking about whatever you want to talk about; however, you must keep in mind that the primary purpose of the meeting is to build a relationship and advance the issues important to anesthesiology. After you meet with the elected official or staff, it is critical that the staff in Washington D.C. know how your meeting with the elected official or staff went. You can report your advocacy activity by clicking on the “Report your advocacy activity” on www.asahq.org, by e-mailing grassroots@asawash.org or by calling (202) 289-2222.

The theme of this year’s Legislative Conference was “All Politics Is Local.” Former Speaker of the House Tip O'Neill is credited with the phrase “all politics is local.” However, it was actually told to him by his father after Speaker O'Neill’s only electoral loss early in his political career.

Every elected official has those words ingrained in his or her brain: “All politics is local.” The people at home in the district are the ones who vote and, as such, to politicians their opinions carry great weight. Smart politicians ask themselves when casting votes on bills, “How will this impact the people back home in my district?”

We, as advocates for anesthesiology, can have an incredible impact on our elected officials if we engage them at the local level — back home in their districts, our homes. The current leadership in the House of Representatives has changed the congressional calendar to allow members more time in their districts to meet with constituents. This provides us with a perfect opportunity to focus on building relationships with our elected officials right in our own backyard.

To take advantage of the extra time elected officials will be spending in the district this year, the ASA Grassroots Network launched the “Advocacy Involvement Challenge.” The Advocacy Involvement Challenge provides ASA members with 25 examples of advocacy activities that will advance our specialty. Each activity completed is worth one point. To encourage members to host an elected official or his or her staff for a site visit, the ASA Grassroots Network is awarding five points to any person who hosts a site visit. To complete this challenge and receive recognition and an award at the ASA Annual Meeting in Chicago, ASA members are asked to complete enough advocacy activities to earn “at least 10 points by October 1, 2011. So just remember “10 in 10”! Just do 10 activities in the first 10 months of this year in order to get engaged in the process and be recognized. To find a complete list of advocacy activities as well as more information on the Advocacy Involvement Challenge, please visit http://asahq.org/For-Members/Advocacy/Advocacy-Resources.aspx.

Our CGA is here to help with advocacy. Our ASA Grassroots and Key Contact programs are led by Kenneth Elmassian, D.O. (MI). This group has been working closely with our stellar ASA D.C. staff, especially Manager of Governmental and Political Affairs Chris Meekins and most recently Grassroots Program Administrator Bryan Shuy. Our Grassroots/Key Contacts database is designed to allow our members to sign up to participate in our grassroots program. This will allow our D.C. office, and state component societies, to learn about you and your advocacy activities as well as allow them to provide advocacy education information to individual members who have joined. Those ASA members with a personal relationship with legislators and/or their staff are considered to be “key contacts,” and their information and activities also need to be tracked. The beauty of this software is that it allows information to flow from Washington, D.C. and the states to individual ASA members, as well as for information to flow from individual ASA members to the state level and on to D.C. In addition, the partnership with our ASAPAC in terms of having grassroots kiosks at the PAC booth has been beneficial to all.
Our Advocacy Education taskforce has just updated our “How to Host a Site Visit Guide.” This effort has been led by Susan Dobbs Curling, M.D. (TX) and Michael Gosney, M.D. (AL).

Our “Celebration of Advocacy” (COA) task force, again partnering with our ASAPAC, brought Charlie Cook as a speaker at our ASAPAC luncheon at last year’s ASA Annual Meeting. This year they are planning for two advocacy panels, one featuring regulatory advocacy and the other featuring advocacy as a part of professionalism and thus ACGME education. This task force is lead by David Broussard, M.D. (LA).

The CGA is also involved in three other important activities within the ASA. The first activity is the selection of the Lansdale fellow. This year's fellow, the fourth in ASA history, is Scott Kercheville, M.D., a current faculty member at the University of Texas, San Antonio. Scott will take a year's leave from his academic career and train and work in a congressional office for the next year. Our CGA will be bringing forth a resolution at this year's annual meeting, at the request of ASA President Mark A. Warner, M.D., to increase the Lansdale fellowship from an every-other-year appointment to an every-year appointment. This change will increase our advocacy efforts in D.C. Our second activity is the selection of the Bertram Coffer, M.D., ASA Excellence in Government Awards, one of which will go to an ASA member, and one to a non-member. We are pleased to announce this year's recipients: David Broussard, M.D. (LA) and Rep. Eddie Bernice Johnson (TX). Congrats to both Dr. Broussard and to Rep. Johnson for their well-deserved recognition for leadership to the ASA on legislative and regulatory advocacy issues important to the medical specialty of anesthesiology! Our third activity is to be involved in the selection of our new resident scholars who do a one-month rotation working on advocacy and health policy in our D.C. office. This is also a program that we hope can increase the number of residents involved each year as a way of helping with our D.C. advocacy efforts. Articles by recent resident scholars can be found beginning on page 33.

Under the leadership of State Legislative & Regulatory Issues Manager Lisa Percy Albany, J.D., and State Affairs Assistant Carly Simpson, our CGA helped develop the topics presented at both the State Issues Forum and the State Affairs Forum at our recent annual ASA Legislative Conference in D.C. Many thanks to Lisa and Carly for arranging for very timely topics and speakers!

Our CGA would like to publicly thank our D.C. office staff for their excellent work on behalf of our specialty and for their support of our committee activities. Ronald Szabat, J.D., LL.M., Executive Vice President, Washington, D.C. and General Counsel, and Manuel Bonilla, M.S., Director of Congressional and Political Affairs, went beyond all expectations in organizing the recent Legislative Conference. Their support and contributions to our committee are critical. Chris Meekins is to be commended for his nonstop dedication to our advocacy efforts and to our committee activities. We also appreciate the help of our Park Ridge staff in assisting with our meeting arrangements and our Communications and Marketing Department with our logo, theme and materials.

In conclusion, for the protection of our patients and for our specialty to continue to move forward, we must engage with lawmakers at the local level because “all politics is local.” Hopefully by reading this brief summary of our CGA activities, you will agree that your ASA CGA is truly a Committee That Gets Advocacy!
In keeping with the theme of this year’s Legislative Conference, “All Politics is Local,” the record number of attendees not only had a chance to lobby their federal lawmakers but to also hear from individuals who provided updates on state legislative and regulatory issues. On May 2, the State Issues Forum featured an update on a number of issues at the state level from our state leaders. The State Affairs Panel, held on May 3, featured Richard Rosenquist, M.D., Chair of ASA’s Committee on Pain Medicine, and Thomas Hill, M.D., a member of the North Carolina Society of Anesthesiologists who is currently serving on the North Carolina Medical Board. Dr. Rosenquist gave a national perspective on interventional pain management issues, and Dr. Hill emphasized the importance of serving on a medical board and how medical boards can impact the specialty.

The following is a summary of state issues that ASA is tracking as of June 2011. It is not a comprehensive list of issues being tracked.

Opt-Outs

Sixteen states have opted out of the federal requirement that a physician supervise the administration of anesthesia by a nurse anesthetist. The list includes Alaska, California, Colorado, Idaho, Iowa, Kansas, Minnesota, Montana, Nebraska, New Hampshire, New Mexico, North Dakota, Oregon, South Dakota, Washington and Wisconsin.

California – In February 2010, the California Society of Anesthesiologists (CSA) and California Medical Association (CMA) sought two forms of relief from the court. Petitioners sought a motion for summary judgment and writ of mandate to direct the Governor to withdraw the opt-out. The judge in the California opt-out lawsuit issued a written order denying the petitioners motion for summary judgment and writ of mandate. The judge granted Respondent Governor Arnold Schwarzenegger’s motion for summary judgment, and the California Hospital Association’s application to file an amicus brief. CSA and CMA agreed to appeal the decision, and in April, CSA and CMA filed their opening brief in their appeal challenging Governor Schwarzenegger’s opt-out decision.

Colorado – Immediately upon learning of the opt-out, the Colorado Society of Anesthesiologists and Colorado Medical Society filed a lawsuit against the governor challenging the legality of the opt-out. In April, the Denver District Court ruled on pretrial motions and dismissed the lawsuit. The court found that the delivery of anesthesia by CRNAs is not contrary to Colorado law. The court found that “a CRNA performing what she or he has been specially trained and licensed to perform, i.e., the administration of anesthesia, is performing an independent nursing function and not a delegated medical function.” ASA is supportive of an appeal of this decision.

Nurse Anesthetist Scope of Practice

Florida – H.B. 4103 would have deleted supervision requirements for ARNPs who provide services at medical offices other than the physician’s primary office location. The Federal Trade Commission (FTC) wrote a letter of support for the bill, citing that “restrictions on the supervisory relationships between physicians and ARNPs impose costs on Florida health-care consumers.” Despite FTC’s letter, this bill died upon adjournment.

Mississippi – H.B. 605/S.B. 2860 would have removed the requirement of a collaborative relationship between nurse practitioners and physicians. Died in committee.

New Jersey – In February 2011, the Department of Health and Senior Services (DHSS) adopted regulations that provided that APNs can only administer anesthesia in accordance with a joint protocol that addresses that an anesthesiologist is: 1) available for a consultation on-site, on call, or by electronic means; and 2) is present during induction, emergence and critical change in status.

North Dakota – Enacted into law, S.B. 2148 eliminates the statutory requirement that prescriptive practices for APRNs include evidence of a collaborative agreement with a licensed physician. The bill also eliminates the requirement that the Board of Nursing consult with the medical profession in the establishment of prescriptive practice standards for APRNs.

Oklahoma – Several bills were introduced relating to scope of practice for nurse anesthetists. H.B. 1351 and S.B. 544 would have removed the requirement that nurse anesthetists be supervised by a physician. Died in committee.

Carly Simpson is State Affairs Assistant for ASA in its Washington, D.C. office.
Vermont – H.B. 358 would have created an expanded scope of practice for advanced practice registered nurses. The bill would have allowed APRNs in clinically integrated settings to perform medical acts independently under practice guidelines approved by the Board of Medicine. APRNs practicing outside of a clinically integrated setting would have been able to perform medical acts independently within a collaborative practice with a licensed physician under written practice guidelines that are mutually agreed upon between the APRN and the collaborating physician. The bill would have also required the Board of Nursing to perform two studies: 1) a comparison of the curriculum and education requirements for medical and osteopathic physicians and advance practice registered nurses and; 2) a study on the collection of baseline numbers of APRNs who are participating in solo practice in Vermont or in group practices consisting only of APRNs by location and specialty, and track changes of these through time. Died upon adjournment.

Pain

Alabama – The Alabama State Board of Medical Examiners issued a proposal that would define interventional chronic pain management as the practice of medicine, including the use of fluoroscopy and other imaging modalities when used to assess the cause of a patient’s chronic pain or to identify anatomic landmarks during interventional techniques. Further, interventional treatment of pain would only be performed by a qualified, licensed physician and it would prohibit such physician from delegating to a nonphysician the authority to utilize such procedures to diagnose, manage, or treat chronic pain patients. The Federal Trade Commission (FTC) wrote to the Alabama State Board of Medical Examiners, urging the medical board to “avoid adopting provisions that would limit the role of CRNAs in pain management more strictly than patient protection requires” and states that “absent evidence that the proposed restrictions are necessary to protect the public, there appears to be no reason to sacrifice the benefits of CRNA pain management services ....” The Alabama State Board of Medical Examiners delayed action on the proposed rule. In January 2011, ASA wrote to the FTC, educating them on the invaluable role of anesthesiologists in treating chronic pain.

Florida – Governor Rick Scott (R) proposed in his budget package to repeal the prescription drug monitoring database. The database was approved in 2009 but has not been implemented. In April, Governor Scott reversed his stance on the database and will move forward with the implementation of the database.

Georgia – Signed by the Governor, S.B. 36 establishes an electronic database of all controlled substances dispensed in Georgia pharmacies over a one-year period.

Illinois – S.B. 140 prohibits any person other than a physician from practicing interventional techniques for pain medicine. The bill defines interventional pain medicine as “the diagnosis and treatment of pain-related medical conditions primarily with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain.” In committee.

Iowa – In November 2010, Polk County District Court entered a “stay” order regarding regulations adopted by the Iowa Board of Nursing (IBN) and Iowa Department of Public Health (IDPH) that authorizes ARNPs to directly supervise the use of fluoroscopy for diagnostic or therapeutic purposes. The court concluded that “there exists a high likelihood that IDPH and IBN acted beyond their statutorily delegated authority in enacting these rules.” The stay returns the law to its position prior to IDPH and IBN’s enactment of the rules. The matter will be fully litigated during a one or two day trial expected to commence in fall 2011.

Maryland – Enacted into law, S.B. 883 establishes the prescription drug monitoring program in the Department of Health and Mental Hygiene. This bill was one of Governor Martin O’Malley’s (D) priorities.

Tennessee – H.B. 1896/S.B. 1935. The bills limit the performance of interventional pain management procedures by an APN or physician assistant (PA) in unlicensed settings. Specifically, an APN or PA may only perform invasive procedures involving any portion of the spine, spinal cord, sympathetic nerves or block of major peripheral nerves under the direct supervision of a Tennessee physician who is actively practicing spinal injections and has current privileges to do so at a licensed facility. Direct supervision is defined as being physically present in the same building as the APN at the time the invasive procedure is performed. The bill also provides that a physician may only practice interventional pain management if the licensee is either: 1) Board certified through the American Board of Medical Specialties (ABMS) in one of the following specialties: anesthesiology; neurological surgery; orthopedic surgery; physical medicine and rehabilitation; or any other board certified physician who has completed an ABMS subspecialty board in pain medicine or completed an ACGME-accredited pain fellowship; 2) a recent graduate in a medical specialty listed in 1) not yet eligible to apply for ABMS board certification; provided, there is a practice relationship with a physician or an osteopathic physician who meets certain requirements; or 3) a licensee who is not board certified in one of the specialties listed in 1) but is board certified in a different ABMS specialty and has completed a post-graduate training program in interventional pain

Continued on page 62