FILED IN DISTRICT COURT
OKLAHOMA COUNTY

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**IN THE DISTRICT COURT OF OKLAHOMA COUNTY
STATE OF OKLAHOMA**

(1) SOUTH WIND WOMEN'S CENTER LLC, D/B/A TRUST WOMEN OKLAHOMA CITY, on behalf of itself, its clinicians and staff, and its patients; and (2) COLLEEN MCNICHOLAS, D.O., on behalf of herself and her patients; and (3) BRIDGET VAN TREESE, M.S.N., APRN-CNP, on behalf of herself and her patients, Plaintiffs, v. (1) MIKE HUNTER, in his official capacity as Attorney General of Oklahoma; and (2) DAVID PRATER, in his official capacity as Oklahoma County District Attorney; and (3) LYLE KELSEY, in his official capacity as Executive Director of the Oklahoma State Board of Medical Licensure and Supervision; and (4) G. ROBINSON STRATTON, III, in his official capacity as Executive Director of the Oklahoma State Board of Osteopathic Examiners; and (5) KIM GLAZIER, in her official capacity as the Executive Director of the Oklahoma Board of Nursing; and (6) GARY COX, in his official capacity as Oklahoma Commissioner of Health, Defendants.	)	Case No. CV-2019-2506 Judge ____________

PLAINTIFFS' MOTION FOR A TEMPORARY INJUNCTION

Pursuant to 12 O.S. § 1382, Plaintiffs South Wind Women's Center LLC, D/B/A Trust Women Oklahoma City, Dr. Colleen McNicholas, and Bridget Van Treese (collectively, "Plaintiffs") hereby move this Court for a temporary injunction restraining

Defendants, their employees, agents, and successors, and all others acting in concert or participation with them, from enforcing 63 O.S. § 1-729.1 (the "Physician In-Person Law"), 63 O.S. § 1-731(A) (the "Physician-Only Law"), and related regulations (collectively, the "Challenged Laws").

1. Trust Women Oklahoma City is a healthcare facility in Oklahoma City, Oklahoma, that provides high-quality reproductive healthcare to women in underserved communities throughout Oklahoma. Dr. McNicholas is a board-certified obstetrician and gynecologist licensed to practice in Oklahoma who provides reproductive healthcare, including abortions, at Trust Women Oklahoma City. Ms. Van Treese is an Advanced Practice Registered Nurse, Certified Nurse Practitioner ("APRN-CNP") licensed to practice in Oklahoma, who provides primary care, women's healthcare, and transgender healthcare at Trust Women Oklahoma City. Plaintiffs bring claims on behalf of themselves, their clinicians and staff, and their patients.

2. In this lawsuit, Plaintiffs seek a declaration that (i) the Challenged Laws are unconstitutional special laws under the Oklahoma Constitution; and (ii) the Challenged Laws violate the due process rights of Plaintiffs and other Oklahomans.

3. Plaintiffs are entitled to a temporary injunction pending final adjudication of their claims. The basis for relief that Plaintiffs request is more fully set forth in the following documents that accompany this motion: (a) Plaintiffs' Memorandum of Law in Support of Temporary Injunction, with supporting exhibits; (b) the Affidavit of Julie Burkhart; (c) the Affidavit of Colleen McNicholas, D.O., M.S.C.I., F.A.C.O.G., with supporting exhibit; (d) the Affidavit of Bridget Ann Van Treese, M.S.N, APRN-CNP, with supporting exhibit; (e) the Affidavit of Daniel Grossman, M.D., with supporting exhibit; and (f) the Affidavit of

Joanne Spetz, Ph.D., with supporting exhibit. In sum, Plaintiffs are likely to succeed on the merits of their claims; Plaintiffs will suffer an irreparable harm if a temporary injunction is not granted; the injury suffered by the Plaintiffs outweighs any injury to the Defendants; and a temporary injunction is in the public interest.

4. Plaintiffs are available for a conference at the Court's earliest convenience.

Respectfully submitted this 8 day of Nov., 2019,

J. Blake Patton, Oklahoma Bar No. 30673
WALDING & PATTON PLLC
518 Colcord Drive, Suite 100
Oklahoma City, OK 73102
Phone: (405) 605-4440
Fax: N/A
Email: bpatton@waldingpatton.com

and

Emily B. Nestler*
District of Columbia Bar Registration No. 973886
Travis J. Tu*
New York Bar Registration No. 4326492
Kirby Tyrrell*
New York Bar Registration No. 5474531
CENTER FOR REPRODUCTIVE RIGHTS
199 Water Street, 22nd Floor
New York, NY 10038
Phone: (917) 637-3723
Fax: (917) 637-3666
Email: enestler@reprorights.org
tjtu@reprorights.org
ktyrrell@reprorights.org

**Out-of-State Attorney Applications Filed*

and

Saul B. Shapiro*
New York Bar Registration No. 2126811
Muhammad Faridi*
New York Bar Registration No. 4604187
Amy Vegari*
New York Bar Registration No. 5200886
Elizabeth Quirk*
New York Bar Registration No. 5129838
Michael Sochynsky*
New York Bar Registration No. 5320064
Jeff Kinkle*
New York Bar Registration No. 5515077
Meghan Larywon*
New York Bar Registration No. 5570536
PATTERSON BELKNAP WEBB &
TYLER LLP
1133 Avenue of the Americas
New York, NY 10036
Phone: (212) 336-2000
Fax: (212) 336-2222
Email: sbshapiro@pbwt.com
mfaridi@pbwt.com

Out-of-State Attorney Applications Filed

ATTORNEYS FOR PLAINTIFFS

EXHIBIT A

IN THE DISTRICT COURT OF OKLAHOMA COUNTY
STATE OF OKLAHOMA

(1) SOUTH WIND WOMEN'S CENTER LLC, D/B/A TRUST WOMEN OKLAHOMA CITY, on behalf of itself, its clinicians and staff, and its patients; and (2) COLLEEN MCNICHOLAS, D.O., on behalf of herself and her patients; and (3) BRIDGET VAN TREESE, M.S.N., APRN-CNP, on behalf of herself and her patients, Plaintiffs, v. (1) MIKE HUNTER, in his official capacity as Attorney General of Oklahoma; and (2) DAVID PRATER, in his official capacity as Oklahoma County District Attorney; and (3) LYLE KELSEY, in his official capacity as Executive Director of the Oklahoma State Board of Medical Licensure and Supervision; and (4) G. ROBINSON STRATTON, III, in his official capacity as Executive Director of the Oklahoma State Board of Osteopathic Examiners; and (5) KIM GLAZIER, in her official capacity as the Executive Director of the Oklahoma Board of Nursing; and (6) GARY COX, in his official capacity as Oklahoma Commissioner of Health, Defendants.	)))))))))))))))))	Case No. ____________ Judge ____________

MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY INJUNCTION

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South Wind Women's Center LLC, D/B/A Trust Women Oklahoma City, Dr. Colleen McNicholas, and Bridget Van Treese (collectively, "Plaintiffs") file this memorandum of law in support of their motion for a temporary injunction barring Defendants Mike Hunter, David Prater, Lyle Kelsey, G. Robinson Stratton, III, Kim Glazier, and Gary Cox (collectively, "Defendants") from enforcing 63 O.S. § 1-729.1 (Exhibit 1, the "Physician In-Person Law") and 63 O.S. § 1-731(A) (Exhibit 2, the "Physician-Only Law") and related regulations (together, the "Challenged Laws") pending final adjudication of this action.

PRELIMINARY STATEMENT

In two fundamental ways, the Challenged Laws violate the Oklahoma Constitution by limiting Oklahoma women's access to medication abortion, a safe and effective method of terminating a pregnancy in its early stages using prescription medication. First, both laws violate the Constitution's prohibition against special laws because they single out Oklahoma women who seek medication abortion and the clinicians who provide this care for disparate treatment without any valid justification. Second, both laws violate the substantive due process guarantees enshrined in the Constitution because they impose an undue burden on a woman's right to choose to end a pregnancy.

The first Challenged Law, the Physician In-Person Law, prohibits physicians in Oklahoma from providing medication abortions via telemedicine, a commonplace method for patients to access their healthcare provider over a secure videoconference line. Indeed, Oklahoma expressly authorizes, and has actively supported, the use of telemedicine to deliver a wide range of healthcare services and to prescribe all kinds of medications. Yet, despite overwhelming evidence that medication abortion is safe and effective whether prescribed in person or via telemedicine, Oklahoma expressly prohibits the use of telemedicine for abortion care. In fact, abortion is the ***only*** healthcare service that providers are statutorily prohibited from providing via telemedicine.

The second Challenged Law, the Physician-Only Law, prohibits Advanced Practice Registered Nurses ("APRNs") from providing medication abortions.[1] Oklahoma—like every other state—expressly authorizes APRNs to prescribe most prescription medications, and APRNs are essential healthcare providers in this state. However, for no sound medical reason, APRNs in Oklahoma are barred from providing medication abortions because the law limits abortion care to physicians only. In fact, Oklahoma permits APRNs to prescribe the ***exact same medications*** that are used in medication abortion if prescribed for non-abortion purposes.

Plaintiffs are likely to succeed in establishing that the Challenged Laws are unconstitutional both because they are unlawful "special laws" and because they violate substantive due process principles. In fact, the Oklahoma Supreme Court has repeatedly declared similar restrictions to abortion care unconstitutional. Just this year, the Oklahoma Supreme Court struck down a law that—like the laws challenged here—unduly restricted access to medication abortion. *See Oklahoma Coalition for Reprod. Justice v. Cline*, 2019 OK 33, 441 P.3d 1145 ("*OCRJ*"). Other state Supreme Courts have likewise invalidated or enjoined physician in-person and physician-only laws passed by other state legislatures. For example, the Iowa Supreme Court has held that a discriminatory ban on the use of telemedicine for medication abortions is unconstitutional. *See Planned Parenthood of the Heartland, Inc. v. Iowa Bd. Of Med.*, 865 N.W.2d

[1] Plaintiffs' request for temporary relief is limited to medication abortion because, as a result of the Physician-Only Law, no APRNs at Trust Women Oklahoma City have been trained to provide aspiration abortion at the clinic to date. However, Plaintiffs also seek declaratory and permanent injunctive relief against the Physician-Only Law's restrictions on aspiration abortion because, if that law were vacated, Plaintiff Bridget Van Treese would promptly acquire the requisite training and provide aspiration abortions in Oklahoma in due course. *See* Petition ¶ 25.

252, 269 (Iowa 2015). And, this year, the Montana Supreme Court upheld a temporary injunction barring enforcement of that state's physician-only law. *See Weems v. State of Montana*, 2019 MT 98, 440 P.3d 4 (Mont. 2019). There is no reason for this Court to rule otherwise.

Plaintiffs and their patients are suffering irreparable harm as a result of the Challenged Laws, and until a temporary injunction is granted, the Challenged Laws will continue to injure Plaintiffs and burden women's access to a safe and effective form of abortion. The State, meanwhile, will not suffer any injury from a temporary injunction, let alone injury sufficient to outweigh the ongoing deprivation of Plaintiffs' and their patients' constitutional rights. For the same reasons, a temporary injunction here would be in the public interest.

Plaintiffs' motion for a temporary injunction should be granted.

STATEMENT OF FACTS

A. Trust Women Oklahoma City

Trust Women Oklahoma City opened in September 2016. Affidavit of Julie Burkhart ("Burkhart Aff.") ¶ 1. Julie Burkhart is the founder and CEO of the Trust Women Foundation, which oversees the Oklahoma City clinic, as well as clinics in Wichita, Kansas and Seattle, Washington. *Id.* Trust Women Oklahoma City provides high-quality reproductive healthcare, including abortion care, well-woman exams, and contraceptive services. *Id.*

Trust Women Oklahoma City is a licensed "Abortion Facility" regulated by the Oklahoma State Department of Health and a member of the National Abortion Federation. *Id.* ¶¶ 6-7. Trust Women Oklahoma City is one of only four clinics in the entire state of Oklahoma where women can access abortion care. *Id.* ¶ 22. Though open five days a week, due in large part to the restrictions being challenged here, the clinic is able to provide abortion services only two days a week. *Id.* ¶ 10.

B. Medication Abortion Is Safe and Effective

Medication abortion terminates a pregnancy with a combination of two oral medications: mifepristone and misoprostol. Affidavit of Dr. Colleen McNicholas ("McNicholas Aff.") ¶ 7. It is non-invasive, requires no anesthesia, and is typically an option for women in the first 10 weeks of pregnancy as measured from the first day of a woman's last menstrual period. *Id.* ¶¶ 8-10. Medication abortion is FDA-approved as a safe and effective means of terminating pregnancy. Affidavit of Dr. Daniel A. Grossman ("Grossman Aff.") ¶ 17. A patient takes mifepristone at the clinic and takes misoprostol 24 to 48 hours later at home, after which the terminated pregnancy is expelled from her uterus. *Id.* Complications from medication abortion are extremely low, with major complications occurring in less than 0.31% of patients. *Id.* ¶ 19.

Medication abortion is the preferred method of abortion for many Trust Women Oklahoma City patients. Medication abortion allows patients to complete the abortion procedure in the privacy of their own homes. Grossman Aff. ¶ 21; Burkhart Aff. ¶ 16. It is also a safer option for women with certain medical conditions. Grossman Aff. ¶ 23. Especially for women who are survivors of sexual assault or abuse, the fact that medication abortion is non-invasive is a significant benefit. *Id.* ¶ 22.

C. Medication Abortion Prescribed Via Telemedicine Is Safe and Effective

Telemedicine is the delivery of healthcare via a secure, two-way teleconference between a patient and her healthcare provider. 36 O.S. § 6802. Oklahoma has been a pioneer in the field of telemedicine. For more than 25 years, Oklahoma has authorized and promoted the use of telemedicine to meet the healthcare needs of patients throughout the state. Grossman Aff. ¶ 32. Under Oklahoma law, telemedicine may be used for any healthcare service "that a healthcare practitioner determines to be appropriately provided by means of telemedicine." 36 O.S. § 6803.

Oklahoma law also recognizes that a doctor-patient relationship can be created via telemedicine—without any in-person encounter. 59 O.S. § 478.1. As a result, telemedicine is now widespread in Oklahoma and used to deliver a broad range of healthcare services, including addiction treatment, chronic disease management, high-risk pregnancy, oncology, radiology, and stroke treatments. Grossman Aff. ¶ 33.

Medication abortion is prescribed via telemedicine in many other states, but not in Oklahoma. *Id.* ¶ 35. This is because Oklahoma's Physician In-Person Law bars doctors from providing medication abortions unless the physician and patient are physically together in the same location. 63 O.S. § 1-729.1. Indeed, medication abortion is the ***only*** form of healthcare that Oklahoma law statutorily disqualifies from telemedicine. Grossman Aff. ¶ 34; 59 O.S. § 478.1.

There is no valid medical justification for this prohibition. Grossman Aff. ¶ 27. As demonstrated in the accompanying declaration of Dr. Daniel Grossman, an OB/GYN and highly regarded expert in that field, medication abortion is safe and effective when provided via telemedicine. *Id.* ¶¶ 26-28. A seven-year study involving over 19,000 medication abortion patients (8,765 of which were seen via telemedicine) demonstrated that medication abortion is equally safe whether prescribed in person or via telemedicine. *Id.* ¶ 28. A more recent study of patients in four states conducted over the course of a year similarly found no significant difference in terms of safety or effectiveness between in-person and telemedicine medication abortions. *Id.* ¶ 29.

Complications are exceedingly rare whether medication abortion is prescribed in person or via telemedicine. In the seven-year study discussed above, the rate of complications from medication abortion was extremely low overall (0.26%) and even *lower* (0.18%) when telemedicine was used. *Id.* ¶ 28. In fact, the risk of adverse events from medication abortion prescribed via telemedicine is comparable to the risk from common over-the-counter medications such as ibuprofen. *Id.* ¶ 31.

Leading medical organizations, including the American College of Obstetricians and Gynecologists ("ACOG"), have endorsed the provision of medication abortion via telemedicine. According to ACOG, there is no medical reason physicians must be physically present to prescribe medication abortions. *Id.* ¶¶ 26, 30. In fact, prescribing medication abortion via telemedicine can be medically *advantageous* because expanding abortion access reduces the delays that women suffer in accessing care, which reduces the risks of abortion complications. *Id.* ¶ 12; McNicholas Aff. ¶¶ 36-37.

D. APRNs Are Able to Safely and Effectively Prescribe Medication Abortion

APRNs are highly trained and skilled nurses. As explained by Dr. Joanne Spetz, a widely published expert on the role of nurses in the U.S. healthcare system, APRNs have undergone a major evolution over the past several decades in terms their education, training, and clinical standards. Affidavit of Dr. Joanne Spetz ("Spetz Aff.") ¶ 9. Today, APRNs are primary healthcare providers for many patients, and serve a critical role in the delivery of gynecological, maternity, acute, and chronic care, among others. *Id.* ¶ 10.

APRNs are essential healthcare providers in Oklahoma. More than 4,000 APRNs practice in Oklahoma across many different areas of medicine. *Id.* ¶ 47. Oklahoma law expressly authorizes APRNs to provide a wide range of services within their scope of practice, ranging from giving injections to delivering babies. *Id.* ¶¶ 49, 54. APRNs in Oklahoma are also closely regulated by the Oklahoma Board of Nursing, which ensures APRNs' qualifications and competency through licensing and disciplinary actions. *Id.* ¶ 46.

APRNs can prescribe medications in every state after obtaining the requisite authority to do so from the state. *Id.* ¶ 28. To obtain prescriptive authority in Oklahoma, APRNs must enter into an agreement with a supervising physician. *Id.* ¶ 55. APRNs may then prescribe medications within their scope of practice, with only limited exceptions. *Id.* ¶ 56. Under Oklahoma regulations, the only drugs that APRNs may not prescribe are certain especially dangerous or addictive medications that are specifically identified on the Board of Nursing's Exclusionary Formulary. O.A.C. § 485:10-16-5(a); Spetz Aff. ¶ 56. The two drugs used for medication abortion, mifepristone and misoprostol, are not included on the Exclusionary Formulary. Spetz Aff. ¶ 60.

Although APRNs provide medication abortions in several states, they are expressly prohibited from doing so in Oklahoma by the Physician-Only Law, which requires all forms of abortion to be provided by physicians only. 63 O.S. §1-731(A); Spetz Aff. ¶ 60.[2] This outmoded law was enacted in 1978, decades before medication abortion became FDA-approved and widely prescribed.

There is no valid medical justification for prohibiting APRNs from prescribing medication abortions. Numerous studies have demonstrated that APRNs can and do provide medication abortions safely and effectively. Spetz Aff. ¶ 61. Leading medical organizations, including ACOG, the American Public Health Association, and the World Health Organization, endorse the provision of medication abortion by APRNs. *Id.* ¶ 64. Moreover, APRNs in Oklahoma already prescribe medications that have comparable risks of side effects to medication abortion. Affidavit of Bridget Van Treese ("Van Treese Aff.") ¶ 21. Indeed, because mifepristone and misoprostol

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[2] Other regulations governing the provision of abortion in Oklahoma presume a physician's involvement in various aspects of abortion care. *See, e.g.*, 63 O.S. §§ 1-738k (requiring certain forms to be completed by the physician performing the abortion); 1-738.2 (requiring patients to be provided with the name of the physician performing the abortion). Plaintiffs also seek to enjoin these related regulations to the extent they would prevent APRNs from providing medication abortions.

are not on the state's Exclusionary Formulary, APRNs in Oklahoma may lawfully prescribe *these same medications* for other indications and treatments—just not for abortion. *Id.* ¶ 20; Spetz Aff. ¶¶ 58-60.

E. Harms and Burdens Inflicted by the Physician In-Person and Physician-Only Laws

The Challenged Laws are significant obstacles to abortion access on their own, and they also exacerbate the numerous barriers women must overcome to access abortion in Oklahoma.

1. Limited Abortion Access in Oklahoma

More than three-quarters of a million women of reproductive age (768,000) live in Oklahoma. Grossman Aff. ¶ 37. Yet there are only four clinics in the entire state where women can access abortion care. *Id.*; Burkhart Aff. ¶ 23.

Only a few physicians in Oklahoma are trained and willing to provide abortion care. *Id.* ¶ 22. Because hostility and violence is directed at those who provide abortion care, physicians in Oklahoma are deterred from providing abortion care out of concern for their wellbeing and the safety of their families. *Id.* ¶ 24. Physicians also choose not to provide abortion care because they fear discrimination or diminished professional opportunities due to the stigma associated with abortion. *Id.* In fact, despite extensive efforts, Trust Women Oklahoma City has been unable to hire a *single* Oklahoma physician to provide abortions. *Id.* ¶ 25. As a result, all physicians who provide abortion care at Trust Women Oklahoma City live in other states and fly into Oklahoma to provide care. *Id.* ¶ 26. Because these physicians must travel significant distances, Trust Women Oklahoma City is only able to offer abortion care two days per week. *Id.* at ¶ 27.

2. Barriers to Abortion in Oklahoma

The limited availability of abortion care in Oklahoma means that women must overcome significant barriers to obtain the care they need. Almost half (46%) of women in Oklahoma live in counties with no abortion provider, and vast swaths of the state have no abortion facility. Grossman Aff. ¶ 37. Women often must travel significant distances to access abortion care; some women in rural parts of the state are hundreds of miles from an abortion facility. Burkhart Aff. ¶ 22.

In addition to long travel distances, the lack of access to abortion care requires many Oklahomans to take time off work, risking lost wages and their employment, and to arrange for childcare, often for multiple days. Then there are the financial costs of the procedure itself. *Id.* ¶ 31; McNicholas Aff. ¶ 36. Because government funds may not be used for most abortions and health insurers rarely cover such care, women must pay for abortion care out of pocket, or seek financial assistance from private funders. Such financial obstacles are particularly difficult for poor women, who represent a substantial percentage of the clinic's patients. Burkhart Aff. ¶ 31.

Stigma, discrimination, and fear of reprisals further impair women's access to abortion care. Some of the clinic's patents seek out abortion services in secret, and must overcome the barriers to abortion without the support of a spouse, partner or family members. Women seeking abortions also encounter hostility and harassment. In fact, anti-abortion protesters routinely confront Trust Women Oklahoma City's patients when they arrive and leave the clinic. *Id.* ¶ 24. All these barriers are exacerbated by Oklahoma laws that limit when, where, and under what conditions women may obtain abortions. For example, women cannot obtain abortion care at public hospitals except in cases of rape, incest, or a life-threatening situation. *See* 63 O.S. § 1-741.1(A). The state subjects abortion facilities to regulations and licensing requirements that do not apply to other healthcare providers. *See* O.A.C. §§ 310:600. And even if they can locate an abortion provider, women in Oklahoma are subject to a state-mandated 72-hour delay period, biased counseling, and other requirements that impede abortion access. *See* 63 O.S. § 1-738.2(B).

3. The Challenged Laws' Harms and Burdens

The Challenged Laws—which prevent Trust Women Oklahoma City from administering medication abortions via telemedicine or by APRNs—are inflicting ongoing and irreparable harm on Oklahoma women and Trust Women Oklahoma City, including its physicians, APRN, and staff. Burkhart Aff. ¶¶ 19-38; McNicholas Aff. ¶¶ 30-42.

As a result of the Challenged Laws, Trust Women Oklahoma City is forced to rely on a limited pool of physicians who are willing to travel to Oklahoma from other states, and thus can only offer abortion care two days per week. Burkhart Aff. ¶ 27. Trust Women Oklahoma City is thereby frustrated in its mission to provide women in Oklahoma with accessible abortion care. *Id.* ¶ 19.

Dr. McNicholas is the medical director for the three Trust Women clinics and provides reproductive healthcare at Trust Women Oklahoma City. Bridget Van Treese is an APRN who provides primary care, women's healthcare, and transgender healthcare at Trust Women Oklahoma City. Both Dr. McNicholas and Ms. Van Treese are highly trained, dedicated clinicians who work to care for patients to the fullest extent of their skills and ability. Their ability to practice medicine and care for patients is impaired significantly by the Physician In-Person and Physician-Only Laws. Van Treese Aff. ¶ 23; McNicholas ¶¶ 30-42.

Further, the Challenged Laws each impose an undue burden on Oklahomans' right to access abortion. As discussed above, both laws limit Trust Women Oklahoma City's provision of abortion care to only two days per week, and they constrain the pool of healthcare providers who can provide such care. McNicholas Aff. ¶¶ 30, 32. The resulting limited availability of abortion services means that patients often must delay appointments by days or weeks to be at the clinic on a day when abortion care is offered and a physician is available. *Id.* ¶ 34; Burkhart Aff. ¶ 34.

Delays are exacerbated by Oklahoma's 72-hour delay requirement, which further complicates the scheduling of abortion procedures. Burkhart Aff. ¶ 35.

Delays in accessing abortion care can push some women beyond the point in pregnancy when medication abortion is available, leaving surgical abortion as their only option. This in fact happens to at least one patient per week at Trust Women Oklahoma City. Burkhart Aff. ¶ 36; McNicholas Aff. ¶ 35. Delays also expose women to unnecessary risks. Grossman Aff. ¶ 10; McNicholas Aff. ¶¶ 38, 40-42. While abortions are very safe procedures, the risks of complications increase as pregnancy progresses. Grossman Aff. ¶¶ 11-12. Furthermore, delays can inflict psychological and emotional harms on women because they are forced to remain pregnant for longer than necessary. Burkhart Aff. ¶ 37; McNicholas Aff. ¶ 39.

In addition to scheduling delays, once women arrive at the clinic, the limited availability of physicians caused by the Challenged Laws means that patients frequently must wait up to eight hours to receive a medication abortion. McNicholas Aff. ¶ 34; Burkhart Aff. ¶ 38. Such lengthy delays exacerbate the significant burdens women face related to travel, missed work, and child care. *Id.* ¶ 38. All these hardships hit poor and rural women the hardest. *Id.* ¶ 31.

If the Physician In-Person Law were enjoined, Trust Women Oklahoma City would begin offering medication abortions via telemedicine. *Id.* ¶ 40. The Trust Women clinics in Seattle and Wichita have already used telemedicine, and the equipment and protocols could be acquired and implemented in very little time. *Id.* ¶ 4. Telemedicine would allow Trust Women Oklahoma City's existing pool of physicians to provide medication abortion care on days when they cannot travel to Oklahoma, and it would make it possible for Trust Women Oklahoma City to recruit additional physicians who are willing and able to provide medication abortion to Oklahoma patients via telemedicine. *Id.* ¶¶ 40-41. Similarly, if the Physician-Only Law were enjoined, Ms.

Van Treese, who already possesses the necessary skills and training to provide medication abortions, would promptly begin offering medication abortions at Trust Women Oklahoma City. *Id.* ¶ 46; Van Treese Aff. ¶¶ 19-20. The clinic could then begin providing abortion more than two days per week, as well as on weekends and during the evening. Burkhart Aff. ¶¶ 43-44.

LEGAL STANDARD

To obtain a temporary injunction, a plaintiff "must show that four factors weigh in [its] favor: 1) the likelihood of success on the merits; 2) irreparable harm to the party seeking injunction relief if the injunction is denied; 3) [its] threatened injury outweighs the injury the opposing party will suffer under the injunction; and 4) the injunction is in the public interest." *Dowell v. Pletcher*, 2013 OK 50, ¶ 7, 304 P.3d 457, 460 (citations omitted).

While temporary injunctions are often sought to preserve the status quo, it is well established that temporary injunctions may alter the status quo "when the need is urgent and the right is clear." *Waveland Drilling Partners III-B, LP v. New Dominion, LLC*, 2019 OK CIV APP 8, ¶ 14, 435 P.3d 114, 119 (quoting *State ex rel. State Highway Commc'n v. Gillam*, 1940 OK 390, ¶ 11, 105 P.2d 773, 775); *see also Thompson v. North*, 1942 OK 346, ¶ 6, 129 P.2d 1011, 1013 (recognizing that temporary injunctions can alter the status quo under Oklahoma law); *Free the Nipple-Fort Collins v. City of Fort Collins*, 916 F.3d 792, 797 (10th Cir. 2019) (recognizing the same under federal law).

The fact that the Challenged Laws are already in effect is not grounds for denying this motion. Trust Women Oklahoma City only began operating a few years ago, and therefore could not have challenged these laws prior to their enactment.[3] And for the women whose rights are burdened by the Challenged Laws, the need is urgent regardless of when these laws were passed.

[3] The Physician-Only Law was enacted in 1978 and the Physician In-Person Law was enacted in 2012.

ARGUMENT

I. Plaintiffs Are Likely to Succeed on the Merits of Their Claims

Plaintiffs are likely to succeed on the merits of their two separate constitutional challenges to both the Physician In-Person Law and the Physician-Only Law. First, both laws are unconstitutional special laws under Article V, Section 59 of the Oklahoma Constitution because applicable general laws already govern these subjects, and these special laws are not reasonably and substantially related to any valid legislative objective. Second, both laws violate Oklahomans' right to abortion care under the Oklahoma Constitution because they both impose an undue burden on women seeking medication abortion.

A. The Challenged Laws Are Unconstitutional Special Laws

The Oklahoma Constitution provides that "[l]aws of a general nature shall have a uniform operation throughout the State, and where a general law can be made applicable, no special law shall be enacted." Art. V, § 59. The "vice" of special laws is that "they do not embrace all the class to which they are naturally related," but instead "create preferences and establish inequalities." *School Dist. No. 85 v. Sch. Dist. No. 71*, 1928 OK 689, ¶ 24, 276 P. 186, 189. The Oklahoma Supreme Court has adopted a three-pronged test for determining whether a statute is an unconstitutional special law: (1) Is the statute a special law or a general law? (2) If the statute is a special law, is a general law applicable? (3) If a general law is not applicable, is the statute a permissible special law? *Reynolds v. Porter*, 1988 OK 88, ¶ 13, 760 P.2d at 822. If a law is special under the first prong, and fails either the second or third prong, it is unconstitutional. *See Lafalier v. Lead-Impacted Cmtys. Relocation Assistance Trust*, 2010 OK 48, ¶ 33, 237 P.3d 181, 194 (stating that a law is unconstitutional under Section 59 if it is a special law and "fails one of the other two prongs"); *Nova Health Sys. v. Pruitt*, 2012 Okla. Dist. LEXIS 674, at *2 (Okla. Dist. Ct.

Mar. 28, 2012) (declaring abortion restriction an unconstitutional special law without reaching third prong of *Reynolds* test). Here, each Challenged Law fails each prong of this test.

1. The Challenged Laws Are Special Laws

"Special laws are those which single out less than an entire class of similarly affected persons or things for different treatment." *Reynolds*, 1988 OK 88, ¶ 14, 760 P.2d at 822. A law is special if it "imposes peculiar disabilities or burdensome conditions in the exercise of a common right on a class of persons arbitrarily selected from the general body of those who stand in precisely the same relation to the subject of the law." *Wall v. Marouk*, 2013 OK 36, ¶ 5, 302 P.3d 775, 779. The "shortcoming of a special law is that it does not embrace all the classes that it should naturally embrace, and that it creates preference and establishes inequality." *Id.*

All other forms of healthcare other than medication abortion may be provided via telemedicine to the extent consistent with a physician's professional judgment. But the Physician In-Person Law is a special law because it singles out medication abortion, physicians who provide medication abortion, and patients seeking medication abortion for disparate treatment. This is clear from the plain text of the statute:

> When RU-486 (mifepristone) or any other drug or chemical is used for the purpose of performing or inducing an abortion, the physician who is prescribing, dispensing, or otherwise providing the drug or chemical shall be physically present, in person, in the same room as the patient when the drug or chemical is first provided to the patient.

63 O.S. § 1-729.1. Oklahoma imposes no analogous requirement that a physician be "physically present" for any other medical procedure.[4] Medication abortion is thus the only healthcare service for which the Oklahoma legislature has seen fit to override the deference given to physicians in all

[4] Although the Oklahoma Telemedicine Act provides that a physician-patient relationship may not be established via telemedicine for the purpose of prescribing opiates, *see* 59 O.S. § 478.1, once that relationship is established in person, even opiates may be prescribed by telemedicine.

other areas of medicine. *See Cline v. Okla. Coal. For Reprod. Justice*, 2013 OK 93, ¶ 27, 313 P.3d 253, 262 (reaffirming unconstitutionality of law that "restricts the long-respected medical discretion of physicians in the specific context of abortion").

Similarly, the Physician-Only Law singles out APRNs who seek to provide medication abortion for discriminatory treatment: "No person shall perform or induce an abortion upon a pregnant woman unless that person is a physician licensed to practice medicine in the State of Oklahoma." 63 O.S. § 1-731(A). Qualified APRNs are thus prohibited from providing medication abortion, even though APRNs in Oklahoma are expressly authorized to prescribe medications and, indeed, can prescribe the exact medicines used for medication abortion as long as they do so for reasons other than abortion. Spetz Aff. ¶¶ 56, 60.

As these laws illustrate, "[a]bortion is the only area of medicine where it appears the Oklahoma Legislature has seen fit to" unconstitutionally "restrict" the "use of certain practices." *Cline*, 2013 OK 93, ¶ 27, 313 P.3d at 262 n.21. Because the Challenged Laws single out provision of medication abortion for disparate and discriminatory treatment, they are special laws under the first prong of the *Reynolds* test.

2. General Laws Are Applicable

Under the second prong, a court must determine "if the subject of the legislation is reasonably susceptible of general treatment or if . . . there is a special situation possessing characteristics impossible of treatment by general law." *Reynolds*, 1988 OK 88, ¶ 15, 760 P.2d at 822. If there is no "special situation," then it is an "invalid special law." *Orthopedic Hosp. of Okla. v. Dep't of Health*, 2005 OK CIV APP 43, ¶¶ 13, 15, 118 P.3d 216, 223. Abortion restrictions can be governed by general laws. In *Nova Health*, for example, the court found a mandatory ultrasound requirement unconstitutional because it "improperly [was] addressed to only patients, physicians and sonographers concerning abortions and [did] not address ***all*** patients, physicians and sonographers concerning other medical care," even though "a general law could clearly be made applicable." 2012 Okla. Dist. LEXIS 674, at **1-2 (emphasis added).

With respect to telemedicine, a general law not only ***could*** be made applicable, a general law ***is*** applicable: the Oklahoma Telemedicine Act. 36 O.S. §§ 6801 *et seq* (1997).[5] This statute, which generally governs the scope of the practice of telemedicine in Oklahoma, expressly authorizes the use of telemedicine for "services that a healthcare practitioner determines to be appropriately provided by means of telemedicine." 36 O.S. § 6803. This general law entrusts healthcare practitioners—not the State—with the determination as to whether a particular procedure or medication can be provided through telemedicine. There is no reason why this general law cannot govern medication abortion as well.

Oklahoma likewise has general laws governing the provision of healthcare by APRNs. Under Oklahoma law, APRNs may provide care and prescribe medicine to the full extent of their medical training to meet the needs of patients, subject to education and licensure requirements. Spetz Aff. ¶¶ 45-46. Oklahoma's general laws authorize APRNs to perform all activities within their scope of practice, including the prescription of a wide range of medications. 63 O.S. § 2-312. Although APRNs may not prescribe especially dangerous or addictive drugs that are listed on the Board of Nursing's Exclusionary Formulary, neither mifepristone or misoprostol is included on that list. In fact, an APRN acting within his or her scope of practice may prescribe both of these medications, but only if they are prescribed for non-abortion purposes.[6] There is no legitimate

[5] *See also* 59 O.S. § 478.1 (2017) (amending the Oklahoma Telemedicine Act to permit the establishment of physician-patient relationships via telemedicine encounters).

[6] Mifepristone may be prescribed to treat high blood sugar for patients with Cushing's syndrome, and misoprostol is used to prevent stomach ulcers, induce labor, manage a miscarriage, or treat a postpartum hemorrhage. Spetz Aff. ¶ 58.

reason why medication abortion should not be governed by the general laws applicable to APRNs' prescriptive authority.

In short, the provision of medication abortion via telemedicine or by APRNs does not present a "special situation" that makes application of Oklahoma's already-existing general laws "impossible." *Reynolds*, 1988 OK 88, ¶ 15, 760 P.2d at 822. Accordingly, both of the Challenged Laws fail the second prong of the *Reynolds* test and should be enjoined for that reason alone. *See Nova Health*, 2012 Okla. Dist. LEXIS 674, at *2 (declaring abortion restriction an unconstitutional special law because "a general law could clearly be made applicable").

3. The Challenged Laws Serve No Valid Legislative Objective

Even if no general laws applied, the Challenged Laws are also unconstitutional because they fail the third prong of the *Reynolds* test. For a statute to be a "permissible special law" under the third prong, it must be "reasonably and substantially related to a valid legislative objective." *Reynolds*, 1988 OK 88, ¶¶ 13, 16, 760 P.2d at 822. The State can make no such showing here. "For a special law to be permissible, there must be some distinctive characteristic warranting different treatment and that furnishes a practical and reasonable basis for discrimination." *Grant v. Goodyear Tire & Rubber Co.*, 2000 OK 41, ¶ 10, 5 P.3d 594, 598. Absent any "distinctive characteristic" providing a "real basis for discrimination," "the distinction becomes arbitrary and without relation to the subject matter." *Id.* Such special laws "cannot withstand constitutional scrutiny." *Id.*

The Challenged Laws are not reasonably or substantially related to a valid legislative purpose. Indeed, when enacting the Physician In-Person Law, the legislature produced no "legislative declaration supported by documented findings" linking the statute to ***any*** legislative objective. *Reynolds*, 1988 OK 88, ¶ 25, 760 P.2d at 822. And there was no legislative declaration linking the Physician-Only Law to ***any*** legislative objective.[7]

Nor can the State provide any post hoc rationalization for the Challenged Laws, as neither serves any valid medical purpose. Medication abortion is one of the safest outpatient procedures in contemporary medical practice. The scientific evidence shows that medication abortion is just as safe and effective when provided via telemedicine or by an APRN as when prescribed in person by a physician: multiple studies have shown that complication rates are extremely low for medication abortion—approximately 0.25%—regardless of whether the procedure is performed in person, via telemedicine, or by an APRN. Grossman Aff. ¶¶ 17-19, 26-29; Spetz Aff. ¶¶ 61-67.[8] Drugs such as penicillin and Viagra, which may be prescribed via telemedicine or by APRNs, present far greater risks than medication abortion. Grossman Aff. ¶ 31. Leading medical groups, including ACOG, have concluded that medication abortion via telemedicine or by an APRN is just as safe as an in-person procedure administered by a physician. Grossman Aff. ¶¶ 26-29; Spetz Aff. ¶ 63. And any suggestion that the Physician-Only Law is medically necessary is fatally undermined by the fact that APRNs may lawfully prescribe mifepristone and misoprostol so long as they are not prescribed to induce an abortion. Spetz Aff. ¶¶ 55-56, 59; Van Treese Aff. ¶¶ 14-15. No "valid legislative objective" is served by singling out medication abortion and banning it in the telemedicine context, or by prohibiting APRNs from providing it.

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[7] By contrast, the Oklahoma Supreme Court has held that an abortion restriction was not an impermissible special law where the "Legislature ha[d] taken great pains to incorporate 16 legislative findings" that sought to link the law to the objective of promoting women's health. *Oklahoma Coalition for Reprod. Justice v. Cline*, 2016 OK 17, ¶ 32, 368 P.3d 1278, 1289. Under this analysis, because there are no such findings here, the special laws at issue are unconstitutional.

[8] In the rare instances when complications do arise following a medication abortion, prohibiting telemedicine or APRN provision of medication abortion would do nothing to address those complications, which occur ***after*** the patient has already left the clinic. Grossman Aff. ¶ 30.

Because the Challenged Laws are unconstitutional special laws, Plaintiffs have established a strong likelihood of success on the merits.

B. The Challenged Laws Violate Women's Constitutional Right to Abortion

The Physician In-Person and the Physician-Only Laws both clearly violate the rights of Plaintiffs' patients to access abortion under the Oklahoma Constitution. The due process protections afforded by the Oklahoma Constitution are equal to, and in some cases greater than, those guaranteed by the federal constitution. *Starkey v. Okla. Dep't of Corrs.*, 2013 OK 43, ¶ 45, 305 P.3d 1004, 1021; *see also Messenger v. Messenger*, 1992 OK 27, ¶ 17, 827 P.2d 865, 872 ("Although the state and federal due process clauses . . . have a coextensive definitional range, we are free, as a matter of state law, to afford protection to state-created rights that is more extensive than that which flows from the federal constitution."). Indeed, the Oklahoma Supreme Court recently reaffirmed that the federal Constitution sets the baseline when considering a challenge to an abortion restriction brought under the Oklahoma Constitution. *See OCRJ*, 2019 OK 33, ¶¶ 15-16, 441 P.3d 1145 (striking down law that restricted the provision of medication abortion to an "outdated" FDA-approved regimen, and reaffirming that where "the United States Supreme Court has spoken" on the right to abortion access, Oklahoma courts are "bound by its pronouncements.")[9]; *see also Oklahoma Coalition for Reprod. Justice v. Cline*, 2012 OK 102, ¶ 2, 292 P.3d 27, 27 (applying federal law to strike down abortion restriction challenged under Oklahoma Constitution). Consequently, women in Oklahoma are entitled to at least the same constitutional protections recognized under federal law.

[9] Although the Oklahoma Supreme Court stated that it was not ruling on whether the Oklahoma Constitution provides a right to an abortion, the Court's ruling compels the conclusion that Oklahoma law uses the federal abortion protections as a baseline, given that the plaintiffs in *OCRJ* sought relief solely under the Oklahoma Constitution.

For over forty years, the United States Supreme Court has held that under the due process clause of the Fourteenth Amendment, a woman has a fundamental right to terminate her pregnancy without undue interference from the State. *See Roe v. Wade*, 410 U.S. 113 (1973); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 846 (1992). Indeed, "[e]very woman in this country has a constitutionally protected right to choose whether to terminate her pregnancy before viability," and states may not impose an "undue burden" on this right. *Burns v. Cline*, 2016 OK 121, ¶ 8, 387 P.3d 348, 351; *Casey*, 505 U.S. at 876. An "undue burden exists, and therefore a provision of law is invalid, if its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability." *Id.* at 878.

The Challenged Laws fail the undue burden test because their purpose and effect are to create obstacles to abortion. As discussed above, the Physician In-Person Law and the Physician-Only Law confer no medical benefits to patients. The state's purpose in continuing to enforce laws that burden abortion access, with no corresponding benefit to patients, is constitutionally highly suspect. *See, e.g.*, *Cline v. Okla. Coalition for Reprod. Justice*, 2013 OK 93, ¶ 27, 313 P.3d 253, 262 (holding that abortion restriction limiting the availability of medication abortion was "so completely at odds with the standard that governs the practice of medicine that it can serve no purpose other than to prevent women from obtaining abortions and to punish and discriminate against those who do").

Even if the Challenged Laws had a valid purpose, it cannot seriously be disputed that they have the *effect* of imposing an undue burden on women seeking abortion care. In *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016), the United States Supreme Court clarified that a state law regulating abortion is unconstitutional if its burdens on abortion access outweigh its benefits. Subsequently, the Oklahoma Supreme Court in *OCRJ* explained that this heightened standard requires Oklahoma courts "to look at the burdens a law imposes on termination access together with the benefits the law confers." *Id.*, 2019 OK 33, ¶ 26, 441 P.3d 1145; *see also Tulsa Women's Reprod. Clinic, LLC v. Hunter*, No. 118,292 (Okla. Nov. 4, 2019) (granting temporary injunction on the basis of *Whole Women's Health* and *OCRJ*). Moreover, when balancing the law's burdens and benefits, courts may not merely defer to the state's professed rationales. Courts instead "must consider the evidence in the record—including expert evidence," to determine if the law ***does in fact*** confer those benefits, and whether they outweigh the burdens imposed by the law. *Id.*; *see also Whole Woman's Health*, 136 S. Ct. at 2311, 2318 (concluding based on the evidence that "there was no significant health-related problem that the new law helped to cure," and that nothing in the "record evidence" showed that the "new law advanced [the State's] legitimate interest in protecting women's health.").

The Oklahoma Supreme Court has repeatedly declared abortion restrictions unconstitutional under this standard. *See Burns v. Cline*, 2016 OK 121, ¶ 18, 387 P.3d 348, 353 (holding that admitting privileges requirement for physicians imposed an undue burden on patients' abortion access because "the record evidence before this Court fails to persuade us that [the law] does anything to advance or protect women's health"); *Nova Health v. Pruitt*, 2012 OK 103, 292 P.3d 28 (same with respect to a law compelling physicians to narrate ultrasound results to abortion patients). Because the results here should be no different, Plaintiffs have a strong likelihood of success.

On the benefits side of the balancing test, the Iowa Supreme Court previously determined that state laws prohibiting the provision of medication abortion via telemedicine confer virtually no benefits to patients. *See Planned Parenthood of the Heartland, Inc. v. Iowa Bd. Of Med.*, 865 N.W.2d 252 (Iowa 2015). The Montana Supreme Court similarly affirmed an injunction barring enforcement of that state's physician-only law in recognition of APRNs' established track record of performing safe and legal abortion care. *Weems v. State of Montana*, 2019 MT 98, 440 P.3d 4 (Mont. 2019); *see also Planned Parenthood of the great Nw. & Hawaiian Islands v. Wasden*, 2019 U.S. Dist. LEXIS 124808, at *6 (D. Idaho July 24, 2019) (denying motion to dismiss challenge to Idaho's physician-only law where plaintiff alleged that abortion care was "well within [APRNs] clinical purview otherwise allowed under Idaho law").[10] The scientific evidence demonstrating the lack of benefits conferred by these laws in Oklahoma is no less compelling. To the contrary, evidence confirming the safety and efficacy of medication abortion delivered by telemedicine and APRNs continues to mount. Grossman Aff. ¶¶ 26-30; Spetz Aff. ¶¶ 61-67.

Given the absence of any medical benefits, even a modest showing on the burdens side of the balancing test would render the Challenged Laws unconstitutional. *See Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 798 (7th Cir. 2013) ("The feebler the medical grounds, the likelier the burden, even if slight, to be 'undue' in the sense of disproportionate or gratuitous."); *Planned Parenthood Ariz., Inc. v. Humble*, 753 F.3d 905, 917 (9th Cir. 2014) (affirming preliminary injunction of abortion restriction based on "non-existent" medical grounds). Here, the burdens that the Challenged Laws impose on patients' abortion access far exceed that threshold. The Challenged Laws sharply limit the number of medical providers who provide medication abortion in this state, and they constrain the number of days when Trust Women Oklahoma City is able to offer such care. Burkhart Aff. ¶¶ 25-30. As a result, patients seeking medication abortion

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[10] Two decades ago, in *Mazurek v. Armstrong*, 520 U.S. 968 (1997), the Supreme Court declined to strike down Montana's physician-only law, but that decision is not controlling here. The plaintiffs in *Mazurek* challenged the law solely on the ground that it had an improper purpose. Here, Plaintiffs have demonstrated that the effect of the Challenged Laws is to impose an undue burden. *See Wasden*, 2019 U.S. Dist. LEXIS 124808, at *11-14 (holding that *Mazurek* does not control where a plaintiff alleges facts demonstrating an undue burden).

face delays in accessing care, longer wait times, and numerous other obstacles. *Id.* ¶¶ 30, 33-35, 38. These delays have also pushed approximately one patient per week at Trust Women Oklahoma City beyond the limited 10-week timeframe when a medication abortion is available. *Id.* ¶ 36. In those circumstances, the Challenged Laws altogether preclude women from accessing an abortion method that they may prefer or that may be medically indicated for them. Grossman Aff. ¶¶ 21-23. These burdens vastly outweigh the non-existent health benefits these laws supposedly confer.

II. Absent Relief, Plaintiffs and Patients Will Continue to Suffer Irreparable Harm

Under Oklahoma law, injury is irreparable where "it is incapable of being fully compensated for in damages or where the measure of damages is so speculative that it would be difficult if not impossible to correctly arrive at the amount of the damages." *Edwards v. Bd. of Comm'rs of Canadian Cty.*, 2015 OK 58, ¶ 29, 378 P.3d 54, 63. Because damages are inadequate or difficult to ascertain for a constitutional violation, a "threatened deprivation of a constitutional right is itself irreparable harm, and … no further showing of irreparable harm is required." *Nova Health Sys. v. Pruitt*, 2015 Okla. Dist. LEXIS 1045, at *10 (Okla. Dist. Ct. Oct. 28, 2015); *see also Planned Parenthood Ass'n of Utah v. Herbert*, 828 F.3d 1245, 1264 (10th Cir. 2016) (a constitutional violation, "standing alone, gives rise to an irreparable injury" because "'[d]amages would [likely] be inadequate or difficult to ascertain.'") (citation omitted).

Enforcement of the Challenged Laws, which violate Plaintiffs' constitutional rights, is causing and will continue to cause irreparable harm if their enforcement is not enjoined. Were it not for these laws, Trust Women Oklahoma City would expand the number of days on which abortion care is provided, and could also begin providing care on the weekends and during the evening. Burkhart Aff. ¶¶ 43-46. Wait times would also decrease by several hours. Burkhart Aff. ¶ 48. This expanded schedule would alleviate the irreparable harm currently imposed on women who have difficulty making a weekday appointment (or who cannot commit an entire day to the appointment) as a result of work, childcare, and/or other obligations. Burkhart Aff. ¶¶ 30-31.[11] Courts have repeatedly found similar restrictions on access to abortion to cause irreparable harm. *See, e.g., Nova Health*, 2015 Okla. Dist. LEXIS 1045, at *11 ("Because Plaintiff's challenges to [various abortion restrictions] allege a violation of constitutional rights, this Court finds that Plaintiff has established a threat of irreparable harm should the acts be enforced."); *Planned Parenthood of Ind. & Ky., Inc. v. Adams*, 937 F.3d 973, 990 (7th Cir. 2019) ("When an alleged deprivation of a constitutional right is involved . . . most courts hold that no further showing of irreparable injury is necessary.'" (citations omitted)); *Planned Parenthood of Minnesota, Inc. v. Citizens for Community Action*, 558 F.2d 861, 867 (8th Cir. 1977) ("Planned Parenthood's showing that the ordinance interfered with the exercise of its constitutional rights and the rights of its patients supports a finding of irreparable injury.").

III. The Balance of Equities Weighs in Plaintiffs' Favor and a Temporary Injunction Serves the Public Interest

In order to obtain a temporary injunction, "the threatened injury to the moving party must also outweigh the injury the opposing party will suffer under the injunction." *Edwards*, 2015 OK 58, ¶ 30, 378 P.3d at 63. Protecting constitutional rights undeniably serves the public interest. *See Entertainment Merchs. Ass'n v. Henry*, 2006 U.S. Dist. LEXIS 74186, at *9 (W.D. Okla. Oct. 11, 2006) (A defendant does not suffer harm "when it is prevented from enforcing an unconstitutional statute because it is always in the public interest to protect [constitutional] liberties.") (citation omitted).

[11] The provision of medication abortion via telemedicine and APRNs would also reduce costs for patients. Plaintiffs anticipate that telemedicine and APRN procedures will cost approximately $100 less than a medication abortion provided in person. Burkhart Aff. ¶ 50.

Here, Defendants face no risk of injury from a temporary injunction. An injunction would not impose any affirmative obligation, administrative burden, or cost upon Defendants. Defendants would merely be prevented from enforcing an unconstitutional statute. As courts have repeatedly held when enjoining abortion restrictions, because the ongoing injury to Plaintiffs' constitutional rights far outweighs any hypothetical harm to Defendants, a "temporary injunction would serve the public interest." *Nova Health*, 2015 Okla. Dist. LEXIS 1045, at *11; *see also Jackson Women's Health Org. v. Currier*, 760 F.3d 448, 458 n. 9 (5th Cir. 2014) (enjoining abortion restrictions will serve the public interest because "'[i]t is always in the public interest to prevent the violation of a party's constitutional rights.'") (citation omitted); *ACLU v. Johnson*, 194 F.3d 1149, 1163 (10th Cir. 1999) (holding that "threatened injury" to constitutional right "outweighs whatever damage the preliminary injunction may cause Defendants' inability to enforce what appears to be an unconstitutional statute").

CONCLUSION

For the foregoing reasons, the Court should grant Plaintiffs' motion for a temporary injunction of 63 O.S. § 1-729.1 (the Physician In-Person Law) and 63 O.S. § 1-731(A) (the Physician-Only Law), and related regulations.

Respectfully submitted this 8 day of Nov., 2019,

J. Blake Patton, Oklahoma Bar No. 30673

WALDING & PATTON PLLC
518 Colcord Drive, Suite 100
Oklahoma City, OK 73102
Phone: (405) 605-4440
Fax: N/A
Email: bpatton@waldingpatton.com

and

Emily B. Nestler*
District of Columbia Bar Registration No. 973886
Travis J. Tu*
New York Bar Registration No. 4326492
Kirby Tyrrell*
New York Bar Registration No. 5474531
CENTER FOR REPRODUCTIVE RIGHTS
199 Water Street, 22nd Floor
New York, NY 10038
Phone: (917) 637-3723
Fax: (917) 637-3666
Email: enestler@reprorights.org
tjtu@reprorights.org
ktyrrell@reprorights.org

**Out-of-State Attorney Applications Filed*

and

Saul B. Shapiro*
New York Bar Registration No. 2126811
Muhammad Faridi*
New York Bar Registration No. 4604187
Amy Vegari*
New York Bar Registration No. 5200886
Elizabeth Quirk*
New York Bar Registration No. 5129838
Michael Sochynsky*
New York Bar Registration No. 5320064

Jeff Kinkle*
New York Bar Registration No. 5515077
Meghan Larywon*
New York Bar Registration No. 5570536
PATTERSON BELKNAP WEBB &
TYLER LLP
1133 Avenue of the Americas
New York, NY 10036
Phone: (212) 336-2000
Fax: (212) 336-2222
Email: sbshapiro@pbwt.com
mfaridi@pbwt.com

Out-of-State Attorney Applications Filed

ATTORNEYS FOR PLAINTIFFS

EXHIBIT 1

63 Okl.St.Ann. § 1-729.1

§ 1-729.1. Physician presence for abortion inducing drugs

Currentness

When RU-486 (mifepristone) or any other drug or chemical is used for the purpose of performing or inducing an abortion, the physician who is prescribing, dispensing, or otherwise providing the drug or chemical shall be physically present, in person, in the same room as the patient when the drug or chemical is first provided to the patient.

Credits

Laws 2012, c. 170, § 1, eff. Nov. 1, 2012.

63 Okl. St. Ann. § 1-729.1, OK ST T. 63 § 1-729.1
Current with enacted legislation of the First Regular Session of the 57th Legislature (2019)

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EXHIBIT 2

Oklahoma Statutes Annotated
Title 63. Public Health and Safety (Refs & Annos)
Chapter 1. Public Health Code
Article 7. Hospitals and Related Institutions
C. Abortions

63 Okl.St.Ann. § 1-731

§ 1-731. Persons who may perform abortions--Violations--Penalty

Currentness

A. No person shall perform or induce an abortion upon a pregnant woman unless that person is a physician licensed to practice medicine in the State of Oklahoma. Any person violating this section shall be guilty of a felony punishable by imprisonment for not less than one (1) year nor more than three (3) years in the State Penitentiary.

B. No person shall perform or induce an abortion upon a pregnant woman subsequent to the end of the first trimester of her pregnancy, unless such abortion is performed or induced in a general hospital.

Credits

Laws 1978, c. 207, § 3, eff. Oct. 1, 1978; Laws 1997, c. 133, § 523, eff. July 1, 1999; Laws 1999, 1st Ex.Sess., c. 5, § 379, eff. July 1, 1999.

Notes of Decisions (10)

63 Okl. St. Ann. § 1-731, OK ST T. 63 § 1-731
Current with enacted legislation of the First Regular Session of the 57th Legislature (2019)

EXHIBIT B

IN THE DISTRICT COURT OF OKLAHOMA COUNTY
STATE OF OKLAHOMA

(1) SOUTH WIND WOMEN'S CENTER LLC, D/B/A TRUST WOMEN OKLAHOMA CITY, on behalf of itself, its clinicians and staff, and its patients; and (2) COLLEEN MCNICHOLAS, D.O., on behalf of herself and her patients; and (3) BRIDGET VAN TREESE, M.S.N., APRN-CNP, on behalf of herself and her patients, Plaintiffs, v. (1) MIKE HUNTER, in his official capacity as Attorney General of Oklahoma; and (2) DAVID PRATER, in his official capacity as Oklahoma County District Attorney; and (3) LYLE KELSEY, in his official capacity as Executive Director of the Oklahoma State Board of Medical Licensure and Supervision; and (4) G. ROBINSON STRATTON, III, in his official capacity as Executive Director of the Oklahoma State Board of Osteopathic Examiners; and (5) KIM GLAZIER, in her official capacity as the Executive Director of the Oklahoma Board of Nursing; and (6) GARY COX, in his official capacity as Oklahoma Commissioner of Health, Defendants.	)))))))))))))))))	Case No. ___________________ Judge ______________________

AFFIDAVIT OF JULIE BURKHART IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY INJUNCTION

STATE OF KANSAS)
) ss.
COUNTY OF SEDGWICK)

JULIE BURKHART, being duly sworn, deposes and says:

1. I am the founder and CEO of the Trust Women Foundation ("Trust Women"). Trust Women operates three clinics that offer high-quality reproductive health care to those in underserved communities, including abortion, transgender care, HIV/AIDS testing, well woman exams, and contraceptive services. Trust Women opened its first clinic in Wichita, Kansas ("Trust Women Wichita") in April 2013. Trust Women opened a second clinic in Oklahoma City, Oklahoma ("Trust Women Oklahoma City") in September 2016, and a third clinic in Seattle, Washington ("Trust Women Seattle") in June 2017.

2. To alleviate the obstacles to access that Oklahoma women currently face when seeking an abortion, Plaintiffs seeks a temporary injunction that would permit us to do two things currently prohibited by Oklahoma law. First, Trust Women Oklahoma City seeks to provide medication abortion using telemedicine. Second, Trust Women Oklahoma City seeks to provide in-person medication abortion under the care of Advanced Practice Registered Nurses ("APRNs").

3. I submit this affidavit in support of Plaintiffs' Motion for a Temporary Injunction to enjoin enforcement of the Oklahoma laws that stand as obstacles to the clinic's efforts to expand abortion access in these ways, including: 63 O.S. § 1-729.1 (the "Physician In-Person Law"), which I understand prohibits the use of telemedicine to provide medication abortions (among other abortion procedures); and 63 O.S. § 1-731(A) (the "Physician-Only Law") and related regulations, which I understand prohibit APRNs from providing abortions, including medication abortion.

4. Trust Women has used telemedicine to safely and effectively provide medication abortion at its clinics in Seattle and Wichita. Under the telemedicine model developed for those

clinics, the patient is physically present at the clinic, and the physician counsels the patient and administers the medication from a distant location using a confidential, two-way videoconferencing system. This model could be readily implemented at Trust Women Oklahoma City were it not for the legal obstacles erected by Oklahoma law.

5. Trust Women Oklahoma City also currently employs a highly skilled and experienced APRN. Medication abortion is within her scope of practice, meaning that she has the training and skills necessary to provide medication abortion. Medication abortion is being provided safely and effectively by APRNs in many other states. Our APRN would readily provide medication abortions were it not for the legal obstacles erected by Oklahoma law.[1]

Abortion Care at Trust Women Oklahoma City

6. Trust Women Oklahoma City has been licensed by the Oklahoma State Department of Health ("OSDH") as an Abortion Facility since the clinic opened in 2016. The clinic has expended substantial effort and resources to comply with Oklahoma's numerous and burdensome regulatory requirements on clinics that provide abortion care. OSDH has never found Trust Women Oklahoma City to be in noncompliance with Oklahoma's abortion regulations or any other laws. This is the first and only time Trust Women Oklahoma City has challenged a legal restriction on abortion care imposed by Oklahoma and OSDH.

7. All the Trust Women clinics, including Trust Women Oklahoma City, are members of the National Abortion Federation ("NAF"), the largest professional association of abortion practitioners in the United States. NAF has established clinical guidelines, which all of its members follow.

[1] I understand that APRNs in Oklahoma are not currently authorized to provide patient care of any type via telemedicine. For this reason, Trust Women Oklahoma City seeks the legal ability to provide medication abortions via telemedicine under the care of physicians, and Trust Women Oklahoma City seeks the legal ability to provide medication abortions in person under the care of APRNs.

8. Based on my experience, patients at Trust Women Oklahoma City seek abortion care for many reasons, including the following: the pregnancy is the result of sexual assault or incest; they have medical conditions or complications during pregnancy that make it dangerous for them to carry a pregnancy to term; they have received a diagnosis of a grave or lethal fetal anomaly; they are in an abusive relationship; they feel that it is not the right time in their lives to have a child; they do not have the ability to care for the child because they have other children; and/or they lack the financial resources to be a parent.

9. Regardless of the reason or reasons that a woman chooses to have an abortion, Trust Women Oklahoma City's goal is to provide this care professionally, safely, and free from judgment.

10. Trust Women Oklahoma City is open five days a week, but it is currently constrained in terms of the number of days per week that we can provide abortion care. For reasons discussed in more detail below, the clinic is usually able to provide abortion care only two days a week.

11. Trust Women Oklahoma City provides abortion care to women who are up to 21.6 weeks pregnant as measured from the first day of a woman's last menstrual period ("LMP"). However, most women who have abortions at Trust Women Oklahoma City are in the first trimester of pregnancy (less than 14 weeks pregnant LMP). In 2018, 69.7% of the clinic's abortion patients were in the first trimester.

12. Two methods of abortion are available to women in early stages of pregnancy at Trust Women Oklahoma City. The first is medication abortion, which is available to women up to 10 weeks LMP. The second is surgical abortion, which is sometimes referred to as aspiration abortion.

13. An abortion performed in the first trimester of a woman's pregnancy, whether a medication or a surgical abortion, costs a patient $650 at Trust Women Oklahoma City.

Medication Abortion at Trust Women Oklahoma City

14. Trust Women Oklahoma City provides medication abortion using a protocol approved by the U.S. Food and Drug Administration ("FDA"). This protocol involves two medications, mifepristone and misoprostol, which together result in the termination of an early pregnancy. At Trust Women Oklahoma City, the patient takes the mifepristone at the clinic, and after leaving the clinic, the patient takes the misoprostol 24 to 48 hours later, typically at home.

15. Trust Women Oklahoma City has provided medication abortion since the clinic opened in 2016. Medication abortion is a very safe and non-invasive procedure. In fact, in 2018, Trust Women Oklahoma City performed 664 medication abortions without a single reportable complication or adverse effect.[2]

16. Based on my experience, patients who choose medication abortion do so for a number of reasons. Some women prefer medication abortion because it allows them to complete the abortion in the privacy of their own homes and it gives them more control over the process. Medication abortion may also be medically preferred for women who have conditions or characteristics, such as obesity or a flexed uterus, that make a surgical abortion medically challenging. Medication abortion may also be the preferred method for survivors of sexual assault because it is non-invasive relative to surgical abortion. Other women, particularly those in abusive relationships or who fear judgment or condemnation from family or friends, may choose medication abortion because it can more easily be explained as a miscarriage.

[2] Reportable complications are those that the state requires abortion facilities to report.

Trust Women Oklahoma City's Desire to Increase Abortion Access

17. Despite the safety, efficacy, and other benefits to patients of medication abortion, Oklahoma has erected numerous legal barriers to medication abortion. Two primary barriers are the Physician In-Person Law, a legal prohibition against physicians' ability to provide medication abortions via telemedicine, and the Physician-Only Law, a legal prohibition against APRNs' ability to provide medication abortion at all. These legal barriers stand as significant obstacles to Trust Women Oklahoma City's ability to care for patients and alleviate burdens on Oklahoma women's abortion access.

18. For reasons discussed below, access to abortion in Oklahoma is limited, and, based on my experience, women often have to overcome numerous substantial obstacles to obtain abortion care. The clinic's ability to use telemedicine and APRNs to provide medication abortions would enable us to significantly expand abortion access to Oklahoma women.

A. <u>Substantial Obstacles to Abortion Access in Oklahoma</u>

19. Oklahoma's Physician In-Person and Physician-Only Laws are significant obstacles to Trust Women Oklahoma City's ability to expand abortion access. Before discussing these legal prohibitions, however, it is important to understand that the harms created by these restrictions are exacerbated by the fact that they exist against a backdrop of numerous other burdens on Oklahoma women's abortion access.

20. Oklahoma has imposed numerous laws that delay or impede women from accessing abortion care. For example, the State has imposed a mandatory waiting period for women seeking abortions, which requires a woman to wait 72 hours after receiving certain state-mandated information before she can have an abortion.

21. Oklahoma also has imposed numerous requirements on abortion facilities that make it difficult for clinics to open or stay in operation. In fact, given all the regulatory burdens, it took me more than thirty months to ensure that Trust Women Oklahoma City's clinic would be in compliance with state regulations and obtain a license from the State as an abortion facility.

22. The number of clinics in Oklahoma that provide abortion care is very small. In fact, there are only four remaining clinics in the entire state of Oklahoma where women can access abortion care. These clinics are located in Oklahoma City, Norman, and Tulsa, which means that women in most of Oklahoma's rural areas, including the entire panhandle and southwest corner of the state, do not have convenient access to an abortion provider. As a result, many women must travel hundreds of miles to reach the nearest abortion provider. In fact, at Trust Women Oklahoma City, approximately 37% of patients who seek medication abortion care live outside of the Oklahoma City metropolitan area.

23. The number of physicians who provide abortion care in Oklahoma is also very limited. Many physicians who live and trained in Oklahoma are unwilling to perform abortions due to the regulatory requirements that Oklahoma imposes on abortion providers, as well as the discrimination and harassment that abortion providers often face.

24. Physicians face discrimination within the medical profession and the local community that threatens their professional opportunities and advancement. Abortion providers also face regular harassment, as well as threatened or actual violence against them and their families. Trust Women Oklahoma City regularly has protestors outside their doors intimidating both providers and patients. This harassment causes fear and stigma for both providers and patients. The names and photographs of physicians who provide care at Trust Women Oklahoma City have been shared on anti-abortion websites. I know how dangerous these threats

can be. Before founding Trust Women, I worked for many years as an advisor to Dr. George Tiller, who provided abortion care in Wichita, Kansas. Dr. Tiller faced threats and violence, including the bombing of his clinic, throughout his career, until he was murdered in 2009 on account of his work as an abortion provider.

25. Prior to opening Trust Women Oklahoma City, I made extensive efforts to recruit Oklahoma-based physicians, but I was ultimately unable to find any local physicians who were willing to provide abortion care at the clinic.

26. To staff the clinic, Trust Women Oklahoma City relies on out-of-state physicians who fly into Oklahoma to provide abortion care. These physicians are licensed in Oklahoma but live elsewhere.

27. Due to physicians' professional and personal commitments in their home states, as well as the extensive travel time and expense required for physicians to fly in, Trust Women Oklahoma City only has physicians who perform abortions at the clinic two days per week. If a physician's flight is cancelled or delayed, travel disruptions can further limit the amount of time physicians can be at the clinic.

28. The limited schedule also means that during the two days that physicians are on-site, they often must see a large number of patients each day. Accommodating so many appointments requires physicians frequently to work very long hours.

29. It has been challenging for me to hire physicians willing and able to commit to this travel and work schedule to provide abortions at Trust Women Oklahoma City.

30. The fact that Trust Women Oklahoma City only provides abortion care two days per week is a significant hardship for many women who need our care.

31. Women seeking abortions often face significant challenges making it to an appointment due to work, childcare, family obligations, and transportation. These burdens hit hardest on low-income and poor women, which is a substantial percentage of Trust Women Oklahoma City's patients. As government funds may not be used for most abortions and health insurers rarely cover the procedure, women must pay out of pocket or seek private financial assistance. At least 29% of the clinic's patients live at or below the federal poverty line and require financial assistance to obtain an abortion.

32. These challenges are compounded by the stigma, discrimination, and fear of reprisal that already impair women's access to abortion. As noted above, women seeking abortions frequently encounter hostility and harassment, including when entering the clinic. Some of our patients seek out abortion services in secret, and must face these challenges without any support from a spouse, partner, or family member.

33. All these burdens are made more difficult and complicated by the fact that Trust Women Oklahoma City is only able to provide abortion care two days per week. For example, because Trust Women Oklahoma City is unable provide abortion care on weekends, a woman who works normal business hours has no choice but to miss work. Patients who lack reliable access to transportation are also disadvantaged by the clinic's limited hours, and may have to borrow a car from a friend, or pay for a taxi or bus, in order to reach the clinic on the date of their appointment.

34. The difficulty women face in overcoming and accommodating these burdens frequently delays their abortion procedures. Some women may be able to rearrange work, childcare or transportation in time to get to the clinic in a week or two, but for other women, the delays can extend for several weeks.

35. Oklahoma's 72-hour mandatory waiting period, which requires a patient to wait 72 hours between receiving state-mandated counseling and having an abortion, compounds these scheduling challenges.

36. Delays in a woman's ability to access abortion can push women beyond the point when they can even have a medication abortion. Medication abortion, as discussed above, is available to women in the first 10 weeks of pregnancy. At Trust Women Oklahoma City, we see approximately one patient per week who would otherwise have medication abortion but is pushed beyond the 10-week timeframe as a result of scheduling difficulties.

37. Delays in a woman's ability to access abortion care also can be harmful in other ways. Though abortion is an extremely safe medical procedure, the risks do increase as the pregnancy progresses. Pregnancy is also uncomfortable or painful for some women, so delay extends this experience. Delays also increase the stress and burdens of maintaining an unwanted pregnancy. This is particularly true for women who have a disease or other medical condition that makes pregnancy a significant health risk or who are pregnant as a result of sexual assault or incest. Delays are also problematic for women who wish to keep their abortion decision private.

38. The limited number of providers and hours of operation also leads to burdens for women once they reach the clinic. On any given day when abortion care is provided, the clinic is likely to see between 30 and 60 patients. Clinic procedures are highly regimented in order to control the flow of patients and ensure that each patient receives the individualized care and attention they deserve. Even so, due to the high demand for our services, it is not uncommon for patients to experience wait times up to 4-8 hours once they arrive at the clinic. Wait times on occasion can be even longer. These long wait times exacerbate the burdens patients face related to work, childcare, and other obligations.

B. Telemedicine and APRNs Would Enable Trust Women Oklahoma City to Overcome Existing Obstacles to Abortion Access

39. Against this backdrop of highly constrained abortion access in Oklahoma, the Physician In-Person and Physician-Only Laws stand as significant obstacles in Trust Women Oklahoma City's ability to care for patients and alleviate burdens on Oklahoma women's abortion access.

40. Were it not for the Physician In-Person Law, Trust Women Oklahoma City would move quickly to integrate telemedicine into its operations. We have provided this service at other Trust Women clinics, so we have the necessary protocols and technology. We have existing relationships with several Oklahoma-licensed out-of-state physicians who are trained and who have already expressed interested in providing medication abortion using telemedicine.

41. I would also be able to recruit more physicians to the clinic. I am confident that there are additional doctors who would be willing and able to care for patients in Oklahoma via telemedicine who, due to their existing professional and family commitments and the burdens associated with travel, are not able or willing to travel to Oklahoma.

42. If not for the Physician-Only Law, I would quickly integrate APRNs into the provision of medication abortions at Trust Women Oklahoma City. We already employ an APRN who is fully trained in medication abortion and ready to provide, so this would also be a straightforward expansion of our abortion care.

43. The clinic's ability to use telemedicine and APRNs to provide medication abortions would enable the clinic to significantly expand access.

44. Telemedicine would allow us to expand the number of days in which we offer abortion care. We currently can only provide care two days per week. Once telemedicine is operational, we would begin by offering abortion care at least three days per week and eventually

expand to more days per week. We plan to offer medication abortions via telemedicine on Saturdays to increase access for women who are unable to make a weekday appointment.

45. Telemedicine would allow us to expand our hours of operation. We currently schedule appointments between 9 AM and 5 PM. With telemedicine, we could add evening hours to meet the needs of patients who are unavailable during the day.

46. Utilizing our APRN for medication abortions also would allow us to offer in-person medication abortions more than just two days per week. If our APRN were lawfully permitted to provide medication abortions, we could offer medication abortion appointments on the three days she is already in the clinic, and potentially even expand the time she spends at the Oklahoma City clinic.

47. Expanding our days and hours would have a significant impact on women's ability to access abortion care in Oklahoma. This expanded schedule would enable Trust Women Oklahoma City to provide abortion care to women who are otherwise unable to visit the clinic on those two days or during normal business hours, thus alleviating the burdens described above.

48. Expanded appointment scheduling would also significantly reduce wait times for women seeking medication abortions. Based on our experience at other Trust Women clinics, we anticipate that wait times for medication abortion via telemedicine would be reduced from up to eight hours to two hours or less.

49. Offering medication abortions on other days and times would also improve wait times for all abortion patients. If medication abortions can be scheduled on other days, there will be fewer patients on the two days physicians are on-site, thereby lowering wait times. The burden of having to spend an entire day at the clinic, which requires patients to take additional

time off from work or school or obtain significant hours of child care, will be greatly reduced, if not eliminated entirely. Fewer patients on days when physicians are on-site also would relieve pressures on the physicians and reduce the frequency that they are required to work long hours.

50. By providing medication abortions via telemedicine and APRNs, we would also be able to lower the price of these medication abortions at Trust Women Oklahoma City from \$650 to \$550. I believe this would ease some of the burden on our patients, many of whom are low-income.

51. For these reasons, both the Physician In-Person and Physician-Only Laws are inflicting ongoing harm on Plaintiffs and their patients. These laws are also constraining abortion access for women in Oklahoma. If these laws are enjoined, Trust Women Oklahoma City would be able to alleviate these harms and burdens by providing medication abortion via telemedicine and through APRNs.

Signed this 5 day of Nov 2019

Julie Burkhart

Sworn to before me this 5th day of November 2019

NOTARY PUBLIC

OFFICIAL SEAL
LINDA DODDS
MY APPOINTMENT EXPIRES
Date 9-29-23

EXHIBIT C

IN THE DISTRICT COURT OF OKLAHOMA COUNTY
STATE OF OKLAHOMA

(1) SOUTH WIND WOMEN'S CENTER LLC, D/B/A TRUST WOMEN OKLAHOMA CITY, on behalf of itself, its clinicians and staff, and its patients; and
(2) COLLEEN MCNICHOLAS, D.O., on behalf of herself and her patients; and
(3) BRIDGET VAN TREESE, M.S.N., APRN-CNP, on behalf of herself and her patients,

Plaintiffs,

v.

(1) MIKE HUNTER, in his official capacity as Attorney General of Oklahoma; and
(2) DAVID PRATER, in his official capacity as Oklahoma County District Attorney; and
(3) LYLE KELSEY, in his official capacity as Executive Director of the Oklahoma State Board of Medical Licensure and Supervision; and
(4) G. ROBINSON STRATTON, III, in his official capacity as Executive Director of the Oklahoma State Board of Osteopathic Examiners; and
(5) KIM GLAZIER, in her official capacity as the Executive Director of the Oklahoma Board of Nursing; and
(6) GARY COX, in his official capacity as Oklahoma Commissioner of Health,

Defendants.

Case No. ___________________

Judge ______________________

AFFIDAVIT OF COLLEEN MCNICHOLAS IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY INJUNCTION

STATE OF MISSOURI)
) ss.
COUNTY OF FRANKLIN)

COLLEEN P. MCNICHOLAS, hereby declares, under penalty of perjury, that the following statements are true and correct:

1. I am an obstetrician and gynecologist certified by the American Board of Obstetrics and Gynecology since 2014. I am licensed to practice in Oklahoma, Missouri, Kansas, Illinois, and Washington. I completed my residency in obstetrics and gynecology at Washington University School of Medicine in St. Louis, Missouri in 2011. I then completed a two-year fellowship there in family planning. My curriculum vitae, which sets forth my experience and credentials more fully, is annexed hereto as Exhibit 1.

2. I am currently the Medical Director of Trust Women Oklahoma City, Trust Women Wichita, and Trust Women Seattle. At Trust Women Oklahoma City and Trust Women Wichita, I provide a spectrum of reproductive health care, including medical and aspiration abortion in the first trimester, second-trimester abortion, and contraceptive care.

3. I am also the Chief Medical Officer at Planned Parenthood of the St. Louis Region and Southwest Missouri, where I oversee and manage the provision of reproductive health care at Planned Parenthood clinics across the region.

4. I have held various teaching positions, including most recently as Associate Professor at the Washington University School of Medicine's Department of Obstetrics and Gynecology's Division of Family Planning, where I continue to serve as a voluntary community faculty member. I have previously served as the Director of the Ryan Residency Program at Washington University, and later, as the Director of a collaborative effort between Oklahoma

University and the Washington University School of Medicine to provide academic and simulated training in the topics of abortion, uterine evacuation, and family planning for residents in obstetrics and gynecology. Prior to my departure from Washington University, I was the Assistant-Director of the Family Planning Fellowship at Washington University. Through my various academic roles, I have taught numerous medical students and have trained nearly 250 residents and fellows in family planning.

5. I submit this declaration in support of Plaintiffs' Motion for a Temporary Injunction to enjoin enforcement of: (i) 63 O.S. § 1-729.1 (the "Physician In-Person Law"), which I understand prohibits the administration of medication abortion by use of telemedicine; and (ii) 63 O.S. § 1-731(A) (the "Physician-Only Law") and related regulations, which I understand prohibit the administration of medication abortion by qualified and licensed advanced practice registered nurses ("APRNs") (collectively, the "Challenged Laws").

6. If not for the Challenged Laws, Trust Women Oklahoma City would be able to safely and effectively perform medication abortions via telemedicine and APRNs. By prohibiting these practices, the Challenged Laws detrimentally impede patient access to care without any corresponding benefit to patient health.

I. Abortion Generally

7. In my experience, abortion is one of the safest and most common medical procedures in contemporary medical practice. Complications arising from abortions are extremely rare. Complication rates for abortion are lower than those for colonoscopies, plastic surgery, and adult tonsillectomies.

8. First trimester abortions are performed either by medication or by aspiration. An

aspiration abortion is accomplished through suction and/or instruments to evacuate the contents of the uterus, but it requires no cutting or incision. Aspiration abortion may involve the use of anesthesia or sedation.

9. Medication abortion involves terminating a pregnancy, non-surgically and non-invasively, through a combination of two prescription medications: mifepristone and misoprostol. Mifepristone works by blocking the hormone progesterone, which is necessary to maintain pregnancy. Misoprostol then causes the uterus to contract and expel its contents, generally within hours, thereby completing the abortion. Medication abortion requires no anesthesia or sedation.

10. At Trust Women Oklahoma City, medication abortion is currently available through 10 weeks of pregnancy, as measured by best obstetric dating from the first day of the last menstrual period ("LMP") or ultrasound if last menstrual period is unknown.

11. In my experience, many people in the first ten weeks of pregnancy prefer medication abortion over aspiration abortion for various reasons. One reason patients prefer medication abortion is because it allows them to complete the process in the privacy of their homes, with the company of loved ones, at a time of their choosing.

12. Patients also prefer medication abortion over aspiration abortion because it enables them to avoid a procedure involving invasive instrumentation. Survivors of rape, sexual abuse, or molestation in particular may choose medication abortion to avoid retraumatization from having instruments placed in their vagina.

13. Medication abortion also may be a preferred option over aspiration abortion for individuals with certain medical conditions. These conditions include anomalies of the

reproductive and genital tract, such as large uterine fibroids, female genital mutilation, vaginismus, or cervical stenosis, as well as severe obesity or an extremely flexed uterus, all of which may make it more difficult to access the pregnancy inside the uterus by routine measures as part of an aspiration abortion.

II. The Provision of Medication Abortion through Telemedicine

14. Telemedicine is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, and information across distance. Telemedicine has been widely adopted across the medical spectrum. It expands access to necessary medical care by increasing the number of available providers and by reducing costs and logistical barriers.

15. Telemedicine serves a particularly important function in states like Oklahoma, where there is a shortage of healthcare providers. For Oklahomans with limited access to primary care physicians, telemedicine increases the number of available healthcare providers across different specialties and can significantly reduce barriers to access.

16. Trust Women Seattle and Trust Women Wichita have both safely provided medication abortion by means of telemedicine. I reviewed and approved the medication abortion telemedicine protocols for Trust Women Seattle and Trust Women Wichita. If the Challenged Laws are enjoined, I could adapt and implement these protocols to enable Trust Women Oklahoma City to provide medication abortion safely and effectively via telemedicine.

17. I have considered how medication abortions are provided at Trust Women Oklahoma City, and I am confident that none of the tasks necessary to provide medication abortions safely and effectively require physicians to be physically present in the same place as

patients. To explain that conclusion, I will briefly describe how medication abortions would be provided at Trust Women Oklahoma City via telemedicine.

18. First, when a patient seeking an abortion calls to schedule an appointment, the scheduler will screen the patient to determine whether they are a potential candidate for medication abortion, aspiration abortion, or both. If they are eligible for a medication abortion, and choose this option, the patient will then choose between medication abortion initiated in-person or via telemedicine and schedule an appointment at the clinic. In compliance with Oklahoma regulations, the patient will be provided with certain information that Oklahoma has mandated that abortion patients receive, and the patient will be scheduled for an appointment at least 72 hours later.

19. Second, when the patient arrives at the clinic, they will first fill out the required paperwork. The patient will then undergo lab tests (typically a RH/HbG blood test), and their vital signs (typically blood pressure, heart rate, temperature, and respiration) will be recorded. These results will be uploaded to the electronic medical record ("EMR") system. All of these tests and assessments will be performed by non-physician clinic staff, which is how these tests and assessments are currently performed at Trust Women Oklahoma City when abortion medications are provided by physicians in person.

20. Third, once the lab work is complete, the patient will be seen for an ultrasound. A trained ultrasound technician in the room with the patient will perform the ultrasound and upload the images to the EMR system.

21. Fourth, after the ultrasound, the patient will meet privately with clinic staff for a consultation to discuss their decision, the process of medication abortion, and what they should

expect during their consultation with the physician and after they leave the clinic.

22. Fifth, a physician who works for Trust Women Oklahoma City but is not physically present in the Oklahoma City clinic will then review the patient's medical history, lab results, vital signs, and ultrasound images through the EMR system to determine the gestational age of the fetus and confirm the patient's eligibility for a medication abortion.

23. Sixth, after the patient has completed their consultation and the physician has reviewed the patient's EMR, the patient and physician will meet via HIPAA-compliant video conferencing. The physician will discuss the patient's medical history, the gestational age of the pregnancy, and the patient's eligibility for medication abortion with the patient, and will answer any additional questions the patient has. After confirming that the patient is ready to proceed with the medication abortion, the physician will then instruct the clinic staff in the room with the patient to provide the first medication, mifepristone, and the patient will then take the medication while the physician watches remotely. The physician will next authorize the clinic staff in the room to provide the second medication, misoprostol, which the patient will take with them when they leave the clinic along with detailed written instructions that remind the patient when to ingest the second medication.

24. Lastly, before the patient leaves the clinic, the patient is scheduled for a follow-up appointment where the patient will be given a pregnancy test (and an ultrasound, if the pregnancy test is positive) to confirm completion of the abortion.

25. The process I describe above will ensure that patients receive safe and effective abortion care, even if the physician is not physically present in the clinic. Based on Trust Women's experience providing medication abortion via telemedicine at Trust Women Seattle

and Trust Women Wichita, and my personal experience providing medication abortion, I can say with confidence that medication abortion can be provided safely and effectively at Trust Women Oklahoma City using telemedicine.

III. The Provision of Medication Abortion through APRNs

26. APRNs have the necessary competencies to provide medication abortion safely and effectively. Over the course of my medical career, I have trained and worked first-hand with numerous nurse practitioners ("NPs"). As the Medical Director of Trust Women clinics, I have worked with and trained NPs. I have also served as the supervising physician for an NP at Washington University through a collaborative practice agreement. Moreover, as Chief Medical Officer at Planned Parenthood of the St. Louis Region and Southwest Missouri, I currently supervise a number of NPs, including NPs who provide medication abortion at the Planned Parenthood location in Illinois. In my experience, NPs generally, and particularly those employed by Trust Women clinics, are well-trained, capable professionals, who provide high-quality care to patients.

27. As Medical Director, I am familiar with the health care provided by Bridget Van Treese, an APRN and certified NP, who works at both our Oklahoma City and Wichita clinics. Ms. Van Treese has significant training and experience providing medical care, including family care. For example, Ms. Van Treese routinely performs pap smears and ultrasounds, conducts testing for sexually transmitted diseases, and inserts and removes IUDs. She also routinely prescribes medications, including Schedule III, IV, and V drugs.

28. Ms. Van Treese is adequately trained and qualified to perform medication abortions. She has experience with all of the relevant protocols and procedures, which include

review and analysis of the patient's medical record, conducting an ultrasound, and private consultation with the patient. She has shadowed physicians providing medication abortion at the Oklahoma City and Wichita Trust Women clinics numerous times. I also understand that she has completed the National Abortion Federation's ("NAF") trainings for medication abortion.

29. There is no medical basis for preventing Ms. Van Treese, or any other APRN with her training and skill set, from practicing to the full extent of their training and scope of practice. Based on my training and experience providing medication abortion and working with APRNs, I can say with confidence that medication abortion can be provided safely and effectively at Trust Women Oklahoma City by APRNs.

IV. <u>The Provision of Medication Abortion through Telemedicine and APRNs Benefits Oklahoma Women</u>

30. I understand that, because of the Physician-Only and Physician In-Person Laws, Trust Women Oklahoma City is currently only able to provide medication abortions two days per week. Trust Woman Oklahoma City relies on out-of-state physicians who fly into Oklahoma to provide abortion care. These physicians must balance their time providing in Oklahoma, and the significant travel time, with their professional and personal commitments in their home states.

31. Such limited availability of abortion services imposes a variety of burdens on patients and healthcare providers, and forces some patients to delay their abortions unnecessarily. If the Challenged Laws are enjoined, I understand that Trust Women Oklahoma City will promptly begin providing medication abortion through telemedicine and APRNs, which will increase access to abortion care and alleviate the burdens that patients and healthcare providers confront.

32. Based on my familiarity with the telemedicine protocols at Trust Women Seattle and Trust Women Wichita, I am prepared to immediately adopt and implement telemedicine protocols at Trust Women Oklahoma City. Physicians at Trust Women Oklahoma City, including myself, would be able to begin providing medication abortions to patients in Oklahoma via telemedicine. Qualified APRNs, such as Ms. Van Treese, would likewise be able to begin administering medication abortion.

33. Telemedicine allows physicians to provide care remotely, eliminating the need to travel to the patients' location. The substantial time that physicians currently spend traveling to and from the clinic from out-of-state could be spent caring for patients via telemedicine. Telemedicine also expands the number of physicians available to treat patients. More physicians may be willing to provide abortion care to Oklahoma patients if they can do so without the substantial travel commitments. As such, the potential pool of physicians available to Trust Women Oklahoma City will increase if telemedicine is permitted. Similarly, allowing APRNs to provide medication abortion eases the burdens on physicians and increases the number of providers available to patients.

34. Increasing the number of providers, whether through telemedicine or APRNs, will increase access to care, because it will allow the clinic to care for more patients and accommodate patients on additional days of the week and outside normal business hours. Increasing the number of providers also reduces wait times. There is a very high demand for abortion services at Trust Women Oklahoma City. To meet this demand, physicians must maintain demanding schedules, and patients are sometimes subject to long wait times—up to 4 to 8 hours.

35. As a result, some people come to the clinic, but are then unable to wait until a physician is able to see them. Although all of the clinic's physicians make their best efforts to ensure that all people receive care, it is not always possible given the volume of patients that need to be seen. If the patient's appointment is scheduled for the second day that providers are on-site and the patient has to leave before receiving care, then the soonest they can be rescheduled is the following week. In these instances, the patient faces at least a week delay, if they can return at all. Allowing for provision of medication abortion through telemedicine and APRNs will increase the number of available providers, provide physicians and patients with added flexibility, and significantly reduce wait times.

36. Expanding access to medication abortion using telemedicine and APRNs also reduces the obstacles patients confront when seeking abortion care. For many of my patients, including those in Oklahoma, it is difficult to visit an abortion clinic during normal business hours. This may be due to demanding and unpredictable work schedules, school, childcare, or other family obligations, or large geographic distances between their home and the nearest clinic. These problems may be compounded if they are trying to keep their decision confidential. This is particularly challenging for those in abusive relationships who face additional difficulties because their efforts to obtain an abortion, if disclosed, put them at risk of further abuse.

37. Trust Women Oklahoma City's ability to offer medication abortion appointments more days of the week, during expanded clinic hours, would make it easier for people to get care, provide patients with more healthcare options, and minimize health risks.

38. Because medication abortion is only available early in pregnancy (specifically, through 10 weeks LMP), the current constraints on Trust Women Oklahoma City's ability to

provide medication abortions prevent some women from accessing care early enough in pregnancy for medication abortion to be an option. During clinic sessions, I often encounter patients who would have preferred a medication abortion, but did not have that option because they were not able to make an appointment within the first 10 weeks of pregnancy.

39. As a healthcare provider, I am particularly concerned about the potential health risks to patients caused by such burdens and delay. Medication abortion is medically preferred for certain patients due to their health conditions, so eliminating this option can increase potential harm. Furthermore, while abortion is extremely safe, the risks and complication rates increase when the pregnancy is further along.

40. In my experience, patients also suffer from heightened emotional and physical stress the longer that they are forced to carry an unwanted pregnancy. Unnecessary barriers to abortion access stigmatize patients for their healthcare choices, and cause them to feel alienated and alone. Failure to obtain ready access to abortion services also tends to cause patients to experience anxiety and depression. This is particularly true for people who are pregnant as a result of sexual assault or incest.

41. Limited abortion access may force people in abusive or controlling relationships to forgo abortion services, and remain in contact with violent partners. This places them and their children at increased risk of violence, and causes psychological harm.

42. Limited abortion access also increases the risk that people may seek out unsafe or unlawful alternatives for ending a pregnancy, which can pose significant risks of complications and adverse outcomes.

43. For all the foregoing reasons, providing medication abortion through telemedicine and APRNs will expand access to safe and legal abortion in Oklahoma and enhance patient safety. By prohibiting the provision of medication abortion through telemedicine and APRNs, the Challenged Laws provide no benefits to patient health. The Challenge Laws instead cause harm by unnecessarily restricting access to safe and legal abortion.

Signed this 4th day of November, 2019.

Colleen McNicholas, D.O., M.S.C.I., F.A.C.O.G.

Sworn to before me this 4TH

day of NOVEMBER, 2019

NOTARY PUBLIC

KRISTINA WINKELMAN
MY COMMISSION EXPIRES
12-5-2022
NOTARY SEAL
#14119325
FRANKLIN COUNTY
NOTARY PUBLIC, STATE OF MISSOURI

EXHIBIT 1

CURRICULUM VITAE
Colleen Patricia McNicholas, DO, MSCI, FACOG

Date: July 2019

Address:

Planned Parenthood of the St. Louis Region and Southwest Missouri
4251 Forest Park
St. Louis, Missouri 63108

Present Position:

Chief Medical Officer
Planned Parenthood of the St. Louis Region and Southwest Missouri

Medical Director
Trust Women

Education:

Undergraduate:	1998-2003	Benedictine University Lisle, Illinois B.S. Forensic Chemistry
Graduate:	2003-2007	Kirksville College of Osteopathic Medicine Kirksville, Missouri Doctor of Osteopathy
	2011-2013	Washington University in St. Louis St. Louis, Missouri Masters of Science in Clinical Investigation
Internship:	2007-2008	Atlanta Medical Center Atlanta, Georgia Internship
Residency:	2008-2011	Washington University School of Medicine Residency in Obstetrics and Gynecology
Fellowship:	2011-2013	Washington University School of Medicine Clinical Instructor – Obstetrics and Gynecology Clinical Fellow – Family Planning

Academic Positions/Employment:

2019 -	Volunteer Clinical Faculty Department of Obstetrics and Gynecology Washington Univeristy School of Medicine Barnes Jewish Hospital
2018- 2019	Associate Professor Department of Obstetrics and Gynecology Washington University School of Medicine

2014-2018	Director, Ryan Residency Training Program Washington University School of Medicine
2013- 2018	Assistant Professor Department of Obstetrics and Gynecology Washington University School of Medicine
2012-2014	Missouri Baptist Medical Center, St Louis, MO Laborist

University and Hospital Appointments and Committees:

Appointments

2013-	Attending Physician Barnes Jewish Hospital St. Louis, MO
2014- 2019	Director, Ryan Residency Training Program Department of Obstetrics and Gynecology Washington University School of Medicine
2016- 2019	Co-Director, Fellowship in Family Planning Department of Obstetrics and Gynecology Washington University School of Medicine
2016-2019	Obstetrics and Gynecology Performance Evaluation Committee Washington University/Barnes Jewish OB/GYN Residency
2016-2019	Washington University School of Medicine Institutional Review Board Member
2018-2019	Washington University School of Medicine Committee on Admissions

Committees:

2014- 2017	American College of Obstetrics and Gynecology
2017-2020	Committee on the Healthcare for Underserved Women Member
2015- 2017 2017-2020	American College of Obstetrics and Gynecology Underserved Liaison to Committee on Adolescent Health Care
2015- 2019	International Federation of Gynecology and Obstetrics (FIGO) Women's Sexual and Reproductive Rights Committee Master Trainer, Integrating Human Rights in Health
2016-	Ibis Reproductive Healthcare Over the counter oral contraceptive working group Policy Subcommittee
2017-	MERCK Global Advisory Board on Contraception

	2017-		Washington University School of Medicine OUT Med Advisory Board
	2019-		International Federation of Gynecology and Obstetrics (FIGO) Committee for Human Rights, refugees, and violence against Women
Volunteer	2015-	2019	Saturday Neighborhood Health Clinic Washington University School of Medicine Volunteer Attending Physician Faculty, Primary Care Volunteer Attending Physician Faculty, Americore Homeless

Medical Licensure and Board Certification:

Licensure

Missouri, Kansas, Oklahoma, Washington, Illinois

Board Certification:

2014- current	American Board of Obstetrics and Gynecology General Obstetrics and Gynecology Diplomate

Honors and Awards:

2001	Gregory Snoke Memorial Scholarship
2001	American Chemical Society Analytical Achievement Award
2001	American Chemical Society Division of Analytical Chemistry 2001 Undergraduate Award
2002	PGG Industries Foundation J. Earl Burrell Scholarship
2003	Senior Academic Award: College of Arts and Science
2006	Presidents Award: Women in Medicine
2011	Kody Kunda Resident Teaching Award
2012	ACOG Health Policy Rotation, LARC Program January 2013
2012	Physicians for Reproductive Health and Choice (PRCH) Leadership Training Academy
2012	President's Award: St. Louis Gynecologic Society, best research presentation
2016	Fellowship in Family Planning, Warrior Award
2016	Physicians for Reproductive Health, Voices of Courage: A Benefit Celebrating Extraordinary Abortion Providers
2016	2015 Roy M. Pitkin Award, Obstetrics and Gynecology (The Green Journal)
2018	Massingill Family Scholarship, 2018 Robert C. Cefalo Leadership Institute
2018	ACOG District VII Mentor of the year award
2019	Arnold P. Gold, Gold Humanism Honor Society Inductee
2019	Planned Paretnhood Media Excellence Award
2019	Human Rights Campaign, St. Louis Leadership Award

Editorial Responsibilities:

2011-	*Reviewer*, Contraception
2011-	*Reviewer*, Journal of Family Planning and Reproductive Health Care
2012-	*Reviewer*, American Journal of Obstetrics and Gynecology
2012-	*Reviewer*, European Journal of Obstetrics and Gynecology and Reproductive Biology
2013-	*Reviewer*, Obstetrics and Gynecology

Professional Societies and Organizations:

2003-	Medical Students for Choice
2006-2011	Association of Reproductive Health Professionals

2006- American Congress of Obstetricians and Gynecologists

Leadership Roles

- 2013: The American College of Obstetricians and Gynecologists/Bayer HealthCare Pharmaceuticals Research Fellowship in Contraceptive Counseling (Selection committee)

- 2012-2019: American Congress of Obstetrics and Gynecology Congressional Leadership Conference, participant
    - 2015: Presenter, Reproductive Health Legislation in the States
    - 2016: Presenter, Reproductive Health Legislation in the States

- 2014-2020: Committee on Health Care for Underserved Women
    - Author, CO-Healthcare for Women with Disabilities
    - Author, Policy statement- Marriage and Family Equality
    - ACOG Liaison, AAMC Family Building Webinar series
    - Author, CO- Trauma informed care

- 2015-current: Committee on Adolescent Health Care, Underserved Liaison

- 2015-current: Missouri ACOG Section Advisory Committee, Member
    - 2015- current: Member, Legislative Committee
    - 2019-current: Secretary/Treasurer

2006- Gay and Lesbian Medical Association
2006- Women in Medicine
Leadership Roles

- 2010-current Board Member
- 2016: Chair of annual conference, Aug 2016
- 2018-2020: Board Treasurer

2008-2011 St. Louis Obstetrics and Gynecology Society
Leadership Roles: resident board member

2011- Society of Family Planning

Invited Presentations:

2001 Cadmium's effect on Osteoclast Apoptosis
12th Annual Argonne Symposium for Undergraduates in Science, Engineering and Mathematics

2002 Cadmium's effect on Osteoclast Apoptosis
2002 Experimental Biology Conference

2012 Contraception for medically complicated women
Women in Medicine Annual meeting

2013 The troubling trend of legislative interference.
Washington University School of Medicine, OBGYN Grand Rounds.

2013	An update on abortion: Why lesbians and those who treat them should care The Gay and Lesbian Medical Association
2013	Findings from the Contraceptive CHOICE Project. Are you meeting your patient's contraceptive needs? Washington University School of Medicine Annual OB/GYN Symposium
2013	Legislative interference and the impact on public health. Washington University Brown School of Social Work.
2014	Business of Medicine Medical Student Elective Course Legislating Medicine Washington University School of Medicine
2014	Practical tips for your first RCT, lessons learned Lecture in Randomized Control Trial course
2014	Uniting tomorrow's leaders of the RJ movement with providers of today National Abortion Federation Annual Meeting
2014	Systems based practice and advocating for your patients Washington University School of Medicine OB/GYN residency core lecture
2014	Abortion in sexual minority populations *National Abortion Federation*
2014	Complications of uterine evacuation St. Louis University OB/GYN Grand Rounds
2014	Medical contraindications in CHOICE Participants using combined hormonal contraception Over the Counter Oral Contraceptive Working Group
2015	Implementing immediate postpartum LARC Kansas University OB/GYN grand rounds
2015	The evidence for immediate Post-partum IUD insertion Kansas City Gynecologic Society
2105	Business of Medicine Medical Student Elective Course Legislating Medicine Washington University School of Medicine
2015	Getting Politics Out of the Exam Room: Combating Legislative Interference in the Patient-Provider Relationship National Abortion Federation Annual Meeting
2015	Are you meeting your patient's contraceptive needs? Tennessee Department of Health.
2015	Colorado Initiative to reduce unintended pregnancy (webinar): Reducing Unplanned Pregnancies in Colorado through Strategies to Promote Long-Acting Reversible Contraception Huffington Post, Live

2105	Method mix it up: Expanding options to meet the unique contraceptive needs of young people FIGO World Conference
2015	Getting to Yes-Interventions to Increase LARC Acceptance with a Focus on IUC Nurse Practitioners Women's Health Annual Symposium
2015	Put your megaphone where your mouth is: Getting your professional society to speak up Forum on Family Planning
2015	When Politics Trumps Science- Why is Birth control at Center Stage? Carbondale Illinois Grand Rounds
2016	Using research to effectively advocate Physicians for Reproductive Health Leadership Training Academy
2016	Partial Participation and Abortion Training in Residency: A Structure for Optimizing Learning and Clinical Care APGO/CREOG
2016	Are we meeting the needs of our teen and adolescent patients? Our role in preventing unintended pregnancy. Barnes Jewish Hospital/Washington University School of Medicine CME Outreach.
2016	The emerging role of physicians as advocates St Louis OB/GYN Society
2016	Legislation and Advocacy Washington University School of Medicine- Elective course Gun violence as a public health issue
2016	Legislative advocacy and the impact on public health Washington University, Brown School of Social Work
2017	GOV 101 Learning to advocate at the MO legislature
2017	Reevaluating the longevity of LARC GrandRounds, BayState Medical Center
2018	Ryan Residency Program Annual Meeting Patient and Community Advocacy in Residency Training
2018	Physician advocacy, the key to public health Keynote Speaker Washington University Center for Community Health Partnership & Research (CCHPR) Global Health Center Summer Research Program
2018	XXII World Congress of Gynecology and Obstetrics Whether, when, and how many: a global movement toward reproductive freedom Rio de Janeiro, Brazil

2018 Domestic and Global epidemiology of abortion
Washington University, Brown School of Social Work

Research Support:

3125-946435
Role: Principal Investigator
MERCK
Ovarian function with prolonged use of the implant
Award: January 2017-June2018
Award Amount: $279,126

U01DK106853 (Colditz, Sutcliffe)
Role: Co-investigator
NIH/NIDDK
LUTS prevention in adolescent girls and women across the lifespan
Award: July 1, 2015 - January 1, 2019

(Peipert, McNicholas)
Role: Co-Principal Investigator
Anonymous Donor
EPIC: Evaluating prolonged use of the IUD/implant for Contraception
Award: Sep8, 2014 – Aug 31, 2018
Award Amount: $ 1,000,000

National Institutes of Health- Loan Repayment Program
Role: Principal Investigator
EPIC: Evaluating prolonged use of the IUD/implant for Contraception
Aug 17, 2014- July 31, 2017
Award Amount: $70,000
Aug 1, 2016- July 31, 2018
Award Amount: $70,000
Aug 1, 2018- July 31, 2020

81615 (Peipert, McNicholas)
Role: Co-Principal Investigator
William and Flora Hewlett Foundation
LIFE: Levonorgestrel Intrauterine system For Emergency Contraception; a multicenter randomized trial
June1, 2014- May 31, 2015
Award Amount: $351,500

IRG-58-010-57 (McNicholas)
Role: Principal Investigator
American Cancer Society Institutional Research Grant (ACS-IRG)
Evaluating the impact of the IUD on HPV and cervical cancer risk
January 1, 2014-December 31, 2014
Award Amount: $30,000

SFPRF12-1 (McNicholas)
Role: Principal Investigator
Society of Family Planning Research Fund
Effectiveness of Prolonged use of IUD/Implant for Contraception (EPIC)
January 2012 – July 2014
Award Amount: $70,000

UL1 TR000448 (Evanoff)
Role: Postdoctoral MSCI Scholar
NIH-National Center for Research Resources (NCRR)
Washington University Institute of Clinical and Translational Sciences (ICTS)
July 1, 2011 – June 30, 2013

5T32HD055172-03 (Macones, Peipert)
Role: Clinical fellow, trainee
NIH T32 Research Training Grant
July 1, 2011 – June 30, 2013

Bibliography:

Peer-reviewed Publications:

1. Allsworth JE, Hladky KJ, Hotchkiss T, McNicholas C, Rohn A. Discussion: 'Douching and the risk for sexually transmitted disease' by Tsai et al. *Am J of Obstet and Gynecol* 2009;200(1):e11-4.

2. Stoddard A, McNicholas C, Peipert JF. Efficacy and safety of long-acting reversible contraception. *Drugs*. 2011 May 28;**71**(8): p. 969-80. PMID: 21668037

3. McNicholas C, Hotchkiss T, Madden T, Zhao Q, Allsworth J, Peipert JF. Immediate postabortion intrauterine device insertion: continuation and satisfaction. *Women Health Iss.* 2012 Jul-Aug; 22(4):e365-369. PMID: 22749197

4. McNicholas C, Peipert JF. Long-acting reversible contraception for adolescents. *Curr Opin Obstet Gyn.* 2012 Oct; 24(5):293-298. PMID: 22781078

5. McNicholas C, Peipert JF. Initiation of long-acting reversible contraceptive methods (IUDs and implant) at pregnancy termination reduces repeat abortion. *Evid Based Med.* 2013 Jun;18(3):e29. PMID: 23161505

6. McNicholas C, Madden T, Zhao Q, Secura G, Allsworth JE, Peipert JF. Cervical lidocaine for IUD insertional pain: a randomized controlled trial. *Am J Obstet Gynecol. 2012* Nov;207(5):384 e381-386. PMID: 23107081

7. McNicholas C, Zhao Q, Secura G, Allsworth J, Madden T, Peipert J. Contraceptive failures in overweight and obese combined hormonal contraceptive users. *Obstet Gynecol*. 2013 March; 121(3):585-92. PMID: 23635622

8. McNicholas C. Transcending politics to promote women's health. *Obstet Gynecol.* 2013 Jul;122(1):151-3. PMID: 23743460

9. Eisenberg D, McNicholas C, Peipert JF. Cost as a barrier to long-acting reversible contraceptive (LARC) use in adolescents. *J Adolescent Health*. 2013 Apr;52(4 Suppl):S59-63. PMID: 23535059

10. Grentzer J, McNicholas C, Peipert J. Use of the etonorgestrel-releasing implant. *Expert Rev. of Obstet and Gynecol.* 8 (4), 337-344. 2013

11. Secura G, McNicholas C. Long-acting reversible contraceptive use among teens prevents unintended pregnancy: a look at the evidence. *Expert Rev. of Obstet Gynecol*. 8(4), 297-299. 2013

12. McNicholas C, Peipert JF, Madipati R, Madden T, Allsworth, J Secura G. Sexually transmitted infection prevalence in a population seeking no-cost contraception. *Sex Transm Dis.* 2013 July;40(7):546-51. PMID: 23965768

13. Sehn JK, Kuroki LM, Hopeman MM, Longman RE, McNicholas CP, Huettner PC. Ovarian complete hydatidiform mole: case study with molecular analysis and review of the literature. *Hum Pathol*. 2013 Dec;44(12):2861-4. PMID: 24134929

14. Madden T, McNicholas C, Zhao Q, Secura G, Eisenberg D, Peipert JF. Association of Age and Parity with IUD Expulsion. *Obstet Gynecol.* 2013 Oct; 124 (4): 718-26. PMID: 4172535

15. Secura G, Madden T, McNicholas C, Mullersman J, Buckel C, Zhao Q, Peipert JF. No-Cost Contraception Reduces Teen Pregnancy, Birth, and Abortion. *New Engl J Med.* 2104 Oct; 371(14); 1316-23. PMCID: 4230891

16. McNicholas C, Madden T, Secura G, Peipert JF. The Contraceptive CHOICE Project Round Up: What we did and what we learned. *Clin Obstet Gynecol.* 2014 Dec; 57(4); 635-43. PMCID: 4216614

17. McNicholas C, Maddipati R, Swor E, Zhao Q, Peipert JF. Use of the Etonogestrel Implant and Levonorgestrel Intrauterine Device Beyond the U.S. Food and Drug Administration-Approved Duration. *Obstet Gynecol,* 2015 Mar; 125(3):599-604.

18. Grentzer J, Peipert J, Zhao Q, McNicholas C, Secura G, Madden T. Risk-based screening for Chlamydia trachomatis and Neisseria gonorrhoeae prior to intrauterine device insertion. *Contraception* 2015 Jun; S0010-7824(15)00250-4. PMID:26093189

19. Mejia M, McNicholas C, Madden T, Peipert J. Association of Baseline Bleeding Pattern on Amenorrhea with Levonorgestrel Intrauterine System Use. *Contraception.* 2016 Nov;94(5):556-560. PMID: 27364099

20. Hou M, McNicholas C, Creinin M. Combined Oral Contraceptive Treatment for Bleeding Complaints with the Etonogestrel Contraceptive Implant: A Randomized Controlled Trial. *Eur J Contracept Reprod Health Care.* 2016 Oct;21(5):361-6. PMID: 27419258

21. Zigler RE, Peipert JF, Zhao Q, Maddipati R, McNicholas C. Long-acting reversible contraception use among residents in obstetrics/gynecology training programs. *Open Access J of Contracept*. 2017 Jan; 2017(8) 1—7. PMID: 29386949

22. Zigler RE, McNicholas C. Unscheduled vaginal bleeding with progestin-only contraceptive use. *Am J of Obstet and Gynecol*. 2017 May;216(5):443-450. PMID: 27988268

23. McNicholas C, Swor E, Wan L, Peipert JF. Prolonged use of the etonogestrel implant and levonorgestrel intrauterine device: 2 years beyond Food and Drug Administration-approved duration. *Am J Obstet Gynecol*. 2017 Jan 29. PMID:28147241

24. McNicholas C, Peripert JF. Is it time to abandon the routine pelvic exam in asymptomatic nonpregnant women? *JAMA* 2017 Mar 7;317(9):910-911. PMID:28267835

25. McNicholas C, Madden T. Meeting the Contraceptive Needs of a Community: Increasing Access to Long-Acting Reversible Contraception. *MO Med*. 2017 May-Jun; 114(3):163-167. PMID:30228573

26. Iseyemi A, Zhao Q, McNicholas C, Peipert JF. Socioeconomic Status As a Risk Factor for Unintended Pregnancy in the Contraceptive CHOICE Project. *Obstet Gynecol*. 2017 Sep;130(3):609-615. PMID: 28796678

27. McNicholas C, Klugman J, Zhao Q, Peipert J. Condom Use and Incident Sexually Transmitted Infection after Initiation of Long-Acting Reversible Contraception. *Am J of Obstet and Gynecol.* 2017 Dec;217(6):672.e1-672.e6. PMID: 28919400

28. Zigler RE, Madden T, Ashby C, Wan L, McNicholas C. Ulipristal Acetate for Unscheduled Bleeding in Etonogestrel Implant Users: A Randomized Controlled Trial. *Obstet Gynecol*. 2018 Oct;132(4):888-894. PMID: 30130151

Non-Peer Reviewed Invited Publications:

1. McNicholas C. Rev. of Recent advances in obstetrics and gynecology, *Royal Society of Medicine Press*, 2008.

2. McNicholas C, Levy B. The original minimally invasive hysterectomy; no hospitalization required. *Expert Rev. of Obstet and Gynecol*. 8(2), 1-3. 2013

Chapters:

1. Gross G, McNicholas C. Rev. of Shoulder dystocia and birth injury: prevention and treatment, by James A. O'Leary 3rd Ed
2. McNicholas C, Peipert JP. Pelvic inflammatory disease. *Practical Pediatric and Adolescent Gynecology*. Oxford. Wiley-Blackwell. ISBN: 978-0-470-67387-4.
3. McNicholas C, Madden T*., 2015 Contraceptive counseling for obese women.* In E. Jungheim (Ed) Obesity and Fertility. Springer, New York. ISBN 978-1-4939-2611-4

Abstracts:

1. McNicholas C, Maddipati R, Secura G, Peipert J. Use of the contraceptive implant beyond the FDA-approved duration. Poster Presentation. North American Forum on Family Planning. Miami, FL October 2014.

2. McNicholas C, Swor E, Peipert J, Secura G. Serum etonogestrel levels in women using the contraceptive implant beyond the FDA-approved duration*. Oral Presentation. North American Forum on Family Planning*. Seattle, WA October 2013.

3. McNicholas C, Zhao Q, Peipert J, Secura G. Condom use and incident sexually transmitted infection after initiation of long-acting reversible contraception. *Oral Presentation. 40th Annual Scientific Meeting of the Infectious Diseases Society for Obstetrics and Gynecology*. Sante Fe, NM Aug 2013.

4. McNicholas C, Madden T, Zhao Q, Secura G, Allsworth JE, Peipert JP. Cervical lidocaine for IUD insertional pain: a randomized controlled trial. *Poster Presentation*. *North American Forum on Family Planning*. Denver, CO. October 2012.

5. McNicholas C, Maddipati R, Allsworth J, Madden T, Peipert J, Secura G. Baseline sexually transmitted infection prevalence in a low risk urban population.
Oral Presentation. *39th Annual Scientific Meeting of the Infectious Diseases Society for Obstetrics and Gynecology.* Whistler, BC Aug 2012.

6. McNicholas C, Maddipati R, Allsworth J, Madden T, Peipert J, Secura G. An epidemiologic comparison of *Chlamydia Trachomatis* and *Trichomonas Vaginalis*: Information from the Contraceptive CHOICE Project. *Poster Presentation*, *39th Annual Scientific Meeting of the Infectious Diseases Society for Obstetrics and Gynecology*. Whistler, BC Aug 2012.

7. McNicholas C, Madden T, Zhao Q, Secura G, Allsworth J, Peipert J. Cervical lidocaine for IUD insertional pain: a randomized control trial. *Oral Presentation. St. Louis Gynecologic Society*. April 2012.

8. Madden T, McNicholas CP, Secura GM, Allsworth JE, Zhao Q, Peipert JF. Rates of Expulsion and Continuation of Intrauterine Contraception at 12 months in Nulliparous and Adolescent Women. *Oral Presentation, Association of Reproductive Health Care Providers.* Sept 2010.

9. McNicholas CP, Madden T, Secura GM, Allsworth JE, Zhao Q, Peipert JF. Rates of Expulsion and Continuation of Intrauterine Contraception at 12 months in Nulliparous and Adolescent Women. *Oral Presentation, Rothman Resident Research Day.* April 2010.

10. McNicholas C. Acute Myelogenous Leukemia (AML) in an HIV Patient. A Diagnosis of exclusion and the implications of Cytogenetics. *Publication and Poster presentation Seaton Hall Research Colloquium.* May 2006.

EXHIBIT D

IN THE DISTRICT COURT OF OKLAHOMA COUNTY
STATE OF OKLAHOMA

(1) SOUTH WIND WOMEN'S CENTER LLC, D/B/A TRUST WOMEN OKLAHOMA CITY, on behalf of itself, its clinicians and staff, and its patients; and (2) COLLEEN MCNICHOLAS, D.O., on behalf of herself and her patients; and (3) BRIDGET VAN TREESE, M.S.N., APRN-CNP, on behalf of herself and her patients, Plaintiffs, v. (1) MIKE HUNTER, in his official capacity as Attorney General of Oklahoma; and (2) DAVID PRATER, in his official capacity as Oklahoma County District Attorney; and (3) LYLE KELSEY, in his official capacity as Executive Director of the Oklahoma State Board of Medical Licensure and Supervision; and (4) G. ROBINSON STRATTON, III, in his official capacity as Executive Director of the Oklahoma State Board of Osteopathic Examiners; and (5) KIM GLAZIER, in her official capacity as the Executive Director of the Oklahoma Board of Nursing; and (6) GARY COX, in his official capacity as Oklahoma Commissioner of Health, Defendants.	))))))))))))))))))	Case No. __________________ Judge ______________________

AFFIDAVIT OF BRIDGET ANN VAN TREESE IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY INJUNCTION

STATE OF KANSAS)
) ss.
COUNTY OF SEDGWICK)

BRIDGET ANN VAN TREESE, being duly sworn, deposes and says:

1. I am an Advanced Practice Registered Nurse, Certified Nurse Practitioner ("APRN-CNP") employed by Trust Women Oklahoma City and one of the plaintiffs in this case. I submit this affidavit in support of Plaintiffs' Motion for a Temporary Injunction to enjoin enforcement of the Oklahoma law 63 O.S. § 1-731(A) (the "Physician-Only Law"), and related regulations. I understand that Oklahoma's Physician-Only Law prevents me from, among other things, providing medication abortions to patients because I am a nurse practitioner and not a physician. If not for the Physician-Only Law, I would provide medication abortion to patients, easing the burden on Trust Women Oklahoma City's physicians and increasing abortion access in Oklahoma.

2. Trust Women Oklahoma City offers high-quality reproductive health care to those in underserved communities, including abortion, transgender care, HIV/AIDS testing, well woman exams, and contraceptive services. There are other Trust Women clinics located in Wichita, KS and Seattle, WA. While I am based in Oklahoma City, I currently work in both the Oklahoma City and Wichita clinics.

My Training and Experience as a Nurse

3. I have worked as a registered nurse since 2013 and as a nurse practitioner since 2017.

4. I graduated from the University of Oklahoma with a bachelor's degree in nursing in 2013. Prior to this, I worked as a nurse technician and Certified Nurse Aide at a local hospital in Lawton, OK. Additionally, I served in the U.S. Air Force Reserves, where I still serve in the rank of Master Sergeant.

5. After graduating in 2013, I obtained my nursing license in Oklahoma and worked as a registered nurse in the medical intensive care unit at the Oklahoma University Medical

Center. I then worked as a travel registered nurse in intensive care units and neurocritical care units in Kansas, Wisconsin, and Illinois. (Travel registered nurses are nurses trained to work in different settings to fill short-term staffing needs.) In these positions, I would care for patients with a wide variety of conditions, including, but not limited to: respiratory failure requiring mechanical ventilation, liver failure, gastrointestinal bleeding, drug overdose, solid organ transplantation, sepsis, septic shock, stroke, and recovery from cardiac surgery. I was also certified to provide palliative care, basic life support, and advanced cardiac life support.

6. In 2017, I received a Master of Science in Nursing degree with a specialty in both Family Practice and Adult-Gerontology Acute Care from the University of South Alabama and became a certified nurse practitioner or "NP." NPs are one of four categories of advanced practice nurses that fall under the umbrella of APRNs. I also obtained my DEA license to prescribe controlled substances and was certified to provide pediatric advanced life support.

7. My NP training included, but was not limited to, a family practice and women's health rotation in Ada, Oklahoma in 2015. In this role, I was able to see firsthand the lack of access to women's health services in rural parts of Oklahoma.

8. After becoming an NP, I worked as an adult/gerontological acute care NP in the emergency department at Oklahoma University Medical Center. In this position, I provided comprehensive care for up to 25 patients per day with acute, sometimes life-threatening medical problems.

9. On occasion, this care included miscarriage evaluation and management, which involved drawing blood to evaluate for the blood hemoglobin level, hematocrit level, and rH factor, which would help me determine if the patient was bleeding too much, needed a blood transfusion, needed to stay in the hospital, or could safely be discharged home after the

Emergency Department visit. I would then perform an ultrasound to determine the presence or absence of fetal cardiac activity. Next, I would perform a pelvic exam using a speculum to evaluate the cervix, and, if needed, use ring forceps to remove any clots or tissue remaining in the cervix.

10. Notably, when caring for patients who suffered a miscarriage, I had the option of providing patients with misoprostol under a physician's order. Misoprostol is one of the two prescription medications used in medication abortion. In the case of miscarriage management, misoprostol causes the uterus to contract and expel the nonviable pregnancy. The purpose and effect of misoprostol is the same when used for medication abortion.

11. In 2019, I became certified as a Family Practice NP in order to provide family-focused care outside the emergency room setting. While I began my education wanting to do acute care, my experiences during training drew me more and more towards issues involving women's health. Working in both rural and urban settings, I saw many women who had not received adequate medical treatment, and I decided that I would focus my career on serving this community. I have seen first-hand how access to adequate medical care is critical to women's health and wellbeing. Conversely, when women face barriers to healthcare, I have seen the adverse impacts such barriers can have on the lives of women and their families. It was this calling that brought me to Trust Women.

12. I began working for Trust Women's Oklahoma and Kansas clinics in May 2019. My typical work schedule includes three days per week at the Trust Women Oklahoma City clinic and two days per week at the Trust Women Wichita clinic.

13. In order to practice in Kansas, I sought and obtained a Kansas Registered Nurse and NP license. Both my Kansas and Oklahoma nursing licenses are in good standing, and I have fulfilled all the necessary continuing education requirements.

14. I have prescriptive authority in both Kansas and Oklahoma, which means that I can write prescriptions for medications. In both states, APRNs must enter into a collaborative practice agreement with a physician in order to prescribe medications. My collaborative practice agreement in Oklahoma is with an Oklahoma-licensed Trust Women Oklahoma City physician.

15. My prescriptive authority under Oklahoma law permits me to prescribe virtually all prescription medications, including Schedule III-V medications. The only prescription medications that Oklahoma law does not allow APRNs to prescribe are those specifically listed in Oklahoma's Exclusionary Formulary. The Exclusionary Formulary is a list of prescription medications that the Oklahoma Board of Nursing has determined may not be prescribed by advanced practice nurses in the state. A copy of the current Exclusionary Formulary published by the Oklahoma Board of Nursing is attached as Exhibit 1 to this declaration.

16. At Trust Women Oklahoma City, I provide primary care, women's healthcare, and transgender healthcare. I am able to serve as a patient's primary care provider. My women's care practice includes performing ultrasounds; conducting pap smears; providing birth control services, including inserting and removing intrauterine devices (IUDs); inserting and removing subdermal implantable contraceptive devices (Nexplanon implant); conducting well woman exams; testing for sexually transmitted diseases; and providing HIV/AIDS care.

My Training and Experience in Medication Abortions

17. I am trained to provide medication abortions. However, due to Oklahoma's Physician-Only Law, I am prevented from providing medication abortions to patients in need of such care.

18. I received training in medication abortion through the National Abortion Federation ("NAF"). NAF is a professional association of abortion providers and sets standards for quality abortion care throughout the United States. NAF offers training on medication abortion for healthcare providers, and I completed the program in 2019. I have also completed the "Medication Abortion in Primary Care" continuing education provided by the University of California San Francisco (UCSF). On over a dozen occasions I have shadowed physicians at Trust Women Oklahoma City and Trust Women Wichita who provide medication abortions. I also frequently conduct follow-up appointments with medication abortion patients.

19. Medication abortion is within my scope of practice based upon my training and skills, and I would provide medication abortion if not for Oklahoma's Physician-Only Law. In my current practice, I regularly exercise the same skills and judgment that would be necessary to safely and effectively provide medication abortions. I take medical histories, conduct physical exams, review medical records and lab results, conduct obstetric ultrasounds, advise patients regarding risks and benefits of medications, and prescribe medications.

20. As discussed above, as an advanced practice nurse with prescriptive authority in Oklahoma, I am authorized to prescribe virtually all medications, except those listed on Oklahoma's Exclusionary Formulary. Mifepristone and misoprostol, the two drugs used in medication abortion, are not listed on Oklahoma's Exclusionary Formulary. As a result, I am authorized by Oklahoma law to prescribe mifepristone and misoprostol ***for any purpose other***

than abortion care. For example, I can lawfully prescribe misoprostol for patients who have suffered a miscarriage.

21. In my practice, I also prescribe numerous medications that have more severe risks and side effects than mifepristone and misoprostol. For example, in my transgender care practice, I prescribe hormone treatments such as estrogen and testosterone therapy whose benefits are accompanied by significant risks. I also prescribe various scheduled drugs with abuse potential such as tramadol and alprazolam, and other drugs with potentially deadly side effects like warfarin.

22. Additionally, I have performed medical procedures that are far more complex and invasive than medication abortion. Medication abortion is a non-invasive procedure that carries a very low risk of adverse effects. By contrast, in my practice, I have performed numerous invasive procedures such as inserting and removing IUDs; intubating a patient with respiratory failure; inserting a chest tube in a patient with a collapsed lung; performing needle decompression of the chest, a procedure which involves inserting a needle into a patient's chest cavity; paracentesis, a procedure in which I extract fluid from the patient's abdomen by inserting a needle and catheter into the patient's abdominal cavity; and lumbar punctures.

My Intention to Provide Medication Abortion in Oklahoma

23. If not for the Physician-Only Law, I would begin providing medication abortions to patients in Oklahoma as soon as the clinic is able to schedule appointments.

24. Medication abortion is already within my scope of practice. I have all the skills and training required to provide medication abortion safely and effectively. I am familiar with Trust Women Oklahoma City's protocols for medication abortion. And I have the prescriptive

authority and relationship with a supervising physician that would allow me to prescribe mifepristone and misoprostol.

25. Beyond having the competency to provide medication abortions, my background in holistic care and general approach to my interactions with my patients make me well suited to provide medication abortions. My women's health and transgender patients, if faced with an unwanted pregnancy, would have the option of receiving abortion care from a health care professional with whom they have built a trusting relationship in their pursuit of other primary care, family planning, and gynecological services.

26. My ability to perform medication abortions would benefit both patients and the clinic. I understand that Trust Women Oklahoma City currently is only able to offer abortion services two days per week when physicians are present. If the Physician-Only Law were no obstacle, I would be able to provide medication abortions on the three days that I work at the Oklahoma City clinic, giving patients the option of obtaining abortion care more days per week. I would also be willing to spend an increased number of days per week at the Oklahoma City clinic, in the likely event that Trust Women would need me to do so in order to keep up with increased patient volume.

27. If APRNs like me were permitted to provide medication abortions in Oklahoma, medication abortion would be more accessible. There would be more qualified healthcare practitioners providing medication abortions, and this would increase the number of days and hours when abortion care could be offered. Patients would have more flexibility in scheduling their appointments, which would be important for many patients, who work jobs with little time off during the week and unpredictable working hours. This would also make it more likely that

patients could be seen within the first ten weeks of pregnancy, when medication abortion is offered, rather than undergo a more invasive surgical abortion later.

28. Moreover, if APRNs were permitted to provide medication abortions, the physicians who travel long distances to get to the clinic could devote more of their clinical time to caring for patients having surgical abortions. This would not only lessen their workload, but it would make it easier for patients in need of surgical abortions to access, schedule, and obtain the care they need. Freeing up physicians' time will decrease waiting times for patients at the clinic, which are currently between 6 and 8 hours. Also, I know that Trust Women Oklahoma City physicians fly in from out of state to provide abortion care. When their flights are delayed, patients must wait longer to access abortion services. Since I am based in Oklahoma City, my provision of abortion care would not be disturbed by these kinds of disruptions and delays.

Signed this 1 day of November.

Bridget Ann Van Treese, M.S.N, APRN-CNP

Sworn to before me this first

day of November 2019

NOTARY PUBLIC

NOTARY PUBLIC - State of Kansas
Danelle F. Brewer
My Appt. Expires 11/6/22

EXHIBIT 1

OKLAHOMA BOARD OF NURSING
2915 North Classen Boulevard, Suite 524
Oklahoma City, Oklahoma 73106
405-962-1800

EXCLUSIONARY FORMULARY FOR ADVANCED PRACTICE REGISTERED NURSES WITH PRESCRIPTIVE AUTHORITY

The Advanced Practice Registered Nurse (Certified Nurse Practitioner, Clinical Nurse Specialist and Certified Nurse Midwife) in accordance with Oklahoma Nursing Practice Act, may prescribe medications that are within the Advanced Practice Registered Nurse's scope of practice, under the medical direction of a supervising physician and an Exclusionary Formulary. The Exclusionary Formulary lists medications or categories of medications that shall not be prescribed by the Advanced Practice Registered Nurse with deemed prescriptive authority through the Board. This authorization shall not include dispensing drugs, but shall not preclude, subject to federal regulations, the receipt of, the signing for, or the dispensing of professional samples to patients, in accordance with the Advanced Practice Registered Nurse's scope of practice.

- **All Schedule I and II Controlled Dangerous Substances cannot be prescribed by the Advanced Practice Registered Nurse with prescriptive authority**. [63 O.S. § 2-312.C]

- The Advanced Practice Registered Nurse with prescriptive authority who prescribes Schedule III-IV Controlled Dangerous Substances will comply with State and Federal Drug Enforcement Agency (DEA) prior to prescribing controlled substances. **No more than a 30-day supply for Schedule III-V drugs** shall be prescribed by an Advanced Practice Registered Nurse with prescriptive authority. [485:10-16-5]

- **If prescribing an opioid, the law can be more restrictive**. The Advanced Practice Registered Nurse with prescriptive authority must follow the *Oklahoma Uniform Controlled Dangerous Substance Act* [63 O.S. § 2-309I] when prescribing an opioid.

- Prescriptions will comply with all applicable state and federal laws. [485:10-16-8(a)]

Reference for the Exclusionary Formulary for Classification Purposes: ***American Hospital Formulary Service Drug Information Book*** **(current)**

The Exclusionary Formulary includes:

All Schedule I and II Controlled Dangerous Substances

28:04 Anesthetics, General

A. Barbiturates
- Sodium Methohexital (Brevital)*
- Sodium Thiopental (Pentothal) (not in AHFS)

B. General Anesthesia Miscellaneous
- Etomidate (Amidate)
  - **Exception:** May be ordered ONLY for Rapid Sequence Intubation by an APRN who is appropriately certified, privileged and credentialed
- Fospropofol (Lusedra)
- Ketamine (Ketalar) (not in AHFS)
- Propofol (Diprivan)

C. Inhalation Anesthetics*
All inhalation anesthetics including but not limited to the following:

- Nitrous Oxide
- Cyclopropane
- Ethylene
- Sevoflurane (Ultane)
- Desflurane (Suprane)
- Enflurane (Ethrane)
- Isoflurane (Forane)

28:08 **Analgesics**
Opiate Agonist

- Opium* (Unless less than 25 mg/dosage unit)

28:16 **Psychotherapeutic Agents**

- Clozapine
  - **Exception:** May be ordered by an APRN with the appropriate certification, REMS registration and supervised by a qualified physician with REMS registration.

28:24 **Anxiolytics, Sedatives, Hypnotics**
Benzodiazepines

- Midazolam (Versed)
  - **Exception:** May be ordered ONLY for Rapid Sequence Intubation by an APRN who is appropriately certified, privileged and credentialed

60:00 **Gold Compounds**
All Gold Compounds including but not limited to:

- Auranofin (Ridaura)*
- Aurothioglucose/Gold Sodium Thiomalate (Solganal, Aurolate)*

78:00 **Radioactive Agents***
All Radioactive Agents including but not limited to: Amyvid (not in AHFS)

The Advanced Practice Registered Nurse with prescriptive authority may submit to the Formulary Advisory Council a written request to amend to the Exclusionary Formulary with documentation verifying a practice-specific prescriptive standard(s). (See the *Formulary Advisory Council Procedure for Amending the Formulary* on the Oklahoma Board of Nursing's web site at: http://www.nursing.ok.gov/prac-amndform.pdf

*Omitted from the print version of AHFS Drug Information because of space limitations. Updated drug information available on AHFS Drug Information website at: http://www.ahfsdruginformation.com

EXHIBIT E

IN THE DISTRICT COURT OF OKLAHOMA COUNTY
STATE OF OKLAHOMA

(1) SOUTH WIND WOMEN'S CENTER LLC, D/B/A TRUST WOMEN OKLAHOMA CITY, on behalf of itself, its clinicians and staff, and its patients; and (2) COLLEEN MCNICHOLAS, D.O., on behalf of herself and her patients; and (3) BRIDGET VAN TREESE, M.S.N., APRN-CNP, on behalf of herself and her patients, Plaintiffs, v. (1) MIKE HUNTER, in his official capacity as Attorney General of Oklahoma; and (2) DAVID PRATER, in his official capacity as Oklahoma County District Attorney; and (3) LYLE KELSEY, in his official capacity as Executive Director of the Oklahoma State Board of Medical Licensure and Supervision; and (4) G. ROBINSON STRATTON, III, in his official capacity as Executive Director of the Oklahoma State Board of Osteopathic Examiners; and (5) KIM GLAZIER, in her official capacity as the Executive Director of the Oklahoma Board of Nursing; and (6) GARY COX, in his official capacity as Oklahoma Commissioner of Health, Defendants.	)))))))))))))))))	Case No. __________________ Judge ______________________

AFFIDAVIT OF DANIEL A. GROSSMAN, M.D. IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY INJUNCTION

STATE OF CALIFORNIA)
) ss.
COUNTY OF ALAMEDA)

DANIEL A. GROSSMAN, M.D., being duly sown, deposes and says:

1. I am a Professor in the Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco (UCSF) and a board-certified obstetrician-gynecologist with over 20 years of clinical experience. I currently provide clinical services, including abortion services, at Zuckerberg San Francisco General Hospital. I am also a Fellow of the American College of Obstetricians and Gynecologists (ACOG), where I previously served as Vice Chair for the Committee on Practice Bulletins for Gynecology. I am currently Chair of the Committee on Health Care for Underserved Women. I am also a Fellow of the Society of Family Planning and a member of the American Public Health Association (APHA). Additionally, I serve as Director of Advancing New Standards in Reproductive Health (ANSIRH) at UCSF. ANSIRH conducts innovative, rigorous, multidisciplinary research on complex issues related to people's sexual and reproductive lives. I am also Senior Advisor at Ibis Reproductive Health, a nonprofit research organization. I am a liaison member of the Planned Parenthood National Medical Committee, and between 2012 and 2015 I provided clinical services with Planned Parenthood Northern California (formerly Planned Parenthood Shasta Pacific). My research has been supported by grants from federal agencies and private foundations. I have published over 170 articles in peer-reviewed journals, and I am a member of the Editorial Board of the journal *Contraception*.

2. I have served as an expert in cases challenging medically unnecessary and targeted regulations of abortion providers, including in a case that was decided by the Iowa Supreme Court, *Planned Parenthood of the Heartland, Inc. v. Iowa Board of Medicine*, 865 N.W. 2d 252 (Iowa 2015). In that case, I testified that the Iowa Board of Medicine's restrictions on the use of telemedicine for medication abortion were medically unjustified and detrimental to

women's health, and the Iowa Supreme Court ultimately struck down the restrictions as unconstitutional. My testimony was also cited by the United States Supreme Court in *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016). That case struck down as unconstitutional a Texas law requiring abortion providers to have hospital admitting privileges, which I opined provided no medical benefit and restricted access to abortion care.

3. I earned a B.S. in Molecular Biophysics and Biochemistry from Yale University and an M.D. from Stanford University of Medicine. I completed a residency in Obstetrics, Gynecology, and Reproductive Sciences at UCSF.

4. A current version of my curriculum vitae (CV), which sets forth my experience and credentials more fully, is attached to this declaration as Exhibit 1. My CV contains a complete list of the publications that I have authored or co-authored.

5. I submit this affidavit in support of Plaintiffs' motion for a Temporary Injunction enjoining enforcement of 63 O.S. § 1-729.1 (the "Physician In-Person Law"). I have reviewed the Physician In-Person Law and I understand that it prohibits physicians from providing any abortion procedure via telemedicine. In my opinion, the Physician In-Person Law serves no valid, medical purpose, and does nothing to enhance the safety of abortion in Oklahoma. Medication abortion is extremely safe, effective, and convenient. Telemedicine is common and widely used to deliver healthcare in Oklahoma, including medications that carry greater risks than medication abortion. The use of telemedicine for medication abortion is as safe and effective as in-person treatment. Accordingly, there is no medical justification for treating abortion differently than any other service that healthcare providers are permitted to provide via telemedicine.

6. The Physician In-Person Law also actively undermines women's health by delaying or preventing women from obtaining an abortion. Based on my professional experience, the availability of medication abortion through telemedicine has the effect of increasing access to medication abortion, which in turn helps women access care earlier in pregnancy. By unnecessarily curtailing the availability of medication abortion, the Physician In-Person Law thus hinders and delays women's access to abortion, which in turn potentially increases health risks and negatively affects public health.

7. The opinions in this affidavit are based on my education, clinical training, experience as a practicing physician over the past twenty-four years, my medical research, regular review of other medical research in my field, and attendance at professional conferences. The facts in this declaration, unless otherwise stated, are based on my personal knowledge.

Access to Safe and Legal Abortion is Vital to Public Health

8. Women seek abortions for a variety of medical, familial, economic, and personal reasons. 59% of women in the United States who seek abortions are already mothers who have decided that they cannot parent another child at this time.[1] In Oklahoma, this figure is 61%.[2] Approximately one out of four women in the United States will have an abortion in their lifetime.[3]

9. Women from many different backgrounds and demographics have abortions. In Oklahoma, 68% of abortion patients are white, 19% are black, and 13% identify with another

[1] Jenna Jerman, Rachel K. Jones, and Tsuyoshi Onda, Guttmacher Inst., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008* (May 2016).
[2] Oklahoma State Department of Health, Abortion Surveillance in Oklahoma: 2002-2018 Summary Report, at 11, https://www.ok.gov/health2/documents/2018%20ITOP%20Report.pdf.
[3] Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014*, 107 American Journal of Public Health 1904–1909 (2017); *see also* Guttmacher Institute, *Abortion Is a Common Experience for U.S. Women, Despite Dramatic Declines in Rates* (2017), https://www.guttmacher.org/news-release/2017/abortion-common-experience-us-women-despite-dramatic-declines-rates.

racial or ethnic classification. 58% of Oklahomans who have abortions are in their 20s, and 26% are in their 30s.

10. It is extremely vital for women to have timely access to legal abortion. Women with unwanted pregnancies face increased risks of poor health outcomes when they do not have access to safe abortion.

11. Abortion is an extremely safe and common medical procedure in the United States. A recent analysis of abortion care in the United States performed by the National Academies of Sciences, Engineering, and Medicine, concluded that abortion is extremely safe, involving minimal risks.[4] Major complications from an abortion occur in less than 0.25% of all cases.[5] Such complications are far rarer than those associated with pregnancy and childbirth. For example, the risk of death associated with childbirth is approximately 14 times higher than the risk of death associated with abortion.[6]

12. However, the risks from abortion increase when the pregnancy is further along. Thus, delaying abortions and imposing significant obstacles on women seeking abortion care raises the risk of complications.[7] Additionally, later abortion is more expensive, is offered at fewer locations, and there are fewer providers.[8]

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[4] National Academies of Science, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the United States*, at 2-26 (2018) ("The clinical evidence makes clear that legal abortions in the United States—whether by medication, aspiration, D&E, or induction—are safe and effective.").

[5] Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications after Abortion*, 125 Obstetrics & Gynecology 175, 181 (2015).

[6] Elizabeth G. Raymond and David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (2012).

[7] Suzanne Zane et al., *Abortion-Related Mortality in the United States: 1998-2010*, 126 Obstetrics & Gynecology 258–265 (2015); *see also* Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Obstetrics & Gynecology 729, 735 (2004).

[8] Rachel K. Jones, Meghan Ingerick, & Jenna Jerman, *Differences in Abortion Service Delivery in Hostile, Middle-ground, and Supportive States in 2014*, Womens Health Issues 212-218 (2018).

13. Some women turn to illegal and potentially less safe methods to terminate unwanted pregnancies when legal abortion is unavailable or difficult to access.[9] Other women that are deprived of access to legal abortion carry unwanted pregnancies to term. Women who carry a pregnancy to term, whether the pregnancy is wanted or unwanted, are at risk of death and major complications from childbirth.[10] In addition, women who carry an unwanted pregnancy are less likely to obtain prenatal care and have lower breastfeeding rates, and these women and their newborns are at risk of poor maternal and neonatal health outcomes.[11] Also, women forced to carry an unwanted pregnancy to term due to lack of access find it harder to bring themselves and their family out of poverty.[12] In many cases, women forced to carry to term who are also victims of partner violence will experience great difficulty escaping that abusive relationship because of the financial, emotional, and legal ties to that partner.[13]

14. For these reasons, ensuring timely access to legal abortion is essential to women's health.

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[9] Daniel Grossman et al., *Self-Induction of Abortion Among Women in the United States*, 18 Reproductive Health Matters 136 (2010); Daniel Grossman et al., *The Public Health Threat of Anti-Abortion Legislation*, 89 Contraception 73, 73 (2014); Tex. Pol'y Eval. Project, Research Brief: *Texas Women's Experiences Attempting Self-Induced Abortion in the Face of Dwindling Option*s (Nov. 17, 2015), http://liberalarts.utexas.edu/txpep/_files/pdf/TxPEP-Research-Brief-WomensExperiences.pdf.

[10] Raymond et al., *supra* note 6, at 216.

[11] AP Mohllajee et al., *Pregnancy Intention and Its Relationship to Birth and Maternal Outcomes*, 109 Obstetrics & Gynecology 678 (2007); Jessica D. Gipson, Michael A. Koenig, & Michelle J. Hinden, *The Effects of Unintended Pregnancy on Infant, Child and Parental Health: A Review of Literature*, 39 Stud. Fam. Plan. 18 (2008).

[12] Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 American Journal of Public Health 407–413 (2018); Ushma D. Upadhyay, M. Antonia Biggs & Diana Greene Foster, *The Effect of Abortion on Having and Achieving Aspirational One-Year Plans*, 15 BMC Women's Health 102 (2015); Am. Pub. Health Ass'n (APHA) Annual Meeting and Expo, Session 4150, Invited Panel: The Turnaway Study: Experiences of Women and Children Following Abortion and Denial of Abortion (see especially Diana Foster et al., *Effect of Being Denied a Wanted Abortion on Women's Socioeconomic Wellbeing* & Diana Foster, Sarah Raifman, & M. Antonia Biggs, *Effect of Abortion Receipt and Denial on Women's Existing and Subsequent Children*), https://apha.confex.com/apha/144am/meetingapp.cgi/Session/49007.

[13] Sarah C.M. Roberts et al., *Risk of Violence From the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, 12 BMC Medicine 144 (2014).

Abortion Methods in the United States

15. In the United States, there are generally two methods of performing an abortion: surgical, which uses various methods depending on the gestational age of the fetus, and medical, which entails the use of medications. This latter method, which is known as a "medical" or "medication" abortion, and which I refer to as "medication abortion," is generally only available through 70 days after the first day of the woman's last menstrual period (LMP) or through ten weeks of pregnancy.

16. Surgical abortion involves the use of instruments to evacuate the contents of the uterus. Whereas first-trimester surgical abortion is generally a simple procedure lasting five to ten minutes, the method becomes longer and more complex later in pregnancy. Surgical abortion often involves sedation and, in rare cases, general anesthesia, which add to the potential risks of the procedure.

17. Medication abortion, which has been approved by the FDA since 2000, involves safely and effectively terminating a pregnancy non-surgically, through a combination of two prescription drugs: mifepristone and misoprostol. Mifepristone works by blocking the hormone progesterone, which is necessary to maintain pregnancy. Misoprostol then causes the cervix to open and the uterus to contract and expel its contents, generally within hours, thereby completing the abortion. This regimen, which has been reviewed and approved by the FDA, safely and effectively terminates a pregnancy, and unlike surgical abortion, no sedation or anesthesia is required.[14]

[14] The FDA-approved label for mifepristone is available at https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf.

18. Prior to a medication abortion, women are typically screened for eligibility and contraindications, receive counseling, and are then provided with the medication. The provider confirms that the woman has an intrauterine pregnancy within the 70-day gestational age range, reviews the woman's medical history to ensure that she is not one of a small number of patients with a particular medical condition that makes her an inappropriate candidate for medication abortion, and discusses the medication abortion decision with the woman to ensure that she has made an educated and informed decision and understands what to do and what to expect. The patient first ingests the mifepristone and then takes the misoprostol twenty-four to forty-eight hours later.

19. Medication abortion is one of the safest procedures in contemporary medical practice. Major complications from medication abortion are extremely rare, and are far rarer than those associated with pregnancy and childbirth.[15] An authoritative study found that the major complication rate among medication abortions was only 0.31%.[16]

20. Medication abortion is the most common method of first-trimester abortion. In the United States, approximately 2.75 million women have had a medication abortion.[17]

21. Many women prefer medication abortion because they can complete the process in the privacy of their homes, with the company of loved ones, and at a time of their choosing.

[15] Raymond et al., *supra* note 6, at 216-217.
[16] Ushma D. Upadhyay et al., *supra* note 5, at 181; *see also* Kelly Cleland et al., Significant Adverse Events and Outcomes After Medical Abortion, 121 Obstetrics & Gynecology 166, 169 (2013) (concluding that only 16 out of every 10,000 medication abortion patients experienced a significant adverse event and fewer than 6 out of every 10,000 patients experienced complications resulting in hospital admission).
[17] Danco, *Mifeprex (mifepristone): FDA Approves Updated Labeling*, at 1 (2016), http://www.earlyoptionpill.com/wp-content/uploads/2016/03/Mifeprex-Label-Update_Press-Release_March302016.pdf.

Studies in the United States and elsewhere have found that women are very satisfied with the medication abortion method, and many prefer it to a first-trimester surgical abortion.[18]

22. Some women choose medication abortion because they fear a procedure involving surgical instruments. Victims of rape, or women who have experienced sexual abuse or molestation, may choose medication abortion to feel more in control of the experience and to avoid trauma from having instruments placed in their vagina.

23. For other women, there are medical reasons why medication abortion is a significantly safer option, and therefore medically preferable to a surgical abortion. These conditions include anomalies of the reproductive and genital tract, such as large uterine fibroids, female genital mutilation, vaginismus, or cervical stenosis, as well as severe obesity or an extremely flexed uterus, all of which make it difficult to access the pregnancy inside the uterus as part of a surgical abortion. For women with these conditions, medication abortion presents a significantly lower risk of both complications and failure than surgical abortion.

24. For all of these reasons, it is critical to public health that women seeking an abortion can access care as early in their pregnancy as possible, when it is safest and, for those who prefer medication abortion or require it for medical reasons, when they have the option of avoiding surgery. Given that medication abortion is only available as an option through the first ten weeks of pregnancy, even a delay of just a few days can potentially mean the difference between having access to medication abortion or not. The Physician In-Person Law, which limits the availability of medication abortion, is therefore depriving women of an option that has many benefits and is better suited for certain patients.

[18] Daniel Grossman, et al., *Changes in Service Delivery Patterns After Introducing Telemedicine Provision of Medical Abortion in Iowa*, Am. J. Public Health 73-78 (2013).

Telemedicine Medication Abortion Is Safe and Effective

25. Telemedicine is the delivery of health care services at a distance through information and communication technology.[19] Telemedicine has been used to expand the reach of physicians in many disciplines around the country and found to be safe and effective.[20]

26. Telemedicine for medication abortion is as safe and effective as in-person treatment.[21] The American College of Obstetricians and Gynecologists ("ACOG"), the leading organization of OB-GYNs, has issued a practice bulletin, most recently affirmed in 2016, which advises that medical abortion can be provided as safely and effectively via telemedicine as in-person treatment.[22]

27. The safety of telemedicine medication abortion has been subjected to rigorous scientific study. The two leading studies in the United States are peer-reviewed studies that I and several colleagues published in 2011 and 2017. In our 2011 Iowa study, we investigated the effectiveness and acceptability of telemedicine medication abortion compared to in-person medication abortion, and we found that the success rates were very similar: 98.7% for telemedicine patients and 96.9% for in-person patients.[23] No patient in this study required hospitalization.[24] In fact, the overall rate of adverse events in the study was less than 0.3%.[25]

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[19] *Id*.

[20] Daniel Grossman & Kate Grindlay, *Safety of Medical Abortion Provided Through Telemedicine Compared With In Person*, 130 Obstetrics & Gynecology 778–782 (2017); *see also* Victoria A. Wade et al., *A Systematic Review of Economic Analyses of Telehealth Services Using Real Time Video Communication*. BMC Health Serv Res 2010; 10:233.

[21] *Id*.

[22] American College of Obstetricians and Gynecologists, *Practice Bulletin No. 143: Medical Management of First-Trimester Abortion* (Mar. 2014), https://www.acog.org/Clinical-Guidance-and-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Gynecology/Medical-Management-of-First-Trimester-Abortion.

[23] Daniel Grossman et al., *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine*, 118 Obstetrics & Gynecology 296, 299 (Aug. 2011); *see also* National Academies of Sciences, Engineering, and Medicine, *supra* note 4.

[24] Grossman et al., *supra* note 23 at 299.

[25] *Id.*at 300

Importantly, we found that there was no significant difference in the occurrence of adverse events between telemedicine and in-person patients.[26]

28. In our 2017 Iowa study, we compared the safety of medication abortion between patients receiving services by telemedicine and those having an in-person visit at Planned Parenthood of the Heartland clinics in Iowa from July 1, 2008 to June 30, 2015.[27] In this 7-year study, 8,765 medication abortions were provided via telemedicine, and 10,405 medication abortions were provided through an in-person appointment.[28] We found that medication abortion patients rarely experienced clinically significant adverse events: only 0.26% of the 19,170 patients experienced an adverse event. The occurrence of an adverse event was even less common when the services were provided by telemedicine: only 0.18% of the 8,765 telemedicine patients experienced an adverse event. Across the entire study, there were no reported deaths or cases requiring surgery.[29]

29. Most recently, I co-published a study in 2019 that compared in-person medication abortion with telemedicine medication abortion over a one-year period in four states: Alaska, Idaho, Nevada, and Washington. Consistent with the Iowa studies, we found that less than 0.31% of patients in each group reported clinically significant adverse events, and there was no statistically significant difference between the two groups.[30]

30. As an expert panel convened by the National Academies of Sciences, Engineering and Medicine recently concluded, there is no medical need for medication abortion to be

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[26] *Id.*

[27] Daniel Grossman & Kate Grindlay, *supra* note 20 (finding that among patients who received medication abortion via telemedicine, the rate of clinically significant adverse effects was only 0.18%).

[28] *Id.*.

[29] *Id*.

[30] Julia E. Kohn et al., *Medication Abortion Provided Through Telemedicine in Four U.S. States*, 134 Obstetrics & Gynecology 343 (2019).

administered in the physical presence of a health care provider.[31] Screening women for contraindications and eligibility, providing counseling, and providing medication can be done with equal safety regardless of whether the physician is physically present in the room with the patient. Additionally, in the rare occasions when complications do arise, it would make no difference whether the patient obtained a medication abortion in person or through telemedicine. This is because in the rare instances when complications do arise from medication abortion, they occur *after* the patient has left the clinic.

31. Additionally, the reported risks of medication abortion are low and similar in magnitude to the adverse effects of common prescriptions and over-the-counter medications such as NSAIDs.[32] The exceptionally low mortality rate associated with medication abortion is also comparable to (or lower than) that associated with common prescription medications such as Viagra.[33] As the National Academies of Sciences, Engineering, and Medicine found, and the Iowa study shows, it is not necessary to provide medication abortion with an in-person visit with the clinician to ensure the safety of the patient, as the risks are essentially the same as common pharmaceuticals routinely obtained from pharmacies and taken at home.[34]

32. I understand that Oklahoma has utilized telemedicine since 1993. The Oklahoma Telemedicine Network, as it was known, was the first large-scale telemedicine network in the United States, and consisted of 45 rural hospitals, 15 regional hospitals, and the University of Oklahoma Sciences Center.[35] In 1997, Oklahoma passed the Oklahoma Telemedicine Act,

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[31] National Academies of Sciences, Engineering and Medicine, *supra* note 4, at 79.
[32] *Id*. at 58.
[33] Mifeprex REMS Study Group, Elizabeth G. Raymond et al., Sixteen Years of Overregulation: Time to Unburden Mifeprex, 376(8) New Eng. J. of Med. 790, 794 (2017).
[34] National Academies of Sciences, Engineering and Medicine, *supra* note 4, at 58.
[35] University of Oklahoma Health Sciences Center, *Telemedicine History; Telemedicine Overview*, https://www.ouhsc.edu/at/Center-for-Telemedicine.

which among other things, affirmatively required health insurers to include coverage for telemedicine services.[36] My understanding is that Oklahoma has consistently promoted the importance of telemedicine, and through organizations such as the Telemedicine Advisory Council, the University of Oklahoma's Center for Telemedicine, and the Oklahoma Rural Health Policy Center, has expanded the reach of telemedicine throughout the state, such that it is now commonplace in hundreds of healthcare facilities, including community health centers and clinics, community mental health centers, correctional facilities, schools, and Native American tribal facilities.[37]

33. A 2017 survey conducted by the Telehealth Alliance of Oklahoma and the Oklahoma State Department of Health found that telemedicine is being utilized across a wide range of medical specialties, including: addiction medicine, autism diagnosis, behavioral counseling, chronic disease management, high risk pregnancy, nephrology, oncology, psychiatry, radiology, and sleep medicine.[38] Neurologists in Oklahoma may now remotely diagnose stroke patients via telemedicine and may prescribe treatments such intravenous tissue plasminogen activator (IV-tPA). Although IV-tPA can be potentially life-saving for ischemic stroke victims, it also presents risks of intracranial hemorrhage and major systemic hemorrhage.[39] Oklahoma patients suffering from severe breathing problems can now consult with a pulmonologist via

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[36] *Id*; 36 O.S. § 6803.

[37] University of Oklahoma Health Sciences Center, *Telemedicine History; Telemedicine Overview*, https://www.ouhsc.edu/at/Center-for-Telemedicine; Samuel Clancy, *Removing Barriers to Telehealth in Oklahoma: Increasing Access to Care and Improving Health Outcomes Across the State*, 60 Okla. L. Rev. 805, 816-17 (2016).

[38] Telehealth Alliance of Oklahoma, *Oklahoma Telehealth Utilization 2017 Survey Results*, http://www.okoha.com/Images/OHADocs/Telemedicine/Telehealth%20Survey%2010-3-2017.pdf.

[39] *Mercy Hospital Logan County Now Offering Telestroke Services*, Mercy Hospital Website (Aug. 1, 2014), https://www.mercy.net/newsroom/2014-08-01/mercy-hospital-logan-county-now-offering-telestroke-services; *Nine Mercy Hospitals in Oklahoma Now Offer Telestroke Services*, Guthrie News Page (Oct. 28, 2014), https://guthrienewspage.wordpress.com/2014/10/28/nine-mercy-hospitals-in-oklahoma-now-offer-telestroke-services; Daniel J. Miller, et al., *Safety of Thrombolysis in Acute Ischemic Stroke: A Review of Complications, Risk Factors, and Newer Technologies*, 1 Neurohospitalist 3, 138-147 (July 2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3726129/.

telemedicine, rather than having to be transferred to a facility in another city to receive treatment.[40]

34. With the exception of opiates and other controlled substances—for which there are sound reasons for treating differently from other prescription medications—my understanding is that Oklahoma does not impose limitations on a physician's ability to prescribe medicine via telemedicine. Thus, except in the case of abortion, Oklahoma authorizes physicians to use telemedicine to provide treatment, including the provision of prescription medications, necessary to meet the patient's medical needs. There is no medically defensible reason for medication abortion to be excluded from the telemedicine services provided in Oklahoma.

35. Telemedicine for medication abortion has been used in Iowa since June 2008,[41] Alaska since 2011,[42] Maine, Idaho, Nevada, and Illinois since 2016,[43] and most recently in Washington, Colorado, Georgia, New Mexico, Hawaii, New York, and Oregon.[44] Providers have found it easy to integrate the new technology for telemedicine into their clinic operations, as it requires the same processes and clinic flow as an in-person visit.[45] Providers using telemedicine report that their interactions with the patients are essentially the same as an in-

[40] Michelle Charles, *SMC Makes Deal for Pulmonology Tele-health Services*, Stillwater News Press (September 25, 2018), https://www.stwnewspress.com/news/local_news/smc-makes-deal-for-pulmonology-tele-health-services/article_648dd3bc-95b5-535b-99aa-6abce110f5cc.html.
[41] Daniel Grossman, et al., *supra* note 18.
[42] Kate Grindlay & Daniel Grossman, *Telemedicine Provision of Medical Abortion in Alaska: Through the Provider's Lens.* J Telemed Telecare 680-685 (2017).
[43] Sarah Boden, *Maine Follows Iowa's Lead on Telemed Abortion Iowa Public Radio*, http://www.iowapublicradio.org/post/maine-follows-iowas-lead-telemed-abortion#stream/0; Angie Leventis Lourgos, *Illinois Clinic Provides Abortions Via Telemedicine, Which Provides Wider Access But Is Prohibited in 19 states,* Chicago Tribune (Jan. 19, 2018), http://www.chicagotribune.com/lifestyles/health/ct-met-telemedicine-abortion-illinois-20171220-story.html; Julie Spitzer, *How One Illinois Clinic Provides Abortions Via Telemedicine*, Becker's Hospital Review, https://www.beckershospitalreview.com/telehealth/how-one-illinois-clinic-provides-abortions-via-telemedicine.html; Julia E. Kohn, et al., *Medication Abortion Provided Through Telemedicine in Four U.S. States*, 134 Obstetrics & Gynecology 343 (2019).
[44] Gyunity TelAbortion: The Telemedicine Abortion Study, available at http://telabortion.org/.
[45] Grindlay & Grossman, *supra* note 42, at 682.

person visit.[46] Medication abortion through telemedicine is both cost and medically effective, and acceptability is high among women who choose this method of treatment.[47] In fact, telemedicine patients are more likely to recommend the service to a friend than face-to-face patients.[48]

36. For these reasons, there is no medical justification for treating medication abortion differently than other telemedicine medical procedures.

<u>Telemedicine Medication Abortion Improves Access for Women Seeking Abortion</u>

37. Telemedicine medication abortion helps to overcome barriers to abortion access because it allows women in underserved areas to access abortion earlier in pregnancy.[49] The number of abortion providers has declined over the last three decades in the United States, resulting in greater distances, longer wait times, and higher costs for some women to obtain treatment.[50] My understanding is that there are currently only four abortion clinics in Oklahoma: Trust Women in Oklahoma City; Planned Parenthood in Oklahoma City; Tulsa Women's Clinic in Tulsa; and Abortion Surgery Center in Norman. Yet there are 768,751 women of reproductive age in Oklahoma.[51] 54 percent of Oklahoma women live in a county without an abortion clinic.[52]

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[46] *Id.* at 683.
[47] Daniel Grossman et al., *supra* note 23, at 300; *see also* Kate Grindlay, Kathleen Lane, & Daniel Grossman, *Women's and Providers' Experiences with Medical Abortion Provided Through Telemedicine: A Qualitative Study.* Women's Health Issues 117-22 (2013).
[48] Daniel Grossman et al., *supra* note 23, at 300.
[49] *Id.* at 296-300.
[50] Alice F. Cartwright et al., *Identifying National Availability of Abortion Care and Distance From Major US Cities: Systematic Online Search*, 20 Journal of Medical Internet Research 5 (2018).
[51] U.S. Census Bureau, Population Division, *Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2018* (June 2018).
[52] Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2014*, 49:1 Perspectives on Sexual and Reproductive Health 17, 23 (2017).

38. Women seeking an abortion face significant personal, social, and financial obstacles. Most abortion patients live on incomes below 200% of the federal poverty level.[53] Oklahoma has one of the highest poverty rates in the country – it is ranked 43rd overall and 44th when it comes to working-age women specifically.[54] Approximately 16% of Oklahomans live in poverty.[55] For these women in particular, it is a struggle to pull together the resources to take time off from work and arrange transportation to obtain an abortion. One study from Arizona found that "the majority of women seeking abortion care had to forego or delay food, rent, childcare, or another important cost to finance their abortion."[56]

39. The majority of Oklahoman women who have abortions are already parents, and many have multiple children.[57] Therefore, they need to organize and/or pay for additional childcare when they have health care visits. These women may have inflexible work schedules and must work within narrow time constraints when arranging health care appointments. Some women must conceal these arrangements from abusive or controlling partners or family members.[58]

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[53] Jerman et al. *supra* note 1, at 11 ("75% of abortion patients are low income, having family incomes of less than 200% of the federal poverty level.").

[54] Talk Poverty, Center for American Progress, Oklahoma 2018 Report, https://talkpoverty.org/state-year-report/oklahoma-2018-report/.

[55] Alemayehu Bishaw and Craig Benson, U.S. Census Bureau, *Poverty: 2015 and 2016*, at 4 (Sep. 2017).

[56] Deborah Karasek, Sarah C.M. Roberts, & Tracey A. Weitz, *Abortion Patients' Experience and Perceptions of Waiting Periods: Survey Evidence Before Arizona's Two-visit 24-Hour Mandatory Waiting Period Law*, 26 Women's Health Issues 60, 64 (2016).

[57] Oklahoma State Department of Health, Abortion Surveillance in Oklahoma: 2002-2018 Summary Report, at 6, https://www.ok.gov/health2/documents/2018%20ITOP%20Report.pdf (61.1% of abortion patients had previously had a child). *See also* Jerman et al., *supra* note 1, at 7 (nationwide, 59% of abortion patients surveyed already had children, and 34% had two or more).

[58] *See* ACOG, *Comm. Op. No. 554: Reproductive & Sexual Coercion*, 121 Obstetrics & Gynecology 411 (2013); Michael Lupfer & Bohne Goldfarb Silber, *How Patients View Mandatory Waiting Periods for Abortion*, 13 Fam. Plan. Persps. 75, 76-77 (1981) (describing problems with delay, including increased expenses and missing additional time at work); Karasek, Roberts, & Weitz, *supra* note 56, at 62-63 (31% reported compromised confidentiality because they had to tell someone they did not want to tell); Sarah E. Baum et al., *Women's Experience Obtaining Abortion Care in Texas After Implementation of Restrictive Abortion Laws: A Qualitative Study*, 11 PLoS One I (2016).

40. When analyzing the impact of an abortion restriction, these existing logistical, financial, stigmatic, and other burdens that women already face in seeking to access abortion care are important factors to consider. In the context of medication abortion, which is only available during the first ten weeks of pregnancy, these burdens can be amplified because women who prefer or require medication abortion must obtain the abortion before the ten-week window has closed. As a result, any delays created or exacerbated by the restriction—even delays of a few days—have the potential to impede access and push women beyond the point when a medication abortion is possible.

41. Telemedicine medication abortion will improve access to abortion in Oklahoma by enabling existing clinics to provide more appointments with shorter wait times.[59] In underserved areas such as Oklahoma, it is often very difficult to staff clinics with local abortion providers. As a result, rather than staffing a clinic with physicians five days a week, clinics will often transport physicians to the clinic to provide services on a limited number of days per week. Allowing for telemedicine medication abortion eliminates this barrier to access by enabling existing clinics to increase both the numbers of days on which services are available, as well as the number of hours a clinic can provide services on a given day. Not only are more doctors available to provide services, but those doctors can spend more time actually providing services, rather than traveling to and from underserved areas such as Oklahoma. The resulting reduction in wait times not only increases access, but promotes women's health. For women who prefer or are medically advised to have a medication abortion rather than a surgical abortion, these decreases in wait times could make the difference between having access to medication abortion or not.

[59] Grindlay et al., *supra* note 47.

42. Prior to the introduction of telemedicine in Alaska, for example, the need to transport physicians limited the clinic's ability to offer abortion services to just once or twice a month.[60] This limitation increased the wait time for women to receive an abortion procedure, at times pushing women beyond the gestational limit for medication abortions.[61] As a result of telemedicine in Alaska, providers were able to schedule additional appointments that better met patients' needs and in turn allowed women to be seen at earlier gestational ages.[62]

43. Between October 2009 and February 2010, we conducted a study in Iowa, in which we performed in-depth interviews with women receiving telemedicine and clinic staff involved in providing medication abortion through telemedicine.[63] Clinic staff cited numerous benefits to introducing telemedicine in their practice: physicians can reach more patients; there is greater efficiency of resources with providers no longer having to travel long distances; and fewer delays related to travel in severe weather.[64] The greatest perceived impact in the study was the enhanced access for their patients.[65]

44. Another analysis suggests that when telemedicine services are available, women have a 46% greater likelihood of having an abortion at or before 13 weeks of pregnancy.[66] Because women often do not become aware that they are pregnant until about five weeks LMP or later, many women struggle to access care within the 10-week period medication abortion is available. By providing more scheduling options, telemedicine allows women to access abortion services earlier in their pregnancies. As explained, the earlier an abortion is performed, the

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[60] Grindlay & Grossman, *supra* note 42, at 681.
[61] *Id*.
[62] *Id.* at 681-682.
[63] Grindlay et al., *supra* note 47 at 118.
[64] *Id.* at 120.
[65] *Id.* at 120-121.
[66] Daniel Grossman, et al., *supra* note 18.

lower the potential risks are for the woman.[67] Thus, access to early abortion care benefits women and the public health because reducing second trimester abortions helps to reduce the rare health risks associated with abortions in the second trimester.

Conclusion

45. Oklahoma's prohibition of telemedicine medication abortion is an arbitrary, burdensome, and unreasonable restriction on the provision of medication abortion that serves no legitimate medical purpose. Because the provision of an in-person medication abortion is medically comparable to the provision of medication abortion via telemedicine, there is no medical justification for treating medication abortion differently from other telemedicine medical procedures. The Physician In-Person Law does nothing to promote women's health in the context of abortion. Rather, it actively undermines women's health by unnecessarily restricting abortion service providers' ability to provide services to women, potentially increasing risk and adversely affecting public health by infringing upon a woman's right to access abortion services.[68]

46. For all of the foregoing reasons, it is my opinion that Oklahoma's prohibition of telemedicine medication abortion will diminish women's access to care and will expose them to increased medical risk by delaying women's access to early abortion care and by preventing some women from obtaining medication abortion entirely.

Signed this 1st day of November 2019.

Daniel Grossman

Daniel Grossman, M.D.

[67] Zane et al., *supra* note 7 at 4.

[68] Grossman et al., *supra* note 18; *see also* Zane et al., *supra* note 7.

PLEASE
SEE ATTACHED
NOTARIZATION

ACKNOWLEDGMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of Alameda)

On November 1,2019 before me, Jacqueline D. Howard, Notary Public
(insert name and title of the officer)

personally appeared Daniel A Grossman,
who proved to me on the basis of satisfactory evidence to be the person~~(s)~~ whose name~~(s)~~ is/~~are~~ subscribed to the within instrument and acknowledged to me that he/~~she/they~~ executed the same in his/~~her/their~~ authorized capacity~~(ies)~~, and that by his/~~her/their~~ signature~~(s)~~ on the instrument the person~~(s)~~, or the entity upon behalf of which the person~~(s)~~ acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature (Seal)

NSP1 JACQUELINE D. HOWARD
COMM. #2223430
NOTARY PUBLIC - CALIFORNIA
ALAMEDA COUNTY
My Commission Expires 12/26/2021

EXHIBIT 1

DANIEL A. GROSSMAN, M. D., F. A. C. O. G.

Advancing New Standards in Reproductive Health, UCSF
1330 Broadway, Suite 1100
Oakland, CA 94612

Current position

Professor, Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco
Director, Advancing New Standards in Reproductive Health (ANSIRH)

Education

Sept. 1985-May 1989	Yale University-Molecular Biophysics and Biochemistry	B.S., 1989
Sept. 1989-June 1994	Stanford University School of Medicine	M.D., 1994
June 1994-June 1998	Resident and Administrative Chief Resident, Obstetrics, Gynecology and Reproductive Sciences, University of California, San Francisco	

Licenses/Certification

1996-Present	California medical licensure (A60282)
2001-Present	Board-certified, American Board of Obstetrics and Gynecology

Principal positions held

Aug. 1998-Feb. 2003 Aug. 2005-2012	Physician, St. Luke's Women's Center, San Francisco, CA
May 2003-Aug. 2005	Health Specialist, The Population Council Regional Office for Latin America and the Caribbean, Mexico City
Aug. 2005-Aug. 2015	Senior Associate (through June 2012), Vice President for Research (starting July 2012), Ibis Reproductive Health
Sept. 2015-Present	Professor, Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco
Sept. 2015-Present	Director, Advancing New Standards in Reproductive Health (ANSIRH)

Other positions held concurrently

Aug. 1998-Feb. 2003	Director of Medical Student Education, Department of Obstetrics and Gynecology, St. Luke's Hospital
Aug. 1998-Feb. 2003	Vice Chair, Department of Obstetrics and Gynecology, St. Luke's Hospital
Aug. 1998-2015	Assistant Clinical Professor, Bixby Center for Global Reproductive Health, Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco
2012-2015	Contract physician, Planned Parenthood Shasta Pacific
Aug. 2015-Present	Senior Advisor, Ibis Reproductive Health

Honors and awards

1988	Howard W. Hilgendorf Jr. Fellowship, Yale University
1988	Robin Berlin Memorial Prize, Yale University
1989	Magna cum laude, Yale University
1990	Medical Scholars Award, Stanford University
1990	Peter Emge Traveling Fellowship, Stanford University
1991-1992	Foreign Language and Area Studies Fellowship, Stanford University
1994	Dean's Award for Research in Infectious Diseases, Stanford University
2007	Ortho Outstanding Researcher Award, Association of Reproductive Health Professionals
2009	Visionary Partner Award, Pacific Institute for Women's Health
2010	Scientific Paper Award, National Abortion Federation
2013	Gerbode Professional Development Fellowship
2013	Abstract selected as one of Top 4 Oral Abstracts at North American Forum on Family Planning
2013	Felicia Stewart Advocacy Award from the Population, Reproductive and Sexual Health Section of the American Public Health Association
2018	Outstanding Resident Teaching Award, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF
2019	Beacon of Science Award, Society of Family Planning

Key words/areas of interest

Abortion, medication abortion, second-trimester abortion, contraception, over-the-counter access to oral contraception, integration of family planning into HIV care and treatment, Latina reproductive health in the US, misoprostol and self-induction of abortion, Mexico, Peru, Bolivia, Dominican Republic, South Africa, Kenya

PROFESSIONAL ACTIVITIES

PROFESSIONAL ORGANIZATIONS

Memberships

2000-Present:	Fellow, American College of Obstetrics and Gynecology (ACOG)
2006-Present:	Fellow, Society of Family Planning
2004-Present:	American Public Health Association
2013-Present:	American Medical Association
2004-2011:	Association of Reproductive Health Professionals
2004-2016:	International Consortium for Medical Abortion
2006-Present:	Liaison Member, Planned Parenthood Federation of America National Medical Committee
2005-Present:	Consorcio Latinoamericano contra el Aborto Inseguro (Latin American Consortium against Unsafe Abortion)
2004-Present:	Working Group on Oral Contraceptives Over-the-Counter

Service to professional organizations

2008-Present:	Society of Family Planning, reviewer of grant proposals, abstract reviewer for annual meeting

2007-Present:	American Public Health Association, Governing Councilor (2007-2009, 2010-2014), Section Secretary (2008-2009), abstract reviewer for annual meeting
2005-2012:	Consorcio Latinoamericano contra el Aborto Inseguro, member of Coordinating Committee
2006-Present:	Working Group on Oral Contraceptives Over-the-Counter, working group coordinator and member of steering committee
2010-2013:	Member, Committee on Practice Bulletins-Gynecology, ACOG
2014-Present:	Member, Committee on Health Care for Underserved Women, ACOG (Vice Chair of Committee 2016-18, Chair 2018-20)
2017-2018	Member, Telehealth Task Force, ACOG
2018-2019	Member, Telehealth Working Group, ACOG
2019	Member, Abortion Access and Training Expert Work Group, ACOG
2010-2016:	Steering Committee member, International Consortium for Medical Abortion
2016	External advisor for Marie Stopes International research strategy meeting, March 23-24, 2016, London, UK

SERVICE TO PROFESSIONAL PUBLICATIONS

2013-Present	Editorial Board, Contraception
2004-Present	Ad hoc reviewer for Obstetrics and Gynecology (10 papers in past 5 years), American Journal of Public Health (4 papers in past 3 years), Reproductive Health Matters (6 articles in past 4 years), Expert Review of Obstetrics and Gynecology (3 review in past year), and Women's Health Issues (4 articles in past 2 years), Lancet (2 reviews in past year)

INVITED PRESENTATIONS (Selected)

International

Second-trimester abortion. Optimizing the Potential for Medication in Pregnancy Termination in South America Conference, Lima, Peru, 2014 (invited talk).

Participation in panel at Harvard University seminar: Politics, Public Health, and Abortion: Examining the Changing Legal Environment in Mexico and Central America, Cambridge, MA, 2014 (invited talk).

Evidence for removing the prescription barrier to hormonal contraception. Annual meeting of the Associacion Française pour la Contraception, Paris, France, March 2015.

Presentations on medical abortion and second-trimester abortion, REDAAS (Red de Acceso al Aborto Seguro) meeting, Buenos Aires, Argentina, May 2015 (invited talk).

Panel participant in panel "Gestational limits for abortion: what purpose do they serve?" and presentations on adolescent pregnancy, telemedicine provision early medical abortion, and second-trimester abortion. Fifth Research Meeting on Unintended Pregnancy and Unsafe Abortion, Mexico City, September 2015 (invited talks).

Moving oral contraceptives over the counter as a strategy to reduce unintended pregnancy. The Human Right to Family Planning Conference, Seattle, WA, October 2015 (invited talk).

Over-the-counter access to hormonal contraception- what are the risks and benefits?, and Introduction of the mifepristone regimen for second-trimester medical abortion in South Africa. XXI FIGO World Congress of Gynecology and Obstetrics, Vancouver, Canada, October 2015 (oral presentations).

Second-trimester abortion. Presentation at the First Latin American Meeting on Public Sector Providers of Legal Abortion, Buenos Aires, Argentina, August 2016 (invited talk).

Safety, effectiveness and acceptability of telemedicine provision of medication abortion in Iowa, NAF regional meeting, Mexico City, September 2017 (invited talk).

Abortion in the United States: A new report on safety and the effects of being denied a wanted abortion. Presentation at "Evidencias y argumentos de salud pública para la legalización del aborto en Argentina," Buenos Aires, Argentina, May 2018 (invited talk).

Self-managed abortion in the United States. Presentation at "Abortion Beyond Bounds," Montreal, Canada, October 2018.

Gestational age limits in the United States: legal and service delivery perspectives. Presentation at "Interrupción del embarazo y edad gestacional," Buenos Aires, Argentina, August 2019 (invited talk).

<u>National</u>

Participation in panel entitled Abortion Scholarship: An Interdisciplinary Conversation, at UC Berkeley Symposium Speech, Symbols, and Substantial Obstacles: The Doing and "Undue"ing of Abortion Law since Casey, Berkeley, 2013 (invited talk).

Impact of restrictive abortion law on women in Texas. North American Forum on Family Planning, Seattle, 2013 (oral presentation).

Randomized Trial of Misoprostol versus Laminaria before Dilation and Evacuation in South Africa. Annual meeting of the National Abortion Federation, San Francisco, 2014 (oral presentation).

Introduction of the mifepristone regimen for second-trimester medical abortion in South Africa. Annual meeting of the National Abortion Federation, Baltimore, April 2015 (oral presentation).

Knowledge, opinion and experience related to abortion self-induction in Texas (oral abstract), and participant in panel "Addressing the global need for safe abortion after the first trimester." North American Forum on Family Planning, Chicago, November 2015 (oral presentations).

Participant in panel "Addressing the Challenges Facing Women's Reproductive Health Care," Academy Health National Health Policy Conference, Washington, DC, February 2, 2016 (invited talk).

Panel presentations entitled "Medical abortion restrictions: From label laws to abortion reversal," "Texas: Ground Zero in the Abortion Wars" and "Stolen Lives: Impact of early adolescent pregnancy on all aspects of health," Annual meeting of the National Abortion Federation, Austin, Texas, April 2016.

Panel presentations entitled "Evaluating Reproductive Health Policy at the State Level" and "Translating research into policy: Contributing data to the public debate when it matters most," North American Forum on Family Planning, Denver, November 2016.

Panel presentation entitled "Abortion Outside the Clinic: Imagining Safe and Legal Abortion in a post-Roe World," Physicians for Reproductive Health Grand Rounds, New York University School of Law, New York, March 2017.

"Safety of medication abortion provided through telemedicine: A non-inferiority study" (oral abstract), "Evaluating the provision of early medical abortion by telemedicine" (panel presentation), and "Use of research in evaluating Texas House Bill 2" (panel presentation). Annual meeting of the National Abortion Federation, Montreal, Canada, April 2017.

Using Evidence to Inform Policy in an Era of Alternative Facts, keynote address at Family Planning Symposium, "Family Planning Post-Election: Putting on our Fatigues," San Diego, May 2017.

"Improving access through over-the-counter status" (panel presentation), "Building bridges, not walls: using telemedicine to expand sexual & reproductive healthcare" (panel presentation), and "Expanding access to medical abortion through clinic-to-clinic telemedicine" (panel presentation). North American Forum on Family Planning, Atlanta, October 2017.

"Prevalence of Self-Induced Abortion Attempts among a Nationally Representative Sample of U.S. Women" (oral abstract), "What do we know about self-induced or self-managed abortion in the United States?" (panel presentation). Annual meeting of the National Abortion Federation, Seattle, April 2018.

"Driving Health Equity Through Innovation in Health Care," panel participant at plenary at the 2018 Planned Parenthood Federation of America National Conference, Washington, DC, April 2018.

Innovative Contraceptive Delivery Models. Presentation at National Reproductive Health Title X Conference, Kansas City, July 2018.

"Medication abortion in the United States" and panel participant in "The NASEM Report on Abortion Safety and Quality: implications for research, training, practice and advocacy." North American Forum on Family Planning, New Orleans, October 2018.

Research on telemedicine and abortion care, panel presentation. Annual meeting of the National Abortion Federation, Chicago, May 2019.

Alternative provision models for medication abortion: from pharmacy dispensing to OTC. Annual meeting of the Mifepristone Coalition, New York City, June 2019.

<u>Regional and other invited presentations</u>

Impact of family planning cuts and abortion restrictions in Texas. Grand rounds presentation, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF, 2013.

Improving access to early medical abortion through the use of telemedicine. Office of Population Research seminar, Princeton University, 2014 (invited talk).

Impact of family planning cuts and abortion restrictions in Texas. Grand rounds presentation, Department of Obstetrics and Gynecology, Emory University School of Medicine, Atlanta, Georgia, February 2015.

Impact of family planning cuts and abortion restrictions in Texas. Grand rounds presentation, Department of Obstetrics and Gynecology, Baylor University School of Medicine, Houston, Texas, April 2015.

The causes and consequences of unintended pregnancy among women in the US military. San Francisco General Hospital grand rounds, September 2015.

Impact of family planning cuts and abortion restrictions in Texas. Grand rounds presentation, Department of Obstetrics and Gynecology, University of New Mexico School of Medicine, Albuquerque, New Mexico, October 2015.

Using evidence and advocacy to improve second-trimester abortion care in South Africa. Grand rounds presentation, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF, December 2015.

UCSF/UCH Consortium Annual Supreme Court Review, panel speaker on Whole Woman's Health v. Hellerstedt, San Francisco, July 2016.

American Gynecological Club meeting, presentation on Reproductive Health in Texas and panel participant, San Francisco, September 2016.

Speaking science to the Court: the experience of experts in Whole Woman's Health v. Hellerstedt, panel participant, UC Hastings, San Francisco, October 2016.

How data made the difference in the Texas abortion case before the US Supreme Court. Grand rounds presentation, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF, November 2016.

Research That Gets Results: A Symposium on Science-Driven Policy Change, panel participant, UCSF, March 2017.

Medication abortion: What is it and how can its potential to improve access to care be realized? Presentation for UCSF Students for Choice, April 2017.

Medication Abortion: Supporting Women Both Inside and Outside the Clinic to Access Safe Care. Grand rounds presentation, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF, November 2017.

Medication Abortion: Supporting Women Both Inside and Outside the Clinic to Access Safe Care. Grand rounds presentation, Department of Obstetrics and Gynecology, Kaiser San Francisco, March 2018.

Medication Abortion: Supporting Women Both Inside and Outside the Clinic to Access Safe Care. Grand rounds presentation, Department of Obstetrics and Gynecology, University of Arizona College of Medicine, Tucson, June 2018.

Medication Abortion: Supporting Women Both Inside and Outside the Clinic to Access Safe Care. Presentation to Medical Students for Choice, University of Kansas Medical Center, July 2018.

Medication Abortion: Supporting Women Both Inside and Outside the Clinic to Access Safe Care. Grand rounds presentation, Department of Obstetrics and Gynecology, University of Alabama at Birmingham, October 2018.

Self-managed abortion in the US: What's happening, and what is our role? Grand rounds presentation, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF, November 2018.

Evidence-based advocacy to improve reproductive health. Annual Creinin Family Planning Lectureship, Department of Obstetrics, Gynecology & Reproductive Sciences, University of Pittsburgh, April 2019.

Evidence-based advocacy to improve reproductive health. Symposium speaker at the 2019 Research Retreat, Department of Obstetrics and Gynecology, University of Colorado, October 2019.

Demedicalizing reproductive health care: from OTC oral contraceptives to self-managed abortion. James C. and Joan Caillouette Lecture at the annual meeting of the Pacific Coast Obstetrical and Gynecological Society, San Diego, October 2019.

OTHER PROFESSIONAL SERVICE

2007	Member of the International Planned Parenthood Federation Safe Abortion Action Fund Technical Review Panel
2007-2009	Steering committee member of the California Microbicide Initiative
2002-2004	Member, Medical Development Team, Marie Stopes International (London)
2013-Present:	Reviewer of fellows' research proposals for the Fellowship in Family Planning
2013-2015	Member of working group on Guidelines for Task Shifting in Abortion Provision convened by World Health Organization

2014	Discovery working group member, Preterm Birth Initiative (PTBi), UCSF
2013-2019	Board member and Secretary (2014-2016), NARAL Pro-Choice America Foundation (service completed September 26, 2019)
2014-Present	Board member, NAF
2015-2019	Board member, Shift/Whole Woman's Health Alliance (service completed May 1, 2019)
2017	Study section member, U54 Contraceptive Center proposal review panel, National Institute of Child Health and Human Development

TEACHING

FORMAL SCHEDULED CLASSES:

Qtr	Academic Yr	Institution Course Title	Teaching Contribution	Class Size
W	2008-09	Harvard School of Public Health; GHP502 International reproductive health issues: Moving from theory to practice	Lecturer; 2 lectures	22
W	2009-10	Harvard School of Public Health; GHP502 International reproductive health issues: Moving from theory to practice	Lecturer; 1 lecture	17
F	2014-15	UCSF Coursera course; Abortion: Quality Care and Public Health Implications	Lecturer; 4 lectures	6,000+ (online)
F	2015-16	University of Texas at Austin; Sociology--Reproductive Health and Population in Texas; SS 301 Honors Social Science	Lecturer; 1 lecture	20
S	2016-17	UC Berkeley School of Law; 224.6 - Selected Topics in Reproductive Justice	Lecturer; 1 lecture	12
S	2018-19	University of Texas at Austin; Sociology—Graduate seminar in human fertility	Lecturer; 1 seminar	8

POSTGRADUATE and OTHER COURSES

Guest lecturer in "Qualitative Research Methods in Public Health," CUNY School of Public Health, September 2011

Women's health from a global perspective. Presentation at Obstetrics and Gynecology Update: What Does the Evidence Tell Us? UCSF CME course, San Francisco, 2007.

Expanding access to medication abortion. Presentation at Obstetrics and Gynecology Update: What Does the Evidence Tell Us? UCSF CME course, San Francisco, 2017.

A world post Roe v. Wade. Presentation at Obstetrics and Gynecology Update: What Does the Evidence Tell Us? UCSF CME course, San Francisco, 2019.

TEACHING AIDS

Contributed to the development of a training slide set on medical abortion in Spanish, 2004
Developed pocket cards on emergency contraception for use by community health workers in the State of Mexico, 2005
Reviewed and provided input on a manual on gynecologic uses of misoprostol published by the Latin American Federation of Obstetric and Gynecologic Societies (FLASOG), 2005
Grossman D. Medical methods for first trimester abortion: RHL commentary (last revised: 3 September 2004). The WHO Reproductive Health Library, No 8, Update Software Ltd, Oxford, 2005. Exerpt available at: http://www.rhlibrary.com/Commentaries/htm/Dgcom.htm.
Grossman D. Medical methods for first trimester abortion: RHL practical aspects (last revised: 3 September 2004). The WHO Reproductive Health Library, No 8, Update Software Ltd, Oxford, 2005.

RESEARCH AND CREATIVE ACTIVITIES

PEER REVIEWED PUBLICATIONS

1. Laudon M, Grossman DA, Ben-Jonathan N. Prolactin-releasing factor: cellular origin in the intermediate lobe of the pituitary. Endocrinology 1990; 126(6):3185-92.
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LANGUAGES

Fluent in Spanish, conversant in French.

EXHIBIT F

IN THE DISTRICT COURT OF OKLAHOMA COUNTY
STATE OF OKLAHOMA

(1) SOUTH WIND WOMEN'S CENTER LLC, D/B/A TRUST WOMEN OKLAHOMA CITY, on behalf of itself, its clinicians and staff, and its patients; and (2) COLLEEN MCNICHOLAS, D.O., on behalf of herself and her patients; and (3) BRIDGET VAN TREESE, M.S.N., APRN-CNP, on behalf of herself and her patients, Plaintiffs, v. (1) MIKE HUNTER, in his official capacity as Attorney General of Oklahoma; and (2) DAVID PRATER, in his official capacity as Oklahoma County District Attorney; and (3) LYLE KELSEY, in his official capacity as Executive Director of the Oklahoma State Board of Medical Licensure and Supervision; and (4) G. ROBINSON STRATTON, III, in his official capacity as Executive Director of the Oklahoma State Board of Osteopathic Examiners; and (5) KIM GLAZIER, in her official capacity as the Executive Director of the Oklahoma Board of Nursing; and (6) GARY COX, in his official capacity as Oklahoma Commissioner of Health, Defendants.	Case No. _________________ Judge ____________________

AFFIDAVIT OF JOANNE SPETZ, PH.D. IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY INJUNCTION

STATE OF CALIFORNIA)
) ss.
COUNTY OF SAN MATEO)

JOANNE SPETZ, Ph.D., being duly sworn, deposes and says:

1. I am a Professor within the Philip R. Lee Institute for Health Policy Studies, Department of Family and Community Medicine, and School of Nursing at the University of California, San Francisco. In these and previous positions, I have engaged in extensive research relating to advanced practice registered nurses ("APRNs"); the impact of laws and regulatory policies on health behaviors and health workforce labor markets; and the quality of care provided by nurses. I have a particular interest in how the organization and regulation of our health care system affects the provision of, and access to, care.

2. I hold an M.A. and Ph.D. in Economics from Stanford University, which I received in 1993 and 1996, respectively. I also received a Bachelor's of Science in Economics from the Massachusetts Institute of Technology.

3. I have authored or supervised numerous studies and systematic reviews evaluating how restrictions on APRNs' scope of practice—that is, rules defining which services licensed APRNs can provide, and under what circumstances—affect health care delivery and access to care. Currently, I am serving as a Co-Investigator in an ongoing study evaluating how state nurse practitioner scope of practice regulations impact access to health care services among those living in underserved areas. I have been a Principal Investigator on multiple grants from the Robert Wood Johnson Foundation measuring progress toward nationwide implementation of recommendations by the Institute of Medicine's Committee on the Future of Nursing, discussed in greater detail below. I recently completed reviews of the literature on the effect of nurse practitioner and nurse midwife scope of practice regulations on access, cost, and quality of health care for the California Health Care Foundation. I am also now Principal Investigator of a study of whether APRN scope of practice affects growth of the workforce for opioid use disorder

treatment with funding from the National Council of State Boards of Nursing.

4. I am a member of a multiple professional societies, such as AcademyHealth (formerly Association for Health Services Research), the American Society of Health Economists, and the International Health Economics Association, and I currently serve on the editorial board and as a reviewer for several academic journals, including *Medical Care Research and Review*, *Health Services Research*, *Health Affairs*, and *Medical Care*. From 2009 to 2011, I served as a Consultant to the Institute of Medicine's Committee on the Future of Nursing, and I am a member of the UnitedHealth Group External Clinician Advisory Board.

5. A full list of my employment history, publications, presentations, professional memberships, and honors and awards is included in my curriculum vitae, which is attached as Exhibit A.

6. As a health care economist, I specialize in evaluating how systemic structures affect access to and quality of health care. The opinions expressed below are informed by my deep familiarity with (and contributions to) the research and literature relating to the role and regulation of APRNs in the United States health care system, as well as my education, training, research, attendance at and participation in conferences relating to health care economics, APRN scope of practice, and health care services, as well as my ongoing review of relevant literature.

7. For my work on this case, I will be reimbursed at a rate of $250/hour for work involving travel, for taking time off work, and for reasonable out-of-pocket costs and travel expenses.

<u>The Role of APRNs in the Health Care System of the United States</u>

8. APRNs are vital participants in the United States health care system.

9. In recent years, APRNs have seen their practice authority expand significantly.

This is for several reasons: states and accreditation bodies have heightened educational standards for APRNs, thereby expanding their expertise; a large and growing body of research has confirmed that APRNs can provide a wide range of medications and procedures safely and effectively; and the nation's physician shortage has worsened, increasing reliance on other practitioners.

10. Today, APRNs around the country are providing a broader range of services than ever before, with fewer conditions and limitations. APRNs can obtain prescriptive authority in every state, including prescribing of Schedule III controlled substances. APRNs practice in a wide range of specialties, including primary, gynecological, maternity, acute, and chronic care. APRNs are particularly important health care providers for low-income patients and those living in medically underserved areas.

11. Citing the robust evidence confirming the safety of APRN provision of care within their scope of practice, and the nation's urgent health care needs, leading authorities—such as the Institute of Medicine, the Federal Trade Commission, and the National Governors Association—recommend that APRNs take on an even greater role in the health care system.[1]

12. I understand that one of the restrictions at issue in this case prohibits APRNs in Oklahoma from providing medication abortion regardless of whether such care is within an APRN's competency and regardless of patient need. I refer to this restriction as the "Physician-

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[1] Institute of Medicine of the Nat'l Academies of Sciences, Engineering & Medicine, *The Future of Nursing: Leading Change, Advancing Health* 106 (2011), https://www.nap.edu/read/12956/chapter/1 [hereinafter "IOM Report"]; Daniel J. Gilman & Tara Isa Koslov, Fed. Trade Comm'n, *Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses* 12 (2014), https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf [hereinafter "FTC Report"]; Nat'l Governors Assoc., *The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care* 8 (2012), https://classic.nga.org/cms/home/nga-center-for-best-practices/center-publications/page-health-publications/col2-content/main-content-list/the-role-of-nurse-practitioners.html [hereinafter "NGA Report"].

Only Law." It is my expert opinion that this Physician-Only Law does not reflect the current research about APRN abilities, undermines APRNs' ability to care for patients, and is out-of-step with APRNs' essential role in the nation's health care system.

13. In support of this conclusion, I begin with an overview of how APRNs are regulated throughout the country. I then describe how APRNs have become an increasingly important component of the health care system in the United States over recent decades, as their training has become more sophisticated and demanding, and their scope of practice and ability to work autonomously has expanded. I then review studies demonstrating high levels of patient care by and satisfaction with APRNs, and APRNs' success in providing services in areas underserved by other health care professionals. Finally, I discuss APRN practice in Oklahoma, APRN provision of abortion services, and the legal barriers facing APRNs in Oklahoma who are qualified to provide medication abortions in the State.

14. In Oklahoma, as elsewhere, state restrictions banning or otherwise deterring APRNs from providing medication abortions are anachronistic and contradict how these clinicians are otherwise regulated.

Regulation of APRNs Across the Country

15. There are four recognized categories of APRNs in the United States. Certified nurse practitioners ("NPs"), who provide a broad array of health services; certified nurse-midwives ("CNMs"), who specialize in reproductive health and child birth; certified registered nurse anesthetists, who administer anesthesia and provide related care; and clinical nurse specialists, who provide advanced nursing care and acute and chronic care management. APRNs who provide abortion care are most likely to be NPs or CNMs.

16. NPs provide a broad array of health services, including taking health histories and

performing physical exams, diagnosing and treating acute and chronic illnesses, providing immunizations, performing procedures, ordering and interpreting lab tests and x-rays, coordinating patient care across multiple providers, providing health education and counseling, and prescribing and managing medications and other therapies (including at least Schedule III controlled substances in every state). The various roles NPs play throughout the country are similar to the roles played by physicians.[2] NPs account for roughly one-quarter of primary care providers nationwide, and NPs are a key source of care in community health centers and nurse-managed health centers, which serve about 20 million patients a year.[3]

17. Today, all states require NP applicants to hold a registered nurse license and prove their competency as an NP through additional certification and/or educational requirements. Forty-five states (including Oklahoma) and the District of Columbia require completion of a master's, postgraduate, or doctorate degree from an accredited NP program, and then certification from a nationally recognized certifying body such as the American Academy of Nurse Practitioners or the American Nurses Credentialing Center.[4] The certification "tests the applicant's knowledge and skill in diagnosing, determining treatments, and prescribing for their patient population of focus."[5] The five states that do not require such national certification for NP licensure (California, Indiana, Kansas, Nevada, and New York) instead require either

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[2] Alexandra Hobson & Alexa Curtis, *Improving the Care of Veterans: The Role of Nurse Practitioners in Team- Based Population Health Management*, 29 Am. Assoc. Nurse Practitioners 644, 645 (2017) ("NPs function in a similar capacity to physicians within the VHA primary care system including serving as primary care providers.").

[3] Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, *Improving Access to Adult Primary Care in Medicaid: Exploring the Potential Role of Nurse Practitioners and Physician Assistants*, 3 (2011).

[4] NGA Report, *supra* note 1.

[5] *Id.* The five remaining states allow NPs to complete a board-approved master's degree with similar course requirements to those accepted by the national certifying bodies in lieu of a national certification. *Id.*

certification, or completion of a board-approved master's degree with similar course requirements to those accepted by the national certifying bodies.[6]

18. CNMs provide primary and specialized care to women, including: primary care; gynecological and family planning services; preconception care; care during pregnancy, childbirth, and the postpartum period; newborn care during the first 28 days of life; and treatment of male partners for sexually transmitted infections. Additionally, they conduct physical examinations; prescribe medications, including certain controlled substances and contraceptive methods; admit, manage, and discharge hospitalized patients; order and interpret laboratory and diagnostic tests; and order the use of medical devices.[7]

19. CNMs are educated in both midwifery and nursing. As with NPs, all states today require CNM applicants to hold a registered nurse license and prove their competency through additional certification and/or educational requirements. CNM licensure is managed by either the state medical board, or by both the nursing and medical boards. The District of Columbia and every state except Pennsylvania require completion of a master's, postgraduate or doctorate degree from an accredited CNM program, and all but four states require certification by the American Midwifery Certification Board.[8]

20. Throughout the country, all APRNs are subject to two principal layers of regulation: licensure and scope of practice. As with many occupations, licensure is "a process that establishes the conditions for entry into an occupation. . . . Generally, an applicant for licensure must demonstrate a minimum degree of competence, based on education and training,

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[6] NGA Report, *supra* note 1.

[7] Hobson & Curtis, *Improving the Care of Veterans* at 645.

[8] Nat'l Council of State Bds. of Nursing, Consensus Model Implementation Status Scoring Grid (last updated Oct. 2018), https://www.ncsbn.org/APRN_Consensus_Grid_Oct2018.pdf [hereinafter "Consensus Model Scoring Grid"].

to obtain the government's permission to provide professional services in a given jurisdiction."[9]

21. Scope of practice rules dictate which patients an APRN may treat; what services they may deliver; and the extent to which they are permitted to practice independently or without direct physician supervision. Scope of practice rules may prohibit APRNs from performing certain services or treating certain categories of patients unless they first complete additional training, obtain a particular certification, or obtain and document a specific form of supervision (e.g., from a physician or a more experienced APRN). APRNs are also trained to recognize those cases in which a patient has complex needs requiring evaluation or treatment beyond the clinician's education, training, or skills—just as a physician would refer patients to a specialty provider if the patient's needs are outside of the physician's area of expertise.

22. APRNs' scope of practice is governed by state law under a state's nurse practice act and is administered and regulated by each state's board of nursing. In Oklahoma, for example, APRN licensure is managed by the Oklahoma Board of Nursing. The broad outlines of health professionals' scope of practice are generally set by state legislatures, which then delegate to the state's board of nursing responsibility for establishing specific rules. These rules are enforced under penalty of professional discipline.

Expanded Role of APRNs in the United States Health Care System

23. The vital role that APRNs play in the delivery of healthcare in the United States represents a substantial advancement in nursing practice from where it stood in the 20th century, or even two or three decades ago. This is a product of three interwoven trends that have coincided with a dramatic increase in the number of APRN graduates: (1) enhanced educational requirements for APRN licensure; (2) steadily expanding APRN scope of practice; and (3)

[9] FTC Report, *supra* note 1.

greater utilization of APRNs' services, particularly in the context of reproductive health and pregnancy care.[10]

Enhanced Educational Requirements for APRNs

24. Today, all NP programs in the United States are offered at the graduate level and are required to be accredited by a nationally recognized nursing or accreditation body.[11] This was not always the case. The first educational programs for NPs were established in the 1960s and 1970s, and they conferred certificates rather than diplomas. Many NPs received their education from programs based out of hospitals rather than universities. However, over the years, certification bodies and state legislatures have uniformly moved to require a graduate degree for new NPs, grandfathering in those licensed earlier. As of 2017, 99.1% of NPs hold graduate degrees.[12] NPs take graduate-level courses in topics including physiology, various body systems, and diagnosis and treatment of illnesses and conditions. NPs then receive further education in their chosen area of focus, such as family practice, pediatrics, women's health, adult-gerontology, psychiatry, or acute care.

25. Although midwifery has a long history—women have likely been assisting other women in childbirth for millennia—nurse midwifery was not established as a distinct field until 1925, and national certifications in nurse midwifery were first offered in 1970 by the American College of Nurse Midwives. A graduate degree has been required for new applicants for

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[10] John K. Iglehart, *Expanding the Role of Advanced Nurse Practitioners – Risks and Rewards*, 368 N. Engl. J. Med. 1935, 1937 (2013); Am. Assoc. of Nurse Practitioners, NP Fact Sheet (last updated Aug. 2019), https://www.aanp.org/all-about-nps/np-fact-sheet [hereinafter "AANP Fact Sheet"].

[11] Westat for the Office of the Assistant Secretary for Planning & Evaluation, *Impact of State Scope of Practice Laws and Other Factors on the Practice and Supply of Primary Care Nurse Practitioners: Final Report*, 27 (2015), https://aspe.hhs.gov/system/files/pdf/167396/ NP_SOP.pdf [hereinafter "ASPE Report"].

[12] AANP Fact Sheet, *supra* note 10.

certification by the American Midwifery Certification Board only since 2010.[13] Today virtually every state (including Oklahoma) requires CNMs to have an advanced degree from an accredited CNM program, and typically those licensed before this requirement went into effect are grandfathered in, which is also the recommendation of the American College of Nurse-Midwives.[14] In 2010 and 2009 studies based on nationwide surveys, approximately 82% of CNMs held master's degrees,[15] and 4.8% of CNMs held doctoral degrees.[16]

26. There is a growing trend toward curriculum standardization for APRNs across institutions.[17] In 2008, after five years of study and debate, a group of nursing accreditation, certification, and licensing organizations, along with several APRN groups, developed a consensus model for the accreditation, education, training, certification and licensure of APRNs.[18] Every state's board of nursing has signed onto the APRN consensus model, although changes to rules and regulations are generally required to be approved by the state legislatures. To date, 16 states have fully enacted the consensus model for all APRN roles.[19] Oklahoma has enacted the model for all APRN roles with respect to educational and national certification

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[13] Am. Coll. Of Nurse-Midwives, Essential Facts about Midwives (last updated May, 2019), http://www.midwife.org/Essential-Facts-about-Midwives [hereinafter "ACNM Fact Sheet"].

[14] Am. College of Nurse-Midwives, Position Statement, *Mandatory Degree Requirements for Entry into Midwifery Practice* (approved June 2015), http://www.midwife.org/default.aspx?bid=59&cat=3&button=Search.

[15] Fullerton J, Schuiling K, Sipe TA. *Findings from the Analysis of the American College of Nurse-Midwives' Membership Surveys: 2006-2008*. 55 Journal of Midwifery & Women's Health (2010), 299-307.

[16] Theresa Ann Sipeet al., *Demographic Profiles of Certified Nurse-Midwives, Certified Registered Nurse Anesthetists, and Nurse Practitioners: Reflections on Implications for Uniform Education and Regulation*, 25 Journal of Professional Nursing 3 (May–June 2009), 180.

[17] ASPE Report, *supra* note 11, at 27.

[18] IOM Report, *supra* note 1.

[19] Consensus Model Scoring Grid, *supra* note 8.

requirements.[20]

Expanded Authority for APRN Practice

27. Perhaps the most significant change over the past two decades is the broadening of APRN practice authority. In 1997 alone, 37 states enacted 83 laws expanding scope of practice for APRNs.[21] Between 2004 and 2012, eight additional states liberalized their scope of practice rules for APRNs.[22] Since 2010, 21 states have enacted regulatory changes that have provided NPs with a greater degree of practice authority, including nine states that now allow NPs to practice without physician oversight.[23] In total, 26 states and the District of Columbia allow NPs to practice and prescribe without physician oversight.

28. Today, NPs hold prescription privileges in all 50 states and the District of Columbia.[24] NPs and CNMs may prescribe controlled substances, including Schedule III substances in every state.[25] As of 2018, 95.7% of NPs prescribed medications, and those in full-time practice write an average of 20 prescriptions per day.[26] This includes drugs that carry risks of significant adverse effects, such as the heart medicine Digoxin, the blood thinner Warfarin,

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[20] *Id.*

[21] Druss et al., *Trends in Care by Nonphysician Clinicians in the United States*, 348 N. Engl. J. Med. 130, 131 (2003) (citing Nat'l Conference of State Legislatures, Health Policy Tracking Service, State Laws Governing Nonphysician Clinicians' Scope of Practice in 1997: Special Report (2002)).

[22] ASPE Report, *supra* note 11, at 18; *see also* Iglehart, *supra* note 10, at 1939.

[23] Joanne Spetz, Healthforce Ctr. at UCSF, *California's Nurse Practitioners: How Scope of Practice Laws Impact Care* 7 (2018).

[24] AANP Fact Sheet, *supra* note 10.

[25] Am. Med. Assoc. Advocacy Resource Ctr., *State Law Chart: Nurse Practitioner Prescriptive Authority* (2017), https://www.ama-assn.org/sites/default/files/media-browser/specialty%20 group/arc/ama-chart-np-practice-authority.pdf; U.S. Dep't of Justice, Drug Enforcement Admin., Controlled Substance Schedules, https://www.deadiversion.usdoj.gov/schedules/ (last visited Oct. 2, 2019); Kathryn Osborne, *Regulation of Prescriptive Authority for Certified Nurse-Midwives and Certified Midwives: 2015 National Overview*, 60 J. Midwifery & Women's Health 519, 530 (2015).

[26] AANP Fact Sheet, *supra* note 10.

and various antibiotics.[27]

29. Notably, the United States Drug Enforcement Administration ("DEA") does not place any unique restrictions on APRN prescription of controlled substances. APRNs may register with the DEA just as physicians do, and they are authorized to prescribe controlled substances consistent with any state-specific requirements (such as additional educational or supervision requirements). Since 2017, they have been allowed to apply for a waiver to prescribe buprenorphine for the treatment of opioid-use disorder outside of narcotics treatment programs.[28]

30. Leading national authorities, such as the National Academy of Medicine of the National Academies of Sciences, Engineering & Medicine (previously called the Institute of Medicine, or "IOM"), the FTC, the National Governors Association, and AARP agree on the need to eliminate scope of practice restrictions that prevent APRNs from practicing to their full capacity. These organizations have all concluded that scope of practice barriers needlessly prevent APRNs from fully utilizing their education and training while diminishing their ability to meet patients' pressing health care needs.[29] In 2008, the Robert Wood Johnson Foundation and IOM launched a two-year study to assess and transform the nursing profession, which

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[27] Digoxin can be toxic to some patients, and the incidence of hospitalization for suspected digoxin toxicity was found to be 2%. GlaxoSmithKline, *Lanoxin (digoxin) Prescription Information* (August 2009), https://www.accessdata.fda.gov/drugsatfda_docs/label/2010/020405s004lbl.pdf. Warfarin can cause hemorrhaging, and about 29,000 emergency room visits per year are due to bleeding complications associated with Warfarin. Warfarin accounts for up to 33% of all adverse drug events in patients 50 years or older. Diane K. Wysowski et al., *Bleeding Complications With Warfarin Use: A Prevalent Adverse Effect Resulting in Regulatory Action*, 167 Arch Intern Med. 13 (2007), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/412786. Adverse reactions to antibiotics, meanwhile, lead to approximately 150,000 visits to emergency rooms annually. Centers for Disease Control and Prevention, *Adverse Drug Events in Adults* (Feb. 23, 2019), https://www.cdc.gov/MedicationSafety/Adult_AdverseDrugEvents.html.

[28] Comprehensive Addiction and Recovery Act of 2016, Pub. L. No. 114-198, 130 Stat. 695 (2016).

[29] IOM Report, *supra* note 1; FTC Report, *supra* note 1, at 4; NGA Report, *supra* note 1, at 11.

culminated with the publication of a report in 2010 entitled *Future of Nursing: Leading Change, Advancing Health.* The report's number one recommendation for the future of nursing is to "[r]emove scope-of-practice barriers. Advanced practice registered nurses should be able to practice to the full extent of their education and training."[30]

Increased Reliance on APRNs Throughout the Country

31. As the number of APRNs has increased and their practice authority has expanded, a growing number of Americans now rely on these clinicians for care. The Kaiser Family Foundation reports that "NPs are . . . by far, the fastest growing segment of the primary care professional workforce; between the mid-1990s and the mid-2000s, their numbers (per capita) grew an average of more than 9% annually, compared with . . . just 1% for primary care physicians."[31] Between 1998 and 2010, the number of Medicare patients receiving care from NPs increased fifteen-fold.[32] Similarly, the proportion of singleton births (i.e., a birth of a single child) attended by CNMs increased nationwide from 5.3 percent in 1994 to 8.4 percent in 2013.[33] The percentage of births attended by CNMs has risen every year since 1989.[34]

32. The growing reliance on APRNs is particularly true in the context of pregnancy care. A study of two nationally representative surveys found that the proportion of patients who saw a non-physician clinician (broadly defined) for any type of healthcare rose from 30.6% to

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[30] IOM Report, *supra* note 1, at 9.

[31] Kaiser Family Foundation, *supra* note 3, at 3.

[32] Yong-Fang Kuo et al., *States With the Least Restrictive Regulations Experienced the Largest Increase in Patients Seen by Nurse Practitioners*, 32 Health Aff. (Millwood) 1236, 1236 (2013).

[33] Sara Markowitz et al., *Competitive Effects of Scope of Practice Restrictions: Public Health or Public Harm?*, 55 J. Health Econ. 201, 217 (2017).

[34] American College of Nurse-Midwives, *Fact Sheet: CNM/CM-attended Birth Statistics in the United States*, June 2015, http://www.midwife.org/acnm/files/ccLibraryFiles/ Filename/000000005464/CNM-CMAttendedBirthStatisticsJune2015.pdf.

36.1% between 1987 and 1997.[35] In many specialties, both the number of patients treated by physicians and non-physicians increased. However, for pregnancy care, the surveys showed a decrease in the proportion of women receiving pregnancy-related care from physicians and an increase in the proportion receiving such care only from non-physicians.[36]

33. NPs have also been serving as primary care providers in hundreds of clinics nationwide, where they treat common conditions such as ear infections and bronchitis. The Kaiser Family Foundation reported in 2011 that NPs "are a key source of primary care in community health centers and in 250 nurse-managed health clinics across the country, which serve about 20 million patients a year. According to one account, about 10,000 NPs run their own practices."[37]

34. At the same time, a substantial number of NPs work in hospitals, providing acute care side-by-side hospitalist physicians. Indeed, health care institutions are increasingly incorporating NPs into inpatient care, often as primary providers, with strong results. According to the American Association of Nurse Practitioners' 2018 national sample survey, nearly half of all NPs in the United States hold hospital privileges.[38]

<u>Research Confirms the Efficacy and Safety of, and Patient Satisfaction With, Care by APRNs</u>

35. There is a large body of literature confirming the efficacy and safety of, and patient satisfaction with, APRN provision of health services. Studies show that APRNs working within their scope of practice treat patients just as effectively as physicians.

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[35] Druss, *supra* note 21, at 133–34.

[36] *Id.* at 135.

[37] Kaiser Family Foundation, *supra* note 3, at 3.

[38] AANP Fact Sheet, *supra* note 10.

36. For example, a report by The Office of the Assistant Secretary for Planning Evaluation in the United States Department of Health and Human Services ("ASPE") notes that "[p]atient satisfaction with and consumer acceptance of NPs are high, and clinical outcomes have repeatedly been found equivalent with those of physicians."[39] According to the National Governors' Association, "[n]one of the studies in [its] literature review raise concerns about the quality of care offered by NPs. Most studies showed that NP-provided care is comparable to physician-provided care on several process and outcome measures. Moreover, the studies suggest that NPs may provide improved access to care."[40] The FTC noted in a 2014 report that "FTC staff are not aware of any contrary empirical evidence to support the contention that there are patient harms or risks associated with APRN prescribing of non-controlled substances."[41] Data from two intensive care units ("ICUs") at Columbia Presbyterian Medical Center in New York—where one unit was staffed by medical residents and the other unit was staffed by NPs and physician assistants—demonstrated equivalent outcomes in hospital mortality, length of hospital stay, length of ICU stay, and discharge destination.[42]

37. Indeed, multiple systematic reviews have found consistent evidence that NPs provide comparable or better care within their scope of practice than do physicians, with comparable or better outcomes.[43] Studies have found comparable safety, accuracy, and

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[39] ASPE Report, *supra* note 11, at 10 & A-2.

[40] NGA Report, *supra* note 1, at 7–8.

[41] FTC Report, *supra* note 1, at 37-38.

[42] Hayley B. Gershengorn et al., *Impact of Nonphysician Staffing on Outcomes in a Medical ICU*, Chest, Vol. 139, 1347-1353 (2011).

[43] *See, e.g.*, Julie Stanik-Hutt et al., *The Quality and Effectiveness of Care Provided by Nurse Practitioners*, 9 J. for Nurse Practitioners 492, 492, 498 (2013); Mary Naylor & Ellen Kurtzman, *The Role of Nurse Practitioners in Reinventing Primary Care*, 29 Health Aff. (Millwood) 893, 894–95 (2010); RP Newhouse et al., *Advanced Practice Nurse Outcomes 1990- 2008: A Systematic Review* 29 Nursing Economics 1, 18 (2011).

satisfaction between APRN and physician care, even for complex, invasive procedures like colonoscopies.[44] Another study comparing the effects of nurse-provided care to physician-provided care concluded that NPs scored higher on quality-of-care measures; NPs achieved higher scores than physicians with respect to patient satisfaction and compliance; NPs spent more time with patients per visit than physicians; and patient knowledge was equivalent between NPs and physicians.[45]

38. Additional studies have been done comparing healthcare in states that have broadened NPs' scope of practice authority against healthcare in states that have not. These studies have found that broader NP scope of practice authority does not diminish the quality of healthcare, whereas narrower NP scope of practice authority is potentially harmful to some patients.

39. For example, a 2017 analysis of the impact of state NP scope of practice regulations on the quality of primary care provided to Medicare beneficiaries concluded: "Our analyses failed to find support for the outcomes-related arguments of those advocating for restricting the [scope of practice] of NPs on the basis of patient safety and offer support for those who claim that NP [scope of practice] restrictions have real consequences for health of populations in areas where access to primary care is low."[46]

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[44] Michele Limoges-Gonzalez et al., *Comparisons of Screening Colonoscopy Performed by a Nurse Practitioner and Gastroenterologists*, 34 Gastroenterology Nursing 210, 212–13, 215 (2011) (no immediate complications reported for either physician or NP groups; no statistically significant differences between physician and NP groups in terms of reported pain, duration of procedure, withdrawal time, sedative and analgesic use, or cecal intubation rates; *greater* neoplasia detection rates in NP group; *greater* satisfaction among patients seen by NPs).

[45] Linda F. Heffernan, *Regulation of Advanced Practice Nursing in Health Care Reform*, 28, No. 2, J. Health & Life Sci. L. 73 (1995) (citing Sharon A. Brown & Deanna E. Grimes, *A Meta-Analysis of Nurse Practitioners and Nurse Midwives in Primary Care*, 44 Nursing Res. 332, 337 (1995)).

[46] Jennifer Perloff et al., *Association of State-Level Restrictions in Nurse Practitioner Scope of Practice With the Quality of Primary Care Provided to Medicare Beneficiaries*, Med. Care Research & Review 18 (2017); *see also, e.g.*, Ellen T. Kurtzman et al., *Does the Regulatory Environment Affect Nurse*

40. Similarly, a 2017 review of the impact of changes in state CNM scope of practice regulations between 1994 and 2013 found that "states that allow for CNMs fully enabled practice, have on average, little or no differences in maternal health behaviors or infant health outcomes as compared to states with more restrictive SOP."[47] Indeed, states that allow CNMs broader practice authority actually have lower rates of labor inductions and C-sections.[48] The authors concluded: "The results point to the conclusion that restrictions on CNM [scope of practice] primarily serve as barriers to practice and removing these restrictions has the potential to improve the efficiency of the health care system for delivery and infant care."[49]

<u>APRNs Play a Critical Role in Caring for Patients in Underserved Areas</u>

41. The United States is experiencing a physician shortage crisis due to the growing cost of medical school, a growing and aging population, and expansion of health insurance under the Affordable Care Act.[50] According to a 2016 study by the Physicians Foundation, many physicians report that they are either "at capacity or overextended," indicating that patient demand for care is increasing disproportionately to physician supply.[51] For example, only 14%

Practitioners' Patterns of Practice or Quality of Care in Health Centers?, 52 Health Servs. Research 437, 445 (2017) ("[T]here was little evidence to reject the null hypothesis —that is, that state-granted NP independence has no effect on NPs' . . . quality of care— across the outcomes studied.").

47 Markowitz, *supra* note 33, at 202.

48 *Id.*

49 *Id.*; see also Meg Johantgen et al., *Comparison of Labor and Delivery Care Provided by Certified Nurse-Midwives and Physicians: A Systematic Review*, 1990 to 2008, 22-1 Women's Health Issues, e73 (2012) ("Based on this systematic review, there is moderate to high evidence that CNMs rely less on technology during labor and delivery than do physicians and achieve similar or better outcomes.").

50 *See* Joy Luhico Austria, *Article: Urging a Practical Beginning: Reimbursement Reform, Nurse-Managed Health Clinics, and Complete Professional Autonomy for Primary Care Practitioners*, 17 DePaul J. Health Care L. 121, 122-23 (2015); UCSF, *UCSF Researchers Offer Solutions to Looming Health Care Provider Shortage* (Nov. 5, 2013), https://www.ucsf.edu/news/2013/11/110081/ucsf-researchers-offer-solutions-looming-health-care-provider-shortage#.

51 The Physicians Foundation, *2016 Survey of America's Physicians: Practice Patterns and Perspectives*, 7, 27 (2016) (80% of physicians respond being overextended or at capacity, with no time to see additional patients).

of physicians report having the necessary time to provide the highest standards of care.[52] One study has projected a shortage of 20,400 physicians by 2020.[53] "The federal Health Resources and Services Administration ("HRSA") estimates that more than 35.2 million people living within the 5,870 Health Professional Shortage Areas ("HPSAs") nationwide do not currently receive adequate primary care services."[54] HPSAs are not limited to rural areas, but also include low-income urban areas. Sections of Oklahoma City and Tulsa, for example, qualify as HPSAs.[55]

42. Fortunately, with growing numbers and expanded practice authority, APRNs are stepping up to meet the United States' pressing health care needs. The FTC observes, "[a]s primary care provider shortages have worsened, APRNs have played an even greater role in alleviating the effects of shortages and mitigating access problems. For example, APRNs make up a greater share of the primary care workforce in less densely populated areas, less urban areas, and lower income areas, as well as in [health professional shortage areas]."[56]

43. The *Future of Nursing* report notes that the health care system's increased reliance on APRNs, as well as physician assistants, "has helped ease access bottlenecks, reduce waiting times, increase patient satisfaction, and free physicians to handle more complex cases."[57]

44. The Office of the Assistant Secretary for Planning Evaluation in the United States Department of Health and Human Services has similarly noted that "NPs are extending access to

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[52] *Id.* at 7.

[53] *Projecting the Supply and Demand for Primary Care Practitioners Through 2020*, Health Resources and Services Administration Bureau of Health ("HSRA") 2, 26 (Nov. 2013), https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projectingprimarycare.pdf.

[54] NGA Report, *supra* note 1, at 2-3.

[55] *See* HPSA Find, Department of Health Resources & Services Administration, https://data.hrsa.gov/tools/shortage-area/hpsa-find (last visited Oct. 2, 2019).

[56] *Id.* at 25.

[57] IOM Report, *supra* note 1, at 98.

care in rural and underserved areas and are key providers in health centers."[58] NPs (along with physician assistants) also account for 51% of all patient visits at federally qualified health centers serving distressed or isolated communities.[59] These findings are consistent with the original intention of NP education: independent practice, particularly in rural communities where physicians were not working.

APRNs in Oklahoma

45. Generally speaking, Oklahoma APRN practice is consistent with the national landscape I have described. APRNs in Oklahoma provide a wide range of health care to patients without the direct involvement of a physician, and they are frequently recognized by patients as their primary care providers.[60]

46. The Oklahoma legislature has delegated authority to the Oklahoma Board of Nursing to set and enforce standards for the practice of nursing. The Oklahoma Board of Nursing licenses and regulates four types of APRNs: NPs, CNMs, clinical nurse specialists, and certified registered nurse anesthetists.[61] As elsewhere, APRNs in Oklahoma are subject to state and national educational requirements, accreditation requirements, certification requirements, licensing requirements, and continuing education responsibilities.

47. At the end of the 2018 fiscal year, there were 4,034 APRNs licensed in Oklahoma.[62] This is a huge increase from just 2014, at which point there were only 2,597

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[58] ASPE Report, *supra* note 11, at 10.

[59] Gale Pryor, *Ahead of the Curve on Primary Care Staffing*, athenaInsight (Apr. 14, 2017), https://www.athenahealth.com/insight/fqhc-staffing-advantages.

[60] O.A.C. § 317:25-7-5.

[61] 59 O.S. § 567.3a.

[62] Oklahoma Board of Nursing, *Fiscal Year 2018 Annual Report*, 20 (2018), https://nursing.ok.gov/nrspop12.pdf.

APRNs in Oklahoma.[63]

48. To apply to be an APRN in Oklahoma, the applicant must hold a current license to practice as a registered nurse, demonstrate completion of an advanced practice registered nursing program for one of the four categories of APRN in a specialty area recognized by the Board of Nursing, and submit evidence of a relevant national certification.[64] Oklahoma requires APRNs to renew their licenses biennially.[65] NPs can be certified by a number of different national certification bodies.[66] CNMs must hold current certification for the practice of nurse-midwifery from the American Midwifery Certification Board.[67]

49. The Oklahoma Nursing Practice Act is the statute that authorizes APRNs to practice in the state within their scope of practice. The Act defines APRNs' scope of practice broadly and provides guidance on the scope of practice for each type of APRN.[68]

50. The Oklahoma Board of Nursing has promulgated detailed regulations that guide APRNs in determining their scope of practice.

51. With respect to NPs, Oklahoma Board of Nursing regulations first establish NPs' educational and licensure requirements.[69] Then the regulations broadly authorize NPs to provide a broad range of health services, including the promotion and maintenance of health; prevention of illness and disability; and the diagnosis and prescription of medications, treatments, and

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[63] *Id.*

[64] O.A.C. § 485:10-15-4; 59 O.S. § 567.5a.

[65] O.A.C. § 485:10-15-5.

[66] Oklahoma Board of Nursing, *Memorandum: Advanced Practice Registered Nurse (APRN) Certification Examinations Approved by the Oklahoma Board of Nursing* (Aug. 30, 2018), https://nursing.ok.gov/prac-natlcert.pdf.

[67] .O.A.C. § 485:10-15-8.

[68] O.A.C. §§ 485:10-15-1-485:10-15-9.1.

[69] O.A.C. § 485:10-15-6.

devices for acute and chronic conditions and diseases.[70] However, within that broad grant of authority, each NP is responsible and accountable for ensuring that s/he is competent to provide the services s/he intends to offer patients, based upon his or her education, training, clinical experience, and national certification(s).[71] Scope of practice is defined in this same manner regardless of an NP's specialty, including adult care, family medicine, pediatric care, women's health care, acute care, etc.[72]

52. With respect to CNMs, Oklahoma Board of Nursing regulations impose unique educational and certification requirements specific to nurse-midwifery practice.[73] "Nurse-midwifery practice" is defined elsewhere by Oklahoma law as the provision of "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."[74]

53. Oklahoma's Board of Nursing has published a decision-making model that assists APRNs in determining their scope of practice.[75] Using this model, an APRN must first determine whether the services s/he intends to offer are statutorily permitted by the Oklahoma Nursing Practice Act or other law. Next an APRN determines whether the services are consistent with relevant nursing standards, standards set by nursing certification and training

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[70] *Id.*

[71] *Id.*

[72] *Id.*

[73] O.A.C. § 485:10-5-8.

[74] 59 O.S. § 567.3a(9).

[75] Oklahoma Board of Nursing, *Decision-Making Model for Scope of Nursing Practice Decisions: Determining Advanced Practice Registered Nurse, Registered Nurse and Licensed Practical Nurse Scope of Practice Guidelines* (Nov. 14, 2017), https://nursing.ok.gov/prac-decmak.pdf.

organizations, evidence-based nursing literature, and scientific evidence.[76] If the answer to all these questions posed by the model is "yes," the APRN finally must consider whether the services are consistent with his or her own training, depth of knowledge, documented clinical competence, and ability to accept the consequences of performing the activity.[77]

54. Given the broad authority granted by Oklahoma law, APRNs in Oklahoma perform a wide range of medical procedures. Among other services, APRNs in Oklahoma provide acute emergency room care (often outside of the presence of a doctor); admit and discharge patients from hospitals; give injections; order and interpret x-rays and other diagnostic tests;[78] perform ultrasounds;[79] and deliver babies.[80]

55. APRNs in Oklahoma also prescribe a wide range of medications. To obtain prescriptive authority in Oklahoma, APRNs must complete graduate level coursework in pharmacotherapeutic management. They must submit proof of continuing education in pharmacotherapeutics when they renew this authority every two years. They must also enter into a collaborative agreement with a physician in which the physician agrees to be available to the APRN for "consultation, collaboration, assistance with medical emergencies, and patient referral[s]."[81]

56. Once they have entered into a collaborative agreement, APRNs, "in accordance

[76] *Id.*

[77] *Id.*

[78] Association of Oklahoma Nurse Practitioners, Ask the Expert – Archive, https://npofoklahoma.site-ym.com/page/AskExpertArchive (last visited Oct. 2, 2019).

[79] O.A.C. § 317:30-5-22.

[80] 59 O.S. § 567.3a(9).

[81] Oklahoma Board of Nursing, *Agreement for Physician Supervising Advanced Practice Prescriptive Authority* (Aug. 8, 2018), https://nursing.ok.gov/pa-1.pdf. Physicians may only enter collaborative agreements with two APRNs, which limits the number of APRNs with prescriptive authority in the state. O.A.C. § 435:10-13-2 (1998).

with [the] Oklahoma Nursing Practice Act, may prescribe medications that are <u>within the Advanced Practice Registered Nurse's scope of practice</u>, under the medical direction of a supervising physician and an Exclusionary Formulary."[82] The Exclusionary Formulary includes all Schedule I and II Controlled Dangerous Substances, as well as some anesthetics, analgesics, psychotherapeutic agents, sedatives, and radioactive agents.[83]

57. To summarize, APRNs in Oklahoma are expressly authorized by law to provide a broad scope of services to meet their patients' healthcare needs, provided APRNs have the education, training, and licensure to competently provide those services. In addition, APRNs in Oklahoma are expressly authorized by law to prescribe medications, with the exception of those medications that have been specifically identified on the Exclusionary Formulary by name or class, provided they enter into a collaborative agreement with a physician.

<u>APRNs and Abortion Care</u>

58. Medication abortion involves the prescription drugs mifepristone and misoprostol, typically taken by the patient orally. Both drugs are also prescribed for purposes other than abortion: mifepristone can be used to treat high blood sugar for patients with Cushing's syndrome and misoprostol can be used to prevent stomach ulcers, induce labor, manage a miscarriage, or treat a postpartum hemorrhage.[84]

59. APRNs in Oklahoma may prescribe mifepristone and misoprostol for reasons other than abortion. As explained above, APRNs are legally authorized in Oklahoma to

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[82] Oklahoma Board of Nursing, *Exclusionary Formulary for Advanced Practice Registered Nurses with Prescriptive Authority* (Sept. 26, 2017), https://nursing.ok.gov/prac-exclusfrm.pdf.

[83] *Id.*

[84] Rebecca Allen, *Uses of Misoprostol in Obstetrics and Gynecology*, Rev. Obstet. Gynecol. 2009 Summer; 2(3): 159-168; Sarah Jane Tribble, *How an abortion pill turned out to be a treatment for a rare disease*, Washington Post (April 8, 2018), https://www.washingtonpost.com/national/health-science/how-a-notorious-abortion-pill-turned-out-to-be-a-treatment-for-a-rare-disease/2018/04/06/824f5214-27a2-11e8-874b-d517e912f125_story.html.

prescribe medications within their scope of practice, provided medications are not listed on Oklahoma's Exclusionary Formulary. Mifepristone and misoprostol do not appear on Oklahoma's Exclusionary Formulary.

60. Nevertheless, it is my understanding that, regardless of their competency and training, APRNs cannot legally provide medication abortions in Oklahoma because Oklahoma law limits abortion care to physicians only. I have reviewed the "Physician-Only Law," and in my professional opinion, the prohibition on prescribing these medications for abortion is out of step with national norms of APRN practice. Furthermore, the prohibition is inconsistent with APRNs being able to prescribe mifepristone and misoprostol for other conditions in Oklahoma.

61. The comparative safety of abortion care provided by APRNs and physicians has been extensively studied. Research has overwhelmingly demonstrated that there is no significant difference in the safety and efficacy of abortion procedures administered by APRNs compared with physicians.[85] Specifically with respect to medication abortion, a recent study found that medication abortions administered by nurse midwives without any physician involvement were just as safe as those administered by physicians, if not safer.[86]

62. Medication abortion has been FDA-approved since 2000. In 2016, the FDA amended the label to expressly state that medication abortions can safely be prescribed by non-physician health care providers, such as APRNs.[87]

63. In addition to the FDA, other leading medical authorities and professional

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[85] *See* Tracy Weitz et al., *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver*, 103(3) Am. J. of Pub. Health 454, 458 (2013).

[86] *See* Helena Kopp Kallner et al., *The Efficacy, Safety and Acceptability of Medical Termination of Pregnancy Provided by Standard Care By Doctors or by Nurse-Midwives: A Randomized Controlled Equivalence Trial*, 122(4) Brit. J. Obstet. & Gynecol. 510, 515 (2014).

[87] FDA, *Questions and Answers on Mifeprex*, https://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm492705.htm.

associations recognize that APRNs can provide medication abortion safely and effectively, including the American College of Obstetricians and Gynecologists ("ACOG"),[88] the American Association of Reproductive Health Professionals ("ARHP"), the American Public Health Association ("APHA"), and the World Health Organization ("WHO").[89]

64. APHA, the nation's leading public health organization, has determined that laws that only permit physicians to perform abortions are unjustified and unsupported by scientific evidence.[90] APHA concluded that laws restricting abortion care to physicians are "outdated" and supports "[t]he provision of medication . . . abortion by appropriately trained and competent NPs, CNMs, and [physician assistants]."[91]

65. Nursing professional organizations have come to similar conclusions and support the provision of early abortion by APRNs, including the American College of Nurse Midwives ("ACNM")[92] and the National Association of Nurse Practitioners in Women's Health.[93]

66. APRNs in Oklahoma are legally permitted to prescribe medications that have comparable safety profiles to medication abortion and medications that carry significantly

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[88] ACOG, *Committee Opinion: Abortion Training and Education* (Nov. 2014), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Abortion-Training-and-Education?IsMobileSet=false.

[89] WHO, *Expanding Health Worker Roles for Safe Abortion in the First Trimester of Pregnancy* (2016), https://apps.who.int/iris/bitstream/handle/10665/206191/WHO_RHR_16.02_eng.pdf.

[90] APHA, *Provision of Abortion Care by Advance Practice Nurses and Physician Assistants*, Nov. 1, 2011, https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/28/16/00/provision-of-abortion-care-by-advanced-practice-nurses-and-physician-assistants.

[91] *Id.*

[92] ACNM, *Position Statement: Access to Sexual and Reproductive Health Care* (2016), http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000087/Accesst o-Comprehensive-Sexual-and-Reproductive-Health-Care-Services-FINAL-04-12-17.pdf.

[93] NANPWH, Resolution on Nurse Practitioners as Abortion Providers (Oct. 1991) (included in National Abortion Federation & Clinicians for Choice, *Role of CNMs, NPs, and PAs in Abortion Care* 3, https://prochoice.org/wp-content/uploads/CNM_NP_PA_org_statements.pdf [last visited Oct. 2, 2019]).

greater risks. For example, in Oklahoma, APRNs are legally permitted to prescribe Alprazolam (Xanax) and Diazepam (Valium), drugs that have significant side effects, abuse potential, and overdose risks.[94] By comparison, mifepristone and misoprostol have few side effects, virtually no abuse potential, and exceptionally low mortality rates.[95] APRNs also are able to prescribe drugs that have mortality rates that are comparable to medication abortion, if not higher. For example, penicillin and Viagra--which APRNs in Oklahoma can prescribe--have higher mortality rates than medication abortion.[96]

67. APRNs are authorized to provide medication abortions in several states, including California, Colorado, Connecticut, Hawaii, Illinois, Maine, Massachusetts, Montana, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, Washington, and Vermont, as well as the District of Columbia (DC). In my expert opinion, there is no reason why APRNs could not also provide medication abortions in Oklahoma.

Conclusion

68. Oklahoma's Physician-Only Law, which bars APRNs from providing medication abortion regardless of his or her competency or a patient's needs, lacks any sound rationale and is irreconcilable with the State's regulation of APRN practice in other respects. The Physician-Only Law also is inconsistent with the nationwide trajectory—particularly evident over the past two decades—towards recognizing APRNs' ability to perform all services within their education and training, especially in areas dealing with shortages of available health care professionals.

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[94] *See* Holly Hedegaard et al., *Drugs Most Frequently Involved in Drug Overdose Deaths: United States, 2011-2016*, 67(9) National Vital Statistics Report, Dec. 12, 2018.

[95] *See* Mitchell Creinin et al., *Mifepristone-Misoprostol Medical Abortion Mortality*, 8(2):26 MedGenMed (2006).

[96] *See* Alfred I. Neugut et al., *Anaphylaxis in the United States: An Investigation Into Its Epidemiology*, 161(1) ARCHIVES INTERNAL MED 15, 18 (2001); Mifeprex REMS Study Group, Elizabeth G. Raymond et al., *Sixteen Years of Overregulation: Time to Unburden Mifeprex*, 376(8) New Eng. J. of Med. 790, 794 (2017).

The Physician-Only Law further lacks any sound justification as a large body of evidence and the experience of multiple states demonstrates that APRNs are fully capable of providing medication abortion safely and effectively. By preventing APRNs from providing medication abortions to patients seeking abortion care, the Physician-Only Law limits women's access to reproductive healthcare and is harmful to patients.

Signed this 3rd day of November 2019

Joanne Spetz

Joanne Spetz, Ph.D.

CALIFORNIA JURAT

A Notary Public or other officer completing this certificate verifies only the identity of the individual who signed the document, to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of **California**
County of **San Mateo**

Subscribed and Sworn to (or affirmed) before me on this 3rd *day of* November, **2019**, by

Joanne Spetz, proved to me on the basis of satisfactory evidence to be the person

who appeared before me.

ALBORZ AHOURAI
Notary Public – California
San Mateo County
Commission # 2196062
My Comm. Expires Jun 4, 2021

Notary Seal

[signature]
Signature of Notary Public

OPTIONAL

Though the information below is not required by law, it may prove valuable to persons relying on the document and could prevent fraudulent removal and reattachment of this form to another document.

Description of Attached Document

Title or Type of Document: Affidavit of Joanne Spetz, PH.D. In Support of Plaintiffs' Motion For A Temporary Injunction

Document / Execution Date: November 3, 2019 Number of Attached Pages: Twenty Seven

Signer(s) Other Than Named Above: N/A and N/A

I solemnly affirm (swear) that the evidence I shall give in this issue (or matter) shall be the truth, the whole truth, and nothing but the truth, (so help me God.)

Joanne Elizabeth Spetz

Capacity(ies) Claimed by Signer:

- ☑ Individual
- ☐ Corporate Officer – Title(s) ______
- ☐ Partner – Limited General
- ☐ Attorney in Fact
- ☐ Trustee
- ☐ Guardian or Conservator
- ☐ Other: ______

Signer is Representing: Witness/ Affiant

RIGHT THUMBPRINT
OF SIGNER
Top of Thumb Here

Joanne Spetz
Signer Signature

EXHIBIT 1

CURRICULUM VITAE

Joanne Spetz

Professor in Residence
Philip R. Lee Institute for Health Policy Studies
& Department of Family & Community Medicine
3333 California Street, Suite 265
University of California, San Francisco
San Francisco, CA 94143-0936
Voice: (415) 502-4443
email: joanne.spetz@ucsf.edu

EDUCATION

1986-90	Massachusetts Institute of Technology	S.B.	Economics
1990-93	Stanford University	M.A.	Economics
1993-96	Stanford University	Ph.D.	Economics

CURRENT POSITIONS

2011-present	University of California, San Francisco	Professor in Residence, Philip R. Lee Institute for Health Policy Studies & Department of Family and Community Medicine
2013-present	Healthforce Center at UCSF	Associate Director for Research
2009-present	Department of Social and Behavioral Sciences, School of Nursing, UCSF	Adjunct Professor/Professor-in-Residence (secondary appointment)
2009-present	Health Services and Policy Analysis Doctoral Program, UC Berkeley	Faculty Affiliate
2011-present	Department of Community Health Systems, School of Nursing, UCSF	Professor-in-Residence (secondary appointment)

PAST POSITIONS

1991-92	Stanford University	Research Assistant, Economics
1992-93	Stanford University	Lecturer, Economics
1993	Stanford University	Teaching Assistant, Economics
1993-95	Palo Alto VA Health Care System	Health Research Specialist
1995-2001	Public Policy Institute of California	Research Fellow
1997	University of California, Santa Cruz	Visiting Professor, Economics
1999-2004	University of California San Francisco	Assistant Adjunct Professor, Department of Community Health Systems, School of Nursing
2001	University of California, Berkeley	Visiting Professor, Public Health
2001-2002	Public Policy Institute of California	Adjunct Fellow
2001-2007	Center for California Health Workforce Studies	Associate Director
2004-2009	University of California San Francisco	Associate Adjunct Professor, Department of Community Health Systems, School of Nursing
2006-2009	Department of Social and Behavioral Sciences, School of Nursing, UCSF	Associate Adjunct Professor
2006-2014	Palo Alto VA Health Care System	Research Scientist (without compensation)

2009-2011	University of California San Francisco	Adjunct Professor, Department of Community Health Systems, School of Nursing
2011-2016	Nursing Management Policy and Leadership Specialty, School of Nursing, Yale University	Clinical Professor
2019	School of Nursing and Midwifery, Edith Cowan University	Visiting Professor

HONORS AND AWARDS

1990	Phi Beta Kappa
1990	Society of Sigma Xi
1990-95	National Science Foundation Fellowship
1993	Teaching Assistant Award, Stanford University
1993-94	Bradley Foundation Fellowship
1994-95	Performance Awards, Department of Veterans Affairs
2005	Best Abstract Award, Workforce Sessions, AcademyHealth
2006	Top 25 Downloaded Papers, Nursing Outlook, summer quarter
2011	Honorary Fellow, American Academy of Nursing
2013	Best Abstract Award, Interdisciplinary Research Group on Nursing Issues, AcademyHealth
2016	Mentorship Award, Interdisciplinary Research Group on Nursing Issues, AcademyHealth
2016	Nursing Outlook Excellence in Education Writing Award (as co-author)
2017	Best of Annual Research Meeting Abstract, AcademyHealth

RESEARCH

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3. **Spetz, J**, Brown, DS, and Aydin, CS. Ongoing Attention to Injurious Inpatient Falls and Pressure Ulcers. JAMA Internal Medicine, 2015, 175 (9): 1580-1581.

RESEARCH GRANTS AND CONTRACTS

Current Grants and Contracts

1. 1 U81HP26494 (Principal Investigator) 9/1/2013 – 8/31/2022
U.S. Bureau of Health Workforce, Health Resources and Services Admin. $1,626,547 total
UCSF Health Workforce Research Center
Other members of research team: Susan Chapman, Elizabeth Mertz, Janet Coffman, Laura Wagner (UCSF)

2. U01 DE025507 (Co-Investigator) 7/1/2015 – 6/30/2020
National Institute for Dental and Craniofacial Research $2,199,999 total
Coordinating Center to Help Eliminate/Reduce Oral health Inequalities in Children
PI: Stuart Gansky, UCSF

3. 4600009546 (Mertz) 6/5/2017-4/30/2020
William K. Kellogg Foundation $224,495
WKKF Dental Therapy Pilot Project Evaluation
PI: Elizabeth Mertz, UCSF

4. (Co-Investigator) 7/1/2017 – 12/31/2019
National Council of State Boards of Nursing
State Nurse Practitioner Scope-of-Practice Regulation and Access to Health Care in Rural and Primary Care Health Professional Shortage Areas
PI: Ying Xue, University of Rochester

5. R01 HS025715-01 (Co-Investigator) 9/01/2017 – 6/30/2020
Agency for Healthcare Research and Quality $722,705 total direct
Looking at birth outcomes and their relationship to registered nurse staffing
PI: Audrey Lyndon, New York University

6. A130763 (Principal Investigator) 9/01/2017 – 6/30/2020
San Francisco Human Services Agency $400,000 total
Evaluation of Support At Home Pilot Program

7. (Principal Investigator) 7/1/2018 – 11/30/2019
George Washington University (subaward) $95,772
Hematology Workforce Survey

8. R101026 (Principal Investigator) 8/1/2018 – 7/31/2020
National Council of State Boards of Nursing $299,947 total/years 1-2
Nurse Practitioner Roles in Addressing the Opioid Crisis: Impact of State Scope of Practice Regulations on Provision of Medication-Assisted Treatment

9. R101036 (Co-Investigator) 8/1/2018 – 7/31/2020
National Council of State Boards of Nursing $300,000 total/years 1-2
Prescriptive Authority and Nurse Practitioner Opioid Prescribing Practices
PI: Ulrike Muench, UCSF

10. (Principal Investigator) 8/13/2018 – 6/30/2020
Massachusetts Health Policy Commission $75,000
Health Care Workforce Support (contract)

11. R21 DA046051-01A1 (Co-Investigator) 2/1/2019 – 1/31/2021
National Institute on Drug Abuse (NIH) $441,792 total
Linking local variation in marijuana and opioid policies to health outcomes
PI: Dorie Apollonio, UCSF

12. 76389 (Principal Investigator) 4/01/2019 – 9/30/2020
Robert Wood Johnson Foundation $75,000 total
Research Manager to Support the National Academy of Medicine Committee on the Future of Nursing 2030

13. 41057 (Principal Investigator) 7/1/2019 – 6/30/2021
California Board of Registered Nursing $410,908 total
RN Workforce Surveys and Analysis

14. 76904 (Principal Investigator) 10/1/2019 – 12/31/2021
Robert Wood Johnson Foundation $185,000 total/26 months
Continuing to measure the success of recommendations implemented to advance the initiative on the Future of Nursing

Pending Grants and Contracts

1. (Principal Investigator) 12/01/2019 – 11/30/2023
Agency for Healthcare Research and Quality $1,561,715 total/years 1-4
Impact of federal and state policies on buprenorphine provider supply, treatment capacity, and opioid harms

2. (Principal Investigator) 07/01/2020 – 06/30/2023
National Institute on Drug Abuse (NIH) $250,000 direct/year 1
Interactions between federal and state policies to increase access to medication treatment for opioid use disorder

3. (Principal Investigator) 03/01/2020 – 02/28/2022
National Council of State Boards of Nursing $300,000 total
Assessing the Impact of Nurse Practitioner Scope of Practice Regulations on Access to Care: An Update of the 2015 U.S. Assistant Secretary for Planning and Evaluation Study

Past Grants and Contracts

1. 99-1039 (Co-Investigator) 6/1/00 – 12/31/00
California HealthCare Foundation $44,700 total/yr 1
Minimum Nurse Staffing Legislation in California $44,700 total/yr 1
Principal Investigator: Edward O'Neil, UCSF

2. 99-1039 (Co-Investigator) 1/1/00 – 1/30/01
California HealthCare Foundation $266,000 total/yr 1
Meeting California's Nursing Workforce Needs in the 21st Century $266,000 total/yrs 1-2
Principal Investigator: Edward O'Neil, UCSF

3. 5 U76 MB 10001-02 (Co-Investigator) 9/30/97 – 9/29/01
Bureau of Health Professions, HRSA, US DHHS $172,500 total/yr 1
Center for California Health Workforce Studies $690,000 total/yrs 1-4
Principal Investigator: Kevin Grumbach, UCSF

4. Three grants awarded 2/1/02 – 1/31/03
California Policy Research Center, California HealthCare Foundation $97,000 total/yr 1
and The California Endowment $97,000 total/yr 1
Admissions and Attritions in California Community College Nursing Programs
Principal Investigator: Jean Ann Seago, UCSF

5. ER02-03 (PI) 10/1/02 – 6/30/03
Public Policy Institute of California $19,000 total/yr 1
The Effect of Changes in Hospital Control on Patient Care, and the Effect of Minimum Wages on Welfare Caseloads $19,000 total/yr 1

6. 53-5701-3060 (PI on subcontract) 9/1/01 – 8/31/03
California HealthCare Foundation $125,000 total/yr 1
Hospital Systems in California $250,000/yrs 1-2

7. R01 CA-81130-01 (Consultant) 10/1/00 – 9/30/03
National Cancer Institute $250,000 direct/yr 1
Use of Cancer Screening in a Managed Care Environment $750,000 direct/yrs 1-3
Principal Investigator: Kathryn Phillips, UCSF

8. 617291 (PI on subcontract) 4/1/03 – 3/31/04
The Brookings Institution $44,175 total/yr 1
The Impact of Federal Health Spending on Cities $44,175 total/yr 1
Principal Investigator: Dan Gitterman, University of North Carolina

9. 1 U79 HP 00032-01 (Co-PI) 9/30/02 – 9/29/04
Bureau of Health Professions, HRSA, US DHHS $183,261 direct/yr 1
Supply, Demand, and Use of Licensed Practical Nurses $183,261 direct/yrs 1-2
Principal investigator: Jean Ann Seago, UCSF

10. Principal Investigator 3/1/04 – 9/30/04
Robert Wood Johnson Foundation $51,000 total/yr 1
Nurses' Valuation of Fringe Employment Benefits $51,000 total/yr 1

11. Principal Investigator of Subcontract 4/30/04 – 9/30/04
Brookings Institution $15,000 total/yr 1
Data Brief: Measuring Federal Health Spending in Urban Economies $15,000 total/yr 1
Principal Investigator: Daniel Gitterman, University of North Carolina

12. 01-1729 (Principal Investigator on subcontract) 9/1/02 – 1/31/05
California HealthCare Foundation $150,000 total/yr 1
Closures of Hospital Services: Effects on California Communities $300,000 total/yrs 1-2
Principal Investigator: Richard Scheffler, UC - Berkeley

13. Co-Investigator 9/1/04 – 2/28/05
Gordon and Betty Moore Foundation
Betty Moore CalNOC Nurse-Related Outcomes $1,427,817 total/yrs1-3
Principal Investigator: Nancy Donaldson, UCSF

14. California Dept. of Consumer Affairs #078-2473-4 (Principal Investigator) 12/1/04 – 6/30/05
California Board of Registered Nursing
California BRN Registered Nurse Workforce Forecasting Analysis $13,292.00 total

15. Co-Investigator 6/1/05 – 3/31/06
Gordon and Betty Moore Foundation
Betty Moore CalNOC Nurse-Related Outcomes $1,427,817 total/yrs1-3
Principal Investigator: Nancy Donaldson, UCSF

16. M382848 (Principal Investigator) 10/1/02 – 10/31/06
California Employment Development Department $73,991 total/yr1
Nurse Workforce Initiative Evaluation $999,750 total/yrs 1-4

17. 20012298 (Co-Investigator) 2/15/02 – 2/14/07
The California Endowment $300,000 total/yr 1
Central Valley Nursing Workforce Diversity Initiative Evaluation $1,500,000 total/yrs 1-5
Principal investigator: Kevin Grumbach, UCSF

18. 1 U79 HP 00004-01 (Associate Director) 9/30/01 – 2/28/07
Bureau of Health Professions, HRSA, US DHHS $250,000 total/yr 1
Center for California Health Workforce Studies $1,250,000 total/yrs 1-5
Principal investigator: Kevin Grumbach, UCSF

19. 1132 (Principal Investigator) 6/1/06 – 5/31/07
Gordon and Betty Moore Foundation $35,466 total
Analysis of Changes in RN Satisfaction Between 2004 and 2006

20. 078-2948-5 (Principal Investigator) 11/17/05 – 6/30/07
California Board of Registered Nursing $245,875 direct/yrs 1-2
RN Workforce Surveys and Analysis

21. CI-07-01 (Co-Investigator) 5/1/04 – 12/31/07
Clinical Research Investigator Program, UCSF Cancer Center $75,000 total/yr 1
Estradiol and Breast Cancer Prevention: Cost-Effectiveness $150,000 total/yrs 1-2
Principal Investigator: Mary Beattie, UCSF

22. 055702 (Co-Investigator) 12/15/05-12/31/07
Robert Wood Johnson Foundation $110,313 direct/yr 2
Rapid Response Team Initiative
Principal Investigator: Nancy Donaldson, UCSF

23. RWJF #051136 and Moore #637 (Principal Investigator)	11/1/04 – 3/31/08
Robert Wood Johnson Foundation, the Gordon & Betty Moore Foundation	$141,617 total/yr 1
The Effect of Information Technology on Nurses and Patients in the Veterans Health Administration	$300,000 total/yrs 1-2

24. 58296 (Co-Investigator)	7/15/06 – 7/14/08
Robert Wood Johnson Foundation	$175,606 total/yr 1
Interdisciplinary Nursing Quality Research Initiative	$346,083 total/yrs 1-2
Principal Investigator: Mary Blegen, UCSF	

25. UC1 HS15096 (Principal Investigator of Subcontract)	9/30/04 – 9/29/08
Agency for Healthcare Research and Quality	$500,000 total/yr 1
Implementation and Evaluation of IT in a Rural Hospital	$1,500,000 total/yrs 1-4
Principal Investigator: Paul Galloway, HMS Incorporated	

26. 05-1372 (Principal Investigator)	3/1/06 – 9/30/08
California HealthCare Foundation	$99,495 direct/yr 1
Distributional Effects of Minimum Nurse-to-Patient Ratios	$150,449 direct/yrs 1-2

27. U01AI51315-01A1 (Co-Investigator)	9/30/03 – 3/31/2009
National Institute of Allergy and Infectious Disease	$231,732 direct/yr 1
Clinical Trial of Short Course vs. INH for LTBI in Jail	$2,485,961 direct/yrs 1-4
Principal Investigator: Mary White, UCSF	

28. 078-3874-7 (Principal Investigator)	9/7/07 – 6/30/09
California Board of Registered Nursing	$414,000 total/yrs 1-2
RN Workforce Surveys and Analysis	

29. 1767 (Principal Investigator)	3/1/08 – 11/1/09
Gordon and Betty Moore Foundation	$57,872 total
Analysis of Changes in RN Satisfaction Between 2004 and 2008	

30. 924 (Principal Investigator)	4/1/06 – 2/28/10
Gordon and Betty Moore Foundation	$78,716 direct/yr 1
Evaluation of the Shared Services Project of the Betty Irene Moore Nursing Initiative	$245,648 direct/yrs 1-3

31. 1899 (Principal Investigator)	9/1/08 – 8/31/10
Gordon and Betty Moore Foundation	$95,632 total/yr 1
Evaluation of Impact of Programs to Expand the Supply of Faculty in the San Francisco Region on Educational Expansion	$200,970 total/yrs 1-2

32. (Principal Investigator)	2/15/10 – 4/30/11
Gordon and Betty Moore Foundation	$65,000 total
Analysis of Changes in RN Satisfaction Between 2004 and 2010	

33. 1R01HS014207-01A2 (Principal Investigator)	7/1/07 – 6/30/11
Agency for Healthcare Research and Quality	$207,090 direct/yr 1
The Effect of Hospital Unions on Staffing and Patient Care	$603,598 direct/yrs 1-4

34. 2561 (Principal Investigator) 9/17/09 – 6/30/11
California Board of Registered Nursing $414,000 total/yrs 1-2
RN Workforce Surveys and Analysis

35. 65993 (Principal Investigator) 5/1/09 – 7/31/11
Robert Wood Johnson Foundation $100,000 total/yrs 1-2
Research on the Future of Nursing

36. 2R01HS10153 (Principal Investigator of Consortium Agreement) 9/1/06 – 8/31/11
Agency for Healthcare Research and Quality $300,000 total/yr 1
Nurse Staffing, Financial Performance, Quality of Care $1,200,000 total/yrs 1-4
Principal Investigator: Barbara Mark, University of North Carolina – Chapel Hill

37. HHSH230200732009C (Principal Investigator) 9/21/07 – 11/30/11
Bureau of Health Professions, U.S. Department of Health and Human Services $2,920,000 total
2008 National Sample Survey of Registered Nurses
Collaborating organization & primary contractor: Westat, Inc.
Project Director: Vasudha Narayanan

38. (Principal Investigator of Subaward) 1/1/10 – 12/31/11
University of Wisconsin (Primary funder: Robert Wood Johnson Foundation) $40,988 total
Evaluation of the ACCEL Nurse Education Program

39. (Principal Investigator of Project under Master Contract) 8/1/11 – 6/30/12
California Department of Public Health $130,000 total
Survey of Nurse Practitioner and Nurse Midwife Use of Health Information Technology
PI of Master Contract: Andrew Bindman, MD, UCSF

40. (Co-Investigator) 6/1/2012 – 11/30/2012
Research Support for the OSHPD Data Clearinghouse $50,000 total
PI: Janet Coffman, UCSF.

41. (Co-Investigator) 4/1/2012-9/30/2012
Reducing the Barriers to Oral Health in California $97,900
PI: Peter Rechmann, DDS, PhD, UCSF.

42. 69986 (Principal Investigator) 4/15/2012 – 4/14/2013
Robert Wood Johnson Foundation $100,000 total
Research Management for the Campaign For Action

43. 1111-002-0702 (Principal Investigator)
California Board of Registered Nursing 7/1/11 – 6/30/13
RN Workforce Surveys and Analysis $414,000 total/yrs 1-2

44. (Principal Investigator) 9/1/11 – 6/30/13
Gordon and Betty Moore Foundation $68,056 total
Analysis of Changes in RN Satisfaction Between 2004 and 2012

45. 2537 (Principal Investigator) 8/1/10 – 7/31/13

Gordon and Betty Moore Foundation $245,475 total
New RN Graduate Hiring Survey

46. 68806 (Principal Investigator) 4/1/11 – 9/30/13
Robert Wood Johnson Foundation $175,000 total
Indicators Tracking Work and Summative Evaluation of the Initiative for the Future of Nursing

47. 70872 (Principal Investigator) 4/15/2013 – 4/14/2014
Robert Wood Johnson Foundation $100,000 total
Research Management for the Campaign For Action

48. 17692 (Principal Investigator) 5/15/2013 – 1/14/2014
California HealthCare Foundation $87,256
Allied and Nursing Health Workforce Almanac

49. (Co-Investigator) 3/1/2014 – 12/31/2014
The California Endowment
Evaluation of ACA Workforce Investments
PI: Sunita Mutha, UCSF

50. (Co-Investigator) 6/1/2014 – 2/28/2015
American College of Rheumatology
Demonstrating Value and Assessing Emerging Models of Payment in Rheumatology
PI: Janet Coffman, UCSF

51. (Co-Investigator) 11/24/2014 – 2/28/2015
California HealthCare Foundation #18630
Medi-Cal Waiver Development: Technical Assistance on Workforce
PI: Sunita Mutha, UCSF

52. 71844 (Principal Investigator) 5/15/2014 – 5/14/2015
Robert Wood Johnson Foundation $100,000 total
Research Management for the Campaign For Action

53. REQ0010424 (Principal Investigator) 7/1/2013 – 6/30/2015
California Board of Registered Nursing $414,000 total
RN Workforce Surveys and Analysis

54. 2537 (Principal Investigator) 8/1/2013 – 7/31/2015
Gordon and Betty Moore Foundation $250,000 total
RN Supply and Demand: Local Forecasting and National Dissemination

55. UD7HP25048 (Co-Investigator) 9/30/2012 – 9/29/2015
U.S. Bureau of Health Professions, Health Resources and Services Administration
Interprofessional Collaborative Practice for Nurse Education, Practice, Quality, and Retention
PI: Carmen Portillo (UCSF)

56. (Principal Investigator of Subaward) 9/1/2013 – 8/31/2015
U.S. Bureau of Health Professions, Health Resources and Services Administration
Rural Nurse Practitioners and Physician Assistants

Primary awardee: University of Washington

57. (Co-Investigator) 12/1/2013 – 11/30/2015
Gordon and Betty Moore Foundation
Disseminating the Emerging HealthCare Leaders Program
PI: Sunita Mutha, UCSF

58. (Principal Investigator) 2/1/2015 – 12/31/2015
California Workforce Investment Board $60,000 total
Effect of the Affordable Care Act on the California Health Workforce

59. (Co-Investigator) 2/1/2015 – 1/31/2016
Health Care Cost Institute $149,134 total
The Effect of State Scope of Practice Laws on Pharmaceutical Utilization
PI: Ulrike Muench, UCSF

60. (Principal Investigator) 2/1/2015 – 6/30/2016
St. Luke's Health Initiatives $95,000 total
Arizona Health Workforce Demand Study

61. 71320 (Principal Investigator) 10/1/2013 – 9/30/2016
Robert Wood Johnson Foundation $102,803 total
Measuring the Success of the Initiative on the Future of Nursing

62. (Co-Investigator) 1/1/2015 – 12/31/2016
National Council of State Boards of Nursing $300,000 total
Impact of State Scope-of-Practice Regulation on the Availability of Nurse Practitioners in Caring for Vulnerable Populations
PI: Ying Xue, University of Rochester

63. (Principal Investigator) 3/1/2015 – 12/31/2016
California Respiratory Care Board $175,000 total
California Respiratory Care Workforce Study

64. 72889 (Principal Investigator) 8/1/2015 – 1/31/2017
Robert Wood Johnson Foundation $75,000 total
Research Management for the Campaign For Action

65. CRN 5374-8948 (Co-Investigator) 5/1/2016 – 7/31/2017
Kaiser Foundation Health Plan $172,174 direct
Current and Future Trends in the Primary Care Workforce
PI: Janet Coffman, UCSF

66. REQ0014653 (Principal Investigator) 7/1/2015 – 6/30/2017
California Board of Registered Nursing $414,000 total
RN Workforce Surveys and Analysis

67. 54827 (Principal Investigator) 6/1/2016 – 6/30/2017
California HealthCare Foundation $65,954
Allied and Nursing Health Workforce Almanac

68. R21082330 (Co-Investigator) 9/1/2015 – 8/31/2017
National Institute for Child Health and Development $466,412 total
Juvenile Court Approaches to Reduce Reproductive Health Disparities
PI: Marina Tolou-Shams, UCSF

69. 174982 (Co-Investigator) 10/1/2016 – 10/31/2017
California HealthCare Foundation $196,041 total
Enhancing the Utilization of Peer Providers in California
PI: Susan Chapman, UCSF

70. 19841 (Co-Investigator) 10/15/2016 – 10/31/2017
California HealthCare Foundation $82,812 direct
Assessing the Adequacy of the Behavioral Health Workforce in California
PI: Janet Coffman, UCSF

71. (Principal Investigator) 12/01/2017 – 11/30/2018
Public Health Institute (primary funding: Gordon & Betty Moore Foundation) $79,930 total
California Future Health Workforce Commission Research Support

72. R01 DA034091 (Principal Investigator - Multiple PI) 9/15/2012 – 5/31/2019
National Institute on Drug Abuse, National Institutes of Health $1,577,389 total
Testing Medical Marijuana's Unintended Consequences for Youth and Young Adults
PIs: Laura Schmidt & Joanne Spetz. Other members of research team: Susan Chapman

73. 25IR-0025 (Co-Investigator) 7/1/2016 – 6/30/2019
California Tobacco Related Disease Research Program
Measuring combined tobacco, e-cigarette, and marijuana use in California
PI: Dorie Apollonio, UCSF

74. (Co-Investigator) 7/1/2017 – 6/30/2019
California Tobacco Related Disease Research Program $300,000 total
Effects of California's 2016 tobacco policies on initiation, use & quitting
PI: Dorie Apollonio, UCSF

75. 0.5342 (Principal Investigator) 7/13/2017 – 6/30/2019
California Board of Registered Nursing $414,000 total
RN Workforce Surveys and Analysis

76. 6939 (Principal Investigator) 11/01/2017 – 6/30/2019
Gordon and Betty Moore Foundation $600,000 total
Developing recommendations for the workforce for care of people with complex health issues

77. G-30280 (Principal Investigator) 4/01/2019 – 6/30/2019
California Health Care Foundation $24,500 total
Nurse Practitioners: Briefing Support

78. 72123 (Principal Investigator) 10/15/2014 – 7/31/2019
Robert Wood Johnson Foundation $1,020,000 total
Multi-Site Evaluation of Innovative Oral Health Workforce Interventions

Co-PI: Dana Hughes, UCSF

79. (Principal Investigator) 6/1/2018 – 8/31/2019
California HealthCare Foundation $62,114 total
Scope of Practice Expansions to Improve Access to Quality Care

80. 74076 (Principal Investigator) 10/1/2016 – 9/30/2019
Robert Wood Johnson Foundation $102,803 total
Measuring the Success of the Initiative on the Future of Nursing

RESEARCH CONSULTING

1997-2000	Center for the Health Professions, UCSF	Consultant & Co-Investigator
2000-2001	California HealthCare Foundation	Consultant & Co-Investigator
2002-2003	Deloitte Research	Research Consultant
2004	Discrimination Resource Center	Consultant & Co-Investigator
2005	Gordon and Betty Moore Foundation	Research Consultant
2005-2007	University of Pennsylvania (Linda Aiken, PI)	Consultant & Co-Investigator
2008-2010	University of Toronto (Linda McGillis Hall, PI)	Consultant & Co-Investigator
2009-2010	International Council of Nurses	Commissioned monograph
2010-2011	Kaiser Permanente	Consultant
2011-2012	Westat / Health Resources and Services Administration	Consultant to National Sample Survey of Nurse Practitioners
2010-2016	Health Systems Innovation Network LLC	Consultant for projects for Kaiser Permanente, Medicare OACT, OPTUM Health, SEIU-UHW Education Fund
2011-2012	James A. Baker Institute at Rice University	Commissioned monograph
2012-2017	TCC Group	Consultant for evaluation of RWJF Advancing Progression in Nursing
2012-2015	Collaborative Alliance for Nursing Outcomes	Research Consultant
2013-2015	Westat / Assistant Secretary for Planning and and Evaluation	Research Consultant to Impact of State Scope of Practice Laws and Other Factors on the Practice and Supply of Primary Care Nurse Practitioners
2013	Joint Center for Political and Economic Studies	Commissioned monograph
2013-2014	RAND / American Association of Colleges of Nursing	Research Consultant
2014-present	American Association for Retired Persons	Technical Assistance Consultant
2013-2014	North Carolina Nursing Association	Expert Consultant
2015-present	Centre for Nursing Research, Edith Cowan University, Joondalup, Western Australia	Technical Consultant on Developing a Reference Case Guideline for Conducting Economic Evaluations of Nurse Staffing and Skill Mix
2015-2017	Association of Women's Health, Obstetric, and Neonatal Nurses	Research consultant
2016-2018	Health Management Associates	Evaluator for grant to Los Angeles County Department of Health Services on Inter-Professional Collaborative Practice (prime funder: HRSA)
2016-2018	Massachusetts General Hospital/Harvard	Expert Advisor to study on Professional

		Roles in the Care of Elders with Complex Needs (Donelan, PI)
2016-2017	American Organization for Nurse Executives	Research consultant
2018	Columbia University	Survey reviewer (Poghosyan, PI)
2018	Massachusetts Health Policy Commission	Research consultant
2018-present	Kaiser Permanente Medical Group Division Of Research	Research consultant on economic modeling (Schmittdiel, PI)
2019	Health Management Associates	Research consultant for study on the LA County Nursing and Allied Health nursing program

PRESENTATIONS

<u>Testimony and Briefings</u>

1999 U.S. House of Representatives Committee on Education and the Workforce, Testimony, "Examining the Impact of Minimum Wages on Welfare to Work"
2001 Illinois Governor's Task Force on Patient Safety, Testimony, "Patient Safety and Staffing"
2001 California Assembly Health Committee, Testimony, "Nursing in California: A Workforce Crisis"
2002 California Postsecondary Education Commission, Research briefing, "Admission Policies and Attrition Rates in Community College Nursing Programs"
2003 California Assembly Health Committee, Testimony, "Hospital Systems in California: An Overview of Bargaining Power"
2003 California Policy Research Center Legislative Briefing, "Admission Policies and Attrition Rates in Community College Nursing Programs"
2004 Nevada Legislative Committee on Health Care Subcommittee to Study Staffing of the System for Delivery of Health Care in Nevada Advisory Committee, Testimony, "Patient Safety and Nurse Staffing"
2004 California Program on Access to Care and Center for California Health Workforce Studies Briefing Moderator, "The Impact of Medi-Cal Cuts of Medical Providers: Doctors, Hospitals, and Clinics"
2004 Massachusetts State Legislature, briefings to the Chair of the House Committee on Health Care, Director of Policy of the Speaker of the House, Deputy General Counsel of House Committee on Ways and Means, and Legislative Director for Chair of Senate Health Committee on minimum nurse-to-patient ratios in California hospitals
2005 California Board of Registered Nursing, report to the Board, "Forecasting the Future Nursing Workforce"
2005 State of California Agency Officials Briefing, "Forecasting the Future Nursing Workforce"
2005 California Program on Access to Care and Center for California Health Workforce Studies Briefing Moderator and Presenter, "California Nurse Shortage: Impact of Nurse Education and Training Initiatives"
2006 California Health Workforce Policy Commission, Presentation on "Regional Nursing Shortages"
2007 California Board of Registered Nursing, Board Meeting, Presentation on "The 2006 Survey of Registered Nurses in California"
2007 California Board of Registered Nursing, Board Meeting, Presentation on "2007 Forecasts of the Supply and Demand for Nurses"
2007 California Governor's Task Force on the Nursing Shortage, Presentation on "Forecasts of Statewide and Regional RN Shortages"
2008 California Community Colleges Economics Development Program Advisory Committee, Strategic Review & Advance Subcommittee, Presentation on "Health Workforce Needs in California and the Role of Community Colleges"

2008 California Board of Registered Nursing, Board Meeting, Presentation on "Endorsement of Nurses into and out of California"
2009 California Board of Registered Nursing, Board Meeting, Presentation on "California's Nursing Workforce in 2008"
2009 California Board of Registered Nursing, Board Meeting, Presentation on "Forecasts of the Supply and Demand of RNs in California"
2009 Institute of Medicine Committee on the Future of Nursing, Presentation on "Scope of Practice of Advanced Practice Nurses in the United States"
2010 California Office of Statewide Health Planning and Development, Healthcare Workforce Policy Commission, Presentation on "The Current State of California's Nursing Workforce"
2010 California Office of Statewide Health Planning and Development and California Workforce Investment Board, Facilitated Panel Discussion on Preparing for Healthcare Reform and Healthcare Workforce Development
2011 California Senate Business, Professions, and Economic Development Committee, testimony on "Status of Nursing Shortages, Education, Workforce Development and Diversity in California"
2011 California Board of Registered Nursing, Board Meeting, Presentations on "Outcomes of Nurses Placed on Probation" and "California's Nursing Workforce in 2010"
2011 California Board of Registered Nursing, Board Meeting, Presentations on "California's Advanced Practice Nursing Workforce" and "Forecasts of the Supply and Demand of RNs in California"
2012 California Office of Statewide Health Planning and Development, Healthcare Workforce Policy Commission, Presentation on "The Current State of California's Nursing Workforce"
2013 California Board of Registered Nursing, Board Meeting, Presentation on "California's Nursing Workforce in 2012"
2013 California Board of Registered Nursing, Board Meeting, Presentation on "Forecasts of the Supply and Demand of RNs in California"
2014 California Public Employees Retirement System Board Meeting, Presentation on "Challenges in Hospital Management"
2015 California Board of Registered Nursing, Board Meeting, Presentation on "California's Nursing Workforce in 2014"
2015 California Board of Registered Nursing, Board Meeting, Presentations on "Forecasts of RN Supply and Demand through 2035" and "Simulation Education and RN Readiness for Practice"
2015 City and County of San Francisco Workforce Investment Board Healthcare Subcommittee (presentation)
2015 California Workforce Development Board Meeting (presentation)
2015 HRSA and SAMSA online briefing on the Peer Provider Workforce
2017 California Board of Registered Nursing, Board Meeting, Presentation on "California's Nursing Workforce in 2016" and "Forecasts of RN Supply and Demand through 2035"
2018 California Healthcare Workforce Policy Commission, Presentation on "Supply and Demand of Registered Nurses in California"
2018 Massachusetts Health Policy Commission, Market Oversight and Transparency Committee, Presentation on "Analysis of Potential Cost Impact of Mandated Nurse-to-Patient Staffing Ratios"
2018 Massachusetts Health Policy Commission, Health Cost Trends Hearing, Presentation on "Analysis of Potential Cost Impact of Mandated Nurse-to-Patient Staffing Ratios"
2019 California Future Health Workforce Commission: Meeting the Demand for Health Care, briefing, Sacramento, CA
2019 California Future Health Workforce Commission: Meeting the Demand for Health Care, briefing, Los Angeles, CA
2019 United States District Court Eastern District of Virginia, Expert witness, Case No. 3:18-CV-428-HEH. Falls Church Medical Center LLC, et al., vs. M. Normal Oliver, et al.

International Conferences

International Health Economics Association

1996, Vancouver: Canada: poster
2003, San Francisco: session organizer, session chair, research presentation
2005, Barcelona: research presentation, poster presentation
2007, Copenhagen: 2 research presentations
2009, Beijing: research presentation
2011, Toronto: research presentation
2013, Sydney, 2 research presentations
2015, Milan, session organizer, 1 research presentation, session chair
2017, Boston, session organizer, 1 research presentation, session chair, discussant
2019, Basel, pre-Congress session organizer, 1 research presentation in pre-Congress session

2008 Conference on the Global Health Workforce, Berkeley, California (poster)
2009 International Seminar on Nursing Workforce and Labour Market Research, sponsored by Dohisha University, Honolulu, Hawaii, (invited research presentation and paper)
2010 Global Health Leadership Forum, "Mixing It Up: How Non-Physicians Can Deliver Care," Berkeley, CA (presenter and discussion leader)
2013 Economics of the Health Workforce, Sydney Australia (presenter)
2015 International Health Workforce Collaborative, London, UK (poster)
2016 International Health Workforce Collaborative, Washington DC (poster)
2018 International Health Workforce Collaborative, Queenstown, New Zealand (poster)
2019 Edith Cowan University, Joondalup, Australia (public lecture)
2019 Sir Charles Gairdner Hospital, Nedlands, Australia (public lecture)
2019 MyVista Aged Care, Joondalup, Australia (panel presentation)
2019 Joondalup Private Hospital, Joondalup, Australia (public lecture)
2019 Hollywood Private Hospital, Nedlands, Australia (public lecture)
2019 University of Western Australia School of Public Health, Perth, Australia (public lecture)
2019 International Health Workforce Collaborative, Ottawa, Canada (poster, podium)

National Conferences and Invited Presentations

AcademyHealth (Association for Health Services Research)

1994, 1996, 1998, 1999, 2001, 2003, 2004, 2006: posters
1997: research presentation
2000: 1 research presentation and 1 poster
2002: 1 research presentation and 1 poster
2005: 2 research presentations, 2 posters, 1 presentation for special interest group
2007: 1 research presentation, 1 panel presentation, 1 poster, and session chair
2008: 2 research presentations, 2 posters, 1 presentation for special interest group, and session chair
2009: 1 research presentation, Chair of program for special interest group
2010: 1 research presentation, 1 poster, session chair, and Chair of special interest group meeting
2011: 3 research presentations, 1 poster
2012: 2 research presentations, 1 poster
2013: 2 research presentations, 1 presentation for special interest group
2014: 2 research presentations, 1 poster, organized 1 invited session & served as chair
2015: 1 research presentation, 1 poster
2016: 2 presentations for special interest group, 1 poster

2017: 3 research presentations, 1 “Best of ARM” presentation, 2 presentations for special interest groups
2018: 1 research presentation, 1 presentation for special interest group, 1 poster
2019: 1 presentation for special interest group

American Society of Health Economists
2006: research presentation, discussant
2008: 2 research presentations, poster
2012: 2 research presentations, session chair
2014: 2 session chairs, 1 research presentation, organized 4 sessions
2016: 2 presentations, discussant, session organizer, pre-conference session presenter
2018: 2 presentations, discussant (2), session organizer (2), session chair (2)

Allied Social Sciences Associations, 1997 (2 research presentations), 1998 (research presentation), 1999 (research presentation), 2002 (session chair and research presentation), 2012 (research presentation), 2016 (discussant)
American Association of Medical Colleges Health Workforce Conference, 2014 (1 research presentation, 1 poster), 2015 (1 research presentation, 1 panel moderator, 1 poster), 2016 (2 research presentations)
American Public Health Association, 1996 (poster), 1998 (research presentation), 1999 (research presentation), 2003 (research presentation)
Association for Public Policy Analysis and Management, 1994 (research presentation), 1996 (roundtable speaker), 1997 (research presentation), 1998 (research presentation), 1999 (session chair, research presentation), 2001 (2 research presentations), 2002 (session chair, research presentation), 2003 (research presentation), 2004 (2 research presentations), 2005 (research presentation)
Forum of State Nursing Workforce Centers annual meeting, 2007 (invited presentation), 2012 (research presentation), 2015 (4 research presentations), 2017 (3 research presentations)
Workshop in Health Information Technology Economics, Washington, DC, 2010 (research presentation), 2012 (research presentation)

1993 The University-Industry Interface in Medical Technology, Institute of Medicine (research presentation)
1994 National Bureau of Economic Research, Summer Workshop (research presentation)
1996 National Conference of State Legislatures, Immigrant and Multicultural Health Conference (panel presentation and moderator)
1996 NurseWeek Editorial Advisory Board (keynote)
2001 Third Annual Evidence-Based Practice Nurse Executive Conference, University of Pennsylvania (panel presentation)
2001 Health Resources and Services Administration, U.S. Department of Health and Human Services (research presentation)
2003 Association of Health Care Journalists, Fourth National Conference (panel presentation)
2003 National Conference of State Legislatures, Nursing Education and State Policy Conference (panel presentation)
2004 Petris Center Conference on Antitrust and Health Care, UC – Berkeley (research presentation)
2004 The Intersection of Nursing and Health Services Research, invitational conference, University of North Carolina at Chapel Hill (research presentation)

2004 Critical Linkages: Patient Safety, Nurse Staffing, and Leadership Solutions, Joint Commission on Accreditation of Healthcare Organizations (presentation)
2005 National Nursing Quality Databases Conference: Building Bridges from Research to Practice, San Francisco, CA (presentation)
2005 National Conference of State Legislatures, session sponsored by Service Employees International Union, "Who Will Care? Strategies to Solve NursingWorkforce Shortages"
2008 VA eHealth University, Tampa, FL (training seminar)
2008 Institute of Medicine, Promoting Team Care Symposium, Los Angeles, CA (presentation)
2008 VA Information Resource Center, Web seminar on evaluating the VA's health IT systems (live web seminar)
2009 Impact of Patient Safety Initiatives on Nursing Workflow and Productivity (funded by AHRQ), Millbrae, California (methodologic expert participant)
2009 The Future of Health Services Research in 2020: Data and Methods (organized by AcademyHealth, funded by Robert Wood Johnson & Commonwealth Foundations), Washington, DC (invited participant)
2010 Association of Women's Health, Obstetric & Neonatal Nurses (AWHONN) Convention, Las Vegas, NV (invited presentation)
2010 Nursing Economics 4th Annual Nurse Faculty/Nurse Executive Summit, Scottsdale, AZ (invited presentation)
2011 Kaiser Permanente National Workforce Planning & Development Conference, Oakland, CA (invited panel)
2012 American Association of Colleges of Nursing, Doctoral Education Conference, Naples, FL (keynote)
2012 Pacific Institute of Nursing, Annual Conference, Honolulu, HI (invited presentation)
2012 Robert Wood Johnson Foundation, Future of Nursing Campaign for Action, "How Do You Measure Your Progress? Dashboard Data and Measuring Nurse Education" (webinar)
2012 American Academy of Nursing, Washington, DC (poster presentation)
2012 Robert Wood Johnson Foundation, Future of Nursing Campaign for Action, "Data: An Overview of What is Collected, Where to Access It and How to Use It"
2013 American College of Nurse Midwives, Briefing on Women's Health Workforce, Washington, DC (speaker)
2013 Collaborative Alliance for Nursing Outcomes, Annual Conference, Seattle WA (podium presentation)
2013 Joint Center for Political and Economic Studies, Report Release Roundtable, Washington DC (presenter)
2014 Health Workforce Technical Assistance Center, "Using Employer Surveys to Assess Health Workforce Demand" (webinar)
2014 American National Standard Institute, Invitational meeting on "Building a Quality, Flexible and Mobile Health Care Workforce for the Future," Washington DC (panelist)
2014 Federal Trade Commission, Workshop on Competition in Health Care, Washington DC (panelist)
2015 Health Workforce Technical Assistance Center, "Entry and Exit of Workers in Long-Term Care" (webinar)
2015 Institute of Medicine Committee for the Evaluation of the Impact of the Institute of Medicine Report: The Future of Nursing: Leading Change, Advancing Health. (presentation)
2015 Sigma Theta Tau International Convention, pre-conference workshop (workshop presentation & management)
2016 RAND Corporation, Webinar, "Best Practices Using Peer Providers in Mental Health and Substance Use Disorders" (invited presentation)

2016 Texas Medical Center, National Convening, Health Workforce Innovations to Support Delivery System Transformation (invited presentation)
2016 Montana State University, Forecasting the RN Workforce Invitational Convening (invited presentation and participation)
2016 SAMHSA Region IX and X Workforce Development retreat, San Francisco, CA
2017 American Organization of Nurse Executives / Robert Wood Johnson Foundation, Invitational Meetings on Advancing Progression in Nursing Program Transition (invited presentation and participation, 2 meetings)
2017 Health Workforce Technical Assistance Center, "Data Collection to Advance Nursing Workforce Planning in California" (webinar)
2017 American Association of Colleges of Nursing, Spring Annual Meeting (invited presentation)
2017 Montana State University, Team-Based Long-Term Care Invitational Meeting (invited presentation and participation)
2018 Health Workforce Research Center Symposium: Workforce Strategies to Improve Health Outcomes, Washington, DC (invited presentation and participation)
2019 Serious Illness Quality Alignment Hub (webinar presenter)
2019 Health Workforce Technical Assistance Center webinar series (presenter)

Regional and Other Invited Presentations

1996 Bay Area Labor Economists, Semi-Annual Meeting (research presentation)
1996 Western Economic Association (research presentation, discussant)
1997 University of California, Davis (research paper)
1997 University of California, Santa Cruz (research paper)
1998 University of California, Davis (research paper)
1998 Bay Area Labor Economists, Semi-Annual Meeting (research presentation)
1998 Western Economic Association (discussant)
1998 Western Regional Science Association (discussant)
1999 Bay Area Labor Economists, Semi-Annual Meeting (research presentation)
2000 California's Minimum Nurse Staffing Legislation Stakeholder Meeting, California HealthCare Foundation (research presentation)
2000 Democrats of Rossmoor (keynote)
2000 Western Regional Science Association (research presentation)
2001 California Organization of Associate Degree Nursing Directors and California Association of Colleges of Nursing Deans and Directors Annual Meeting (keynote)
2001 The Petris Center for Health Care Markets and Consumer Welfare, Charity Care Conference (group discussion leader)
2001 California Office of Statewide Health Planning and Development (research paper)
2001 Catalyst Corporation, Advisory Committee (keynote)
2002 College of Marin Nursing School Graduation (keynote)
2002 Union College, Schenectady, New York (research presentation)
2004 Causes and Consequences of the Nurse Shortage: Developing a Solution in Illinois, University of Illinois at Chicago (research presentation)
2005 Nurse-to-Patient Ratios: Research and Reality. Sponsored by the Massachusetts Health Policy Forum and Boston Federal Reserve Bank New England Public Policy Center, Boston, MA (presentation)
2006 Increasing Diversity in the Health Care Professions. Sponsored by the Discrimination Research Center and California State University, Sacramento (presentation)
2006 SEIU Nurse Alliance Legislative Leadership Meeting, Sacramento, CA (presentation)
2006 University of Minnesota, School of Business (research seminar)

2007 Increasing Career Opportunities in Nursing and Allied Health in the Los Angeles Area. Sponsored by the LA Health Collaborative, Los Angeles, CA (presentation)
2008 ADVANCE for Nurses, Forum for Healthcare Recruitment, Sacramento, CA (roundtable panel speaker)
2008 MIT Club of Northern California Healthcare Forum, "National Health Reform: Single Payer vs. Managed Competition," Palo Alto, CA (presenter)
2009 Connecticut Nursing Leadership Forum, "Minimum Staffing Ratios: Research and Strategies," Wallingford, CT (presenter)
2010 SEIU Nurse Alliance Legislative Leadership Meeting, Sacramento, CA (presentation)
2010 George Washington University, School of Nursing & Department of Health Policy, School of Public Health and Health Services, "Nurses and Unionization" (invited seminar)
2010 University of Toronto, School of Nursing, "Nursing Shortage: Myth or Reality" (expert panel with Christine Kovner, Cheryl Jones, and Carol Brewer)
2010 Medical Industry Leadership Institute, Carlson School of Business, University of Minnesota, "Nurses and Unionization" (invited seminar)
2010 University of Indiana / Purdue University at Indianapolis, Department of Economics, "Nurses and Unionization" (invited seminar)
2010 University of Washington, School of Public Health, "Nurses and Unionization" (invited seminar)
2010 Western Institutes of Nursing (2 podium presentations)
2011 Collaborative Alliance for Nursing Outcomes, Annual Conference (2 presentations)
2011 University of California San Francisco, "The Present and Future of California's Registered Nurse Labor Market: Shortages, Surpluses, and Surprising Trends." (webinar)
2011 Princeton University, Department of Economics, Industrial Relations Section, "The Impact of Nursing Unions on Wages, Staffing, and Patient Outcomes" (invited seminar)
2012 San Francisco General Hospital, Nursing Practice Council, Journal Club presentation
2012 California Organization of Associate Degree in Nursing Program Directors, "How Do We Measure Success? Data Needs for the Changing Health Workforce" (invited keynote)
2012 University of North Carolina, Globalization of the Nursing Workforce invitational meeting (invited presentation)
2012 University of California San Francisco, "The Present & Future of California's Registered Nurse Labor Market: Shortages, Surpluses, and New Trends." (webinar)
2012 Association of California Nurse Leaders, San Francisco Chapter, "The Impact of Nurse Unions on Wages, Staffing, and Patient Outcomes" (invited keynote at monthly meeting)
2012 University of California Berkeley Health Services Research Colloquium
2012 Minnesota Nurse Leadership Summit (invited keynote)
2013 University of North Carolina, Cecil Sheps Center (research seminar)
2013 University of California San Francisco, "The Nursing Labor Market in California: Still in Surplus?" (webinar)
2013 Association of California Nurse Leaders, East Bay Chapter, "New Developments in California's RN Labor Market" (invited keynote at monthly meeting)
2013 UCSF Global Health Economics Consortium Colloquium, San Francisco (speaker and workshop leader)
2014 Service Employees International Union-United Health Workers Education Fund, "Impact of the 2010 Affordable Care Act on the CA Labor Force" (webinar)
2014 Northwest Organization of Nurse Executives, annual Fall Conference (invited panel presentation)
2015 Pennsylvania State University, Health Services Research Colloquium, "What Predicts a Nurse Practitioner Working in Primary Care?" (invited colloquium presentation)
2015 University of Hawaii Manoa School of Nursing, Dean's Invited Lecture (3 presentations)

2015 California Institute for Nursing and Health Care, Seismic Shift in Nursing Roles event (Panel presentation)
2015 Tobacco-Related Disease Research Program, Marijuana Regulation: Lessons from Tobacco-Related Disease Research and Tobacco Control (presentation)
2015 California Hospital Association Workforce Committee (presentation)
2015 California Health Workforce Initiative Meeting (presentation)
2016 University of Minnesota, Division of Health Policy and Management (invited presentation)
2016 California Organization of Associate Degree of Nursing Program Directors and California Association of Colleges of Nursing Joint Conference (keynote presentation)
2016 Bay Area Black Nurses Association, Flo Stroud Pre-Conference (invited presentation)
2017 JVS Health Workforce Advisory Board (invited presentation)
2017 Greater Bay Area Mental Health & Education Workforce Collaborative, Oakland, CA (invited presentation)
2017 Holy Names University, 3rd Annual Nursing Symposium: The Power of Nursing: Agents for Change (invited presentation)
2017 West Virginia Future of Nursing Coalition, Statewide Convening, Charleston, West Virginia (invited presentation)
2017 California Health Workforce Initiative Meeting (presentation)
2018 Riverside Registered Nursing Regional Summit, Riverside, California (presentation)
2018 Orange County Registered Nursing Regional Summit, Irvine, California (presentation)
2018 Central Valley Registered Nursing Regional Summit, Fresno, California (presentation)
2018 Sacramento Registered Nursing Regional Summit, Sacramento, California (presentation)
2018 Los Angeles Registered Nursing Regional Summit, Los Angeles, California (presentation)
2018 San Diego Registered Nursing Regional Summit, San Diego, California (presentation)
2018 Bay Area Registered Nursing Regional Summit, Oakland, California (presentation)
2019 California State University Los Angeles Evidence-Based Nursing Summit (keynote)

TEACHING AND MENTORING

FORMAL SCHEDULED CLASSES FOR UCSF STUDENTS

<u>Full Charge</u>

2001-2006	N287E: Advanced Financial Management	4 units	Master's level
2002	N226: Clinical Implications of Managed Care	1 unit	Master's level
2006	N289A: Advanced Quantitative Research Methods	4 units	Doctoral level
2007	S222: Health Economics and Policy	2 units	Master's level
2013-present	BioE297/285: Health Care Finance and Economics	2 units	Master's level
2014	MHA200B: Introduction to Health Systems Management	3 units	Master's level
2014-present	MHA204: Healthcare Finance, Technology, and Business	3 units	Master's level
2016-present	HPL Health Economics (co-faculty)	3 units	Master's level
2017-present	HPL Health Economics 2 (co-faculty)	3 units	Master's level

<u>Guest Lectures</u>

1999	N287E: Advanced Financial Management	3 lectures	Master's level
2001, 2009	SOC222: Health Economics and Policy	1 lecture	Master's level
2002-2003	N150: Community Health Nursing	1 lecture	Master's level
2004-2011	CP133: Health Economics & Pharmacoeconomics	1 lecture	Doctoral level
2004-present	S284: Health Care Economics	1 lecture	Graduate level
2004, 2005	S210: Proseminar in Health Policy	1 lecture	Master's level
2005-2009	N262.06: Research Utilization in Health Policy	1 lecture	Master's level

2006	N248: Patient Safety Seminar	1 lecture	Master's level
2007-2013	CP123: Health Policy	1 lecture	Doctoral level
2012	N241: Dimensions of Leadership	1 lecture	Master's level
2012	Stories from the Bedside Grand Rounds	1 lecture	Doctoral level
2014-present	GHS209: Comparative Health Systems	1 lecture	Master's level
2014	CP133: Health Policy for Pharmacists	1 lecture	Doctoral level

<u>Research Residencies and Independent Studies</u>

2005	N4710: Independent Study: Olga Ivanco (2 quarters)	Master's in Nursing
2006	N276: Research Rotation: Michelle Tellez	Doctorate in Nursing
2006	N249: Independent Study: Michelle Tellez	Doctorate in Nursing
2006-2007	N276: Research Rotation: Barbara Burgel	Doctorate in Nursing
2008	N276: Research Rotation: Shin-Hye Park (2 quarters)	Doctorate in Nursing
2008	N276: Research Rotation: Hyang Yuol Lee	Doctorate in Nursing
2010-2011	Inter-Professional Health Education Program	One student from each school
2010	N471: Practicum in Health Policy: Katherine Chadwick	Master's in Nursing
2013	N471: Practicum in Health Policy: Emma Moore	Master's in Nursing
2013	N276: Research Rotation: Lorinda Coombs	Doctorate in Nursing
2015	N276: Research Rotation: Renee Smith	Doctorate in Nursing
2016	N276: Research Rotation: Zoey Stafford	Doctorate in Nursing

<u>Post-Graduate and Other Courses</u>

2003	Robert Wood Johnson Foundation Scholars in Health Policy Research Postdoctoral Program	2-hour lecture
2008	Institute for Health Policy Studies Postdoctoral Seminar	1.5-hour seminar
2008	Robert Wood Johnson Foundation Scholars in Health Policy Research Postdoctoral Progam	30-minute presentation
2009	Institute for Health Policy Studies Postdoctoral Seminar	1.5-hour seminar
2012-2014	Pathway to Health and Society	2-hour seminar
2011-2016	Decision and Cost Effectiveness Analysis (master's level)	Student mentor

TEACHING AT OTHER UNIVERSITIES

<u>Full Charge</u>

1992	Stanford University	Lecturer, Mathematics review for doctoral students
1993	Stanford University	Lecturer, Econ 1: Introductory economics
1993	Stanford University	Lecturer, Econ 156: Health economics
1997	University of California, Santa Cruz	Visiting Professor, Health economics
2001	University of California, Berkeley	Visiting Professor, School of Public Health, health economics

<u>Guest Lectures</u>

1997	San Francisco State University	Department of Economics, Health economics
1999	San Jose State University	Department of Health Management, Health workforce
2000	Mills College, Oakland	Department of Economics, Health policy
2008	University of California, Berkeley	School of Public Health, Health economics
2009	University of California, Berkeley	School of Public Health, Health economics
2009	University of California, Berkeley	School of Public Health, Health workforce
2010	University of California, Berkeley	School of Public Health, Health economics
2010	University of Indiana / Purdue University at Indianapolis	Department of Economics, Health economics
2011	University of California, Berkeley	School of Public Health, Health workforce

2011	University of California, Berkeley	School of Public Health, Health economics
2012	University of California, Berkeley	School of Public Health, Health workforce
2015	University of California, Berkeley	School of Public Health, Health workforce
2017	University of California, Berkeley	School of Public Health, Health workforce

SPECIAL COURSES

2010 Berkeley Global Health Workforce Economics Network, weeklong course on International Human Resources for Health, Berkeley, California (course faculty)

2011 World Health Organization/Global Health Workforce Economics Network, weeklong course on International Human Resources for Health, Rio de Janeiro, Brazil (course faculty)

2012 Master's student preceptorship, Yale University, School of Nursing

STUDENT SUPERVISION AND MENTORING

Post-Doctoral Students

2012-2016	Michelle Ko, MD, PhD	UCSF, Department of General Internal Medicine & Institute for Health Policy Studies
2015-2017	Kristine Himmerick, PhD, PA	UCSF, Healthforce Center
2016-2018	Nancy Dudley, PhD, RN	San Francisco VA Post-Doctoral Scholar

Pre-Doctoral Students

1996-1999	Michael Ash, PhD	UC Berkeley, Economics	Mentor
1997-1999	Mark Smith, PhD	Yale University, Economics	Internship sponsor, mentor
1997-2000	Shannon Mitchell, PhD	UC Berkeley, Public Health	Dissertation committee
2000-2002	Alison Kris, PhD, RN	UCSF, Community Health Systems	Dissertation committee
2003-2006	Sue Seo, PhD	UC Berkeley, Public Health	Dissertation committee
2004-2007	Michelle Tellez, PhD, RN	UCSF, Community Health Systems	Dissertation committee
2006-2007	Lisa Thomas, PhD, RN	UCSF, Social & Behavioral Sciences	Dissertation committee
2006-2007	Barbara Burgel, PhD, RN	UCSF, Community Health Systems	Mentor
2007-2009	Teresa Serratt, PhD, RN	UCSF, Social & Behavioral Sciences	Dissertation committee
2008-2011	Shin-Hye Park, PhD, RN	UCSF, Community Health Systems	Dissertation committee
2009-2010	Nickie Gallaher, PharmD	UCSF, School of Pharmacy	Research project advisor
2011-2013	Jose Dy Bunpin, PhD, RN	UCSF, Community Health Systems	Dissertation committee
2014-2015	Bahar Navab	UC Berkeley, Public Health	Qualifying committee
2014-2016	Satu Larson, PhD, RN	UCSF, Social & Behavioral Sciences	Dissertation committee
2014-2016	Bronwyn Fields, PhD, RN	UC Davis, School of Nursing	Dissertation committee
2015-2017	Debby Rogers, MSN, RN	UCSF, Social & Behavioral Sciences	Dissertation committee
2017-2019	Kirsten Wisner, RN	UCSF, Family Health Nursing	Dissertation committee
2017-2019	Shira Winter, RN	UCSF, Social & Behavioral Sciences	Dissertation committee

FACULTY MENTORING

2007-2016	Michelle Tellez, PhD, RN	California State University East Bay	Mentoring, collaboration
2007-2010	Lisa Thomas, PhD, RN	University of Nevada Reno	Mentoring, collaboration
2009-2010	Renee Hsia, MD	UC San Francisco, Medicine	Mentor for KL2 award
2009-2011	Teresa Serratt, PhD, RN	Idaho State University	Mentoring, collaboration
2010-present	Elizabeth Mertz, PhD	UC San Francisco, Dentistry	Mentoring, collaboration
2011-present	Henry Michtalik, MD	Johns Hopkins University, Medicine	Mentor for K award
2012-present	Laura Wagner, PhD, RN	UC San Francisco, Nursing	Mentoring, collaboration
2012-present	Bianca Frogner, PhD	University of Washington, Medicine	Mentoring, collaboration
2014-present	Ulrike Muench, PhD, RN	UC San Francisco, Nursing	Mentoring, collaboration
2017-present	Jason Flatt, PhD	UC San Francisco, Institute on	Mentoring, collaboration

Health and Aging

SERVICE

COMMISSIONS AND ADVISORY COMMITTEES

1996-2000	California Strategic Planning Committee for Nursing	Advisory Committee
1996-2000	California Strategic Planning Committee for Nursing, Modeling Research, and Development Workgroup	Member
2001-2003	The Scope of Practice of Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives (study funded by U.S. Health Resources and Services Administration, conducted by SUNY – Albany), Advisory Committee	Member
2002-2006	California Board of Registered Nursing, Nursing Workforce Advisory Committee	Member
2002-2005	Central Valley Nursing Diversity Project, Steering Committee	Member
2002-2004	National Commission for VA Nursing	Member
2003	Johnson & Johnson Faculty Grants Advisory Committee, Northern California	Member
2003-2004	Creating a National Nurse Practitioner Database (study funded by U.S. Health Resources and Services Administration, conducted by SUNY – Albany), Advisory Committee	Member
2004-2009	California Institute on Nursing and Health Care, Statewide Master Plan Project, Data Focus Area, Advisory Committee	Member
2005-2016	California Board of Registered Nursing, Education Issues Workgroup	Member
2006	California Institute on Nursing and Health Care, Diversity Project, Advisory Committee	Member
2006-2007	Robert Wood Johnson Foundation and Rutgers Center for State Health Policy, Invitational Conference on The Economics of Nursing: Paying for Quality Nursing Care, Advisory Committee	Member
2009-2011	Institute of Medicine, Committee on the Future of Nursing	Consultant
2011-2012	Bipartisan Policy Center Health Professional Workforce Initiative, Advisory Committee	Member
2011-2016	UCSF US Centre for Evidence-based Patient Care Quality Improvement -- A Joanna Briggs Institute Affiliated Centre	Founding Faculty
2011-2012	New Mexico Robert Wood Johnson Foundation Nursing and Health Policy Collaborative, Market for Nurse Practitioners in New Mexico Study, National Advisory Committee	Member
2011-2011	Collaborative Alliance for Nursing Outcomes (CALNOC)	Operations Team
2011-present	California Action Coalition for the Future of Nursing	Workgroup Leader
2012-2013	Emergency Department Quality Indicators Project, Stanford Center for Primary Care and Outcomes Research, funded by U.S. Agency for Healthcare Research and Quality	Internal Expert Group
2012-2015	Institute of Medicine, Standing Committee on Credentialing Research in Nursing	Member
2013-2017	Association of Women's Health Obstetric and Neonatal Nurses, Science Team for Perinatal Nurse Staffing Research Project	Member
2013-2016	Process Redesign Advisory Group, National Center for Inter-Professional Education	Member

2014	Institute of Medicine, Planning Committee for Workshop on Credentialing Research in Nursing	Member
2014	National Governor's Association Policy Academy, Building a Transformed Health Care Workforce	Expert Faculty
2014-present	UnitedHealth Group External Clinician Advisory Board	Member
2016	National Academy of Science Engineering and Medicine, Planning Committee for Workshop on Future Financing of Health Professions Education, IPHE Global Forum	Member
2017-present	HealthImpact & California Action Coalition, Advisory Committee	Member
2017-present	California Board of Registered Nursing, Nursing Workforce Advisory Committee	Member
2017-present	California Future Health Workforce Commission, Technical Advisory Committee	Member
2017	Health Teams for Frail Elders Conference, Planning Committee	Member
2018	National Academy of Science Engineering and Medicine, Planning Committee for Strengthening the Connection between Health Professions Education and Practice: A Joint Workshop	Member
2019	National Academies of Science Engineering and Medicine, Committee on Consideration of Generational Issues in Workforce Management and Employment Practices	Member

TECHNICAL ASSISTANCE AND CONSULTATION

2010 Colorado Health Institute, Alternative Primary Care Clinicians: A Workshop on Best Practices for Surveying the NP and PA Workforce. Expert meeting for consultation and guidance. Denver, Colorado.

2010 American Nurses Association. Expert Roundtable on economic issues facing nursing, in preparation for 2011 Policy Conference. Silver Spring, Maryland.

2011 National Longitudinal Survey of New Graduate Nurses, New York University. Technical review meeting.

2012 Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Technical Expert Panel, Effective Strategies to Increase the Supply of Primary Care Providers and Services. Washington, DC.

2012 Bureau of Health Professions, U.S. Department of Health and Human Services, Expert Panel, Data and Methods for Tracking the Supply, Demand, Distribution and Adequacy of the Primary Care Workforce. Washington, DC.

2012 Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Technical Expert Panel, Analysis of Physician Time Use Patterns under the Medicare Fee Schedule. Washington, DC.

2012 Robert Wood Johnson Foundation, Academic Progression in Nursing (APIN) Applicant Information Session, webinar presenter

2013 Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Technical Expert Panel, Health Practitioner Bonuses and Their Impact on the Availability and Utilization of Primary Care Services. Washington, DC.

2018 External Expert Meeting on Background Factors and Service Innovations Affecting the Behavioral Health Workforce and Implications for Workforce Modeling and Projections. Health Resources and Services Administration. Washington, DC.

SERVICE TO PROFESSIONAL ORGANIZATIONS

AcademyHealth (formerly Association for Health Services Research)

2002-2003 Program Committee for Workforce sessions at Annual Research Meeting

2006-2007	Program Committee for Workforce sessions at Annual Research Meeting
2007-2008	Theme Leader for Workforce sessions at Annual Research Meeting
2008-2009	Program Committee for Workforce sessions at Annual Research Meeting
2009	Invited participant at Summit on Health Services Research Data & Methods
2009, 2010	Resume reviewer/mentor at Annual Research Meeting
2009-2010	Theme Leader for Workforce sessions at Annual Research Meeting
2010-2011	Program Committee for Annual Research Meeting
2012-2013	Program Committee for Workforce sessions at Annual Research Meeting
2014	Poster Walk Leader
2015-2016	Program Committee for Workforce sessions at Annual Research Meeting; Program Committee for Late-Breaking Abstracts
2019-2021	Membership Committee, Member
2019	Program Committee for Workforce sessions at Annual Research Meeting

Interdisciplinary Research Group on Nursing Issues (special interest group of AcademyHealth)

2005-2007	Treasurer
2007-2008	Nominating Committee
2008-2009	Chair-Elect
2009-2010	Chair
2010-2011	Program Committee
2012-2013	Program Committee

International Health Economics Association

2002-2003	Program Committee for Convention
2003	Poster Award Committee
2003	Session chair for biennial meeting (2 sessions)
2004-2005	Scientific Committee member
2010-2011	Scientific Committee member
2012-2013	Scientific Committee member
2014-2015	Scientific Committee member
2016-2017	Scientific Committee member
2016-2017	Planning Committee for pre-conference Teaching Day
2018-2019	Scientific Committee member
2018-2019	Lead Organizer, Economics of Health Workforce Pre-Congress Session
2018-present	Lead Organizer, Health Workforce Special Interest Group

American Society of Health Economists

2007-2008	Scientific Committee member
2011-2012	Scientific Committee member
2013-2014	Conference Host Committee
2015-2016	Scientific Committee member
2017-2018	Scientific Committee member

Association for Public Policy Analysis and Management

1999	Session chair for annual conference
2000-2003	Policy Council member
2001-2002	Nominations Committee
2002-2003	Session chair for annual conference
2002-2003	Conference program committee member

Other organizations

1991-1992	Stanford Economics Graduate Student Assoc.	Co-chairperson
1996	Western Economic Association	Session chair for annual conference
1996-2003	Bay Area Labor Economists	Co-chairperson
1999	Health Economics Research Organization	Session chair for annual conference
2002	Health Economics Research Organization	Session organizer for annual conference
2010	Workshop on Health IT and Economics	Program Committee for annual conference
2012-2013	International Health Workforce Collaborative	Program Committee for U.S. delegation
2013	Economics of the Health Workforce Conference	Program Committee
2014-present	International Health Workforce Collaborative	Program Committee for U.S. delegation
2015-2016	International Health Workforce Collaborative	Host Program Committee

SERVICE TO PROFESSIONAL PUBLICATIONS

2005-2007	Medical Care Research and Review	Guest Editor for special issue
2005-present	BioMed Central	Statistical Review Panel
2008-present	Medical Care Research and Review	Editorial Board
2009-2013	BMC Health Services Research	Associate Editor
2011-2016	Nursing Economics	Columnist: Economic$ of Health Care and Nursing
2013-2016	BMC Health Service Research	Editorial Advisor
2018-2019	Health Affairs	Consulting Editor for Theme Issue
2018-present	HSR: Health Services Research	Editorial Board
2018-2019	Journal of the American Geriatrics Society	Co-Editor of special issue
2019	Medical Care Research and Review	Co-Editor of special issue

RESEARCH AND PROPOSAL REVIEWS

California HealthCare Foundation, manuscript reviewer, 2001
Robert Wood Johnson Foundation, proposal reviewer, 2003
Institute for Social and Economic Research and Policy (ISERP), Columbia University, proposal reviewer, 2005
Hospital Ownership and Performance, Research Project Funded by Robert Wood Johnson Foundation, expert panel for meta-analysis, 2005
The Social and Economic Consequences of Tobacco Control Policy, book chapter reviews at proposal and completion stages. Book commissioned by the American Legacy Institute, edited by Peter Bearman, Kathryn Neckerman, and Leslie Wright. 2005-2006
Blackwell Publishing, Book proposal review, 2007
National Science Foundation, Research proposal review, 2008
Department of Veterans Affairs, Pilot Project Grant reviews, 2009
Department of Veterans Affairs, Nursing Research Initiative Merit Review Panel, 2010
Health Research Board of Ireland, Collaborative Applied Research Grants review, 2012
Research Foundation – Flanders, Post-Doctoral Fellowship review, 2015
Review Panel for RFA-DA-18-005: Expanding Medication Assisted Treatment for Opioid Use Disorders in the Context of the SAMHSA Opioid STR Grants, National Institute on Drug Abuse, 2017
Chair for ZDA1 HXO-H (06) S, Multisite Clinical Trials (2 RFAs), National Institute on Drug Abuse, February 2018
Agency for Healthcare Research and Quality, Healthcare Effectiveness and Outcomes Research Study Section Member, June 2018-present

UNIVERSITY SERVICE

UCSF Campus-Wide

2004 Research proposal reviewer, Sigma Theta Tau, Alpha Eta Chapter (UCSF)
2006 Ad hoc review for business proposal for Asian Cardiovascular Center at UCSF
2010 Search committee for Director of Health and Society Pathway at UCSF
2010 Inter-Professional Education Day Curriculum Ambassador Mentor
2012 Inter-Professional Health Education Day Group Facilitator
2012 Center for Health Care Value Training Initiative Committee
2012 Asian Health Institute Roundtable Speaker
2014-present Office of Sponsored Research Advisory Board Member
2017 Consultation on Risk Assessment Methodology for UCSF Audit and Advisory Services

International Visitors

Nov 2001 Justine Curnow, Australian Medical Workforce Advisory and the Australian Health Workforce Advisory Committee. Participated in meeting of four UCSF faculty and staff.
May 2002 Division of Health Policy Research, National Health Research Institutes, Taiwan. Organized meeting with Dr. Ivy Tsai regarding Taiwan's Future Requirement for Physicians and WTO's Influence Upon It.
Sept 2003 Dr. James Buchan, Faculty of Social Sciences and Health Care, Queen Margaret University College, Edinburgh, Scotland. Meetings and consultation regarding minimum nurse staffing ratios in California and Australia, as part of project for British National Health Service.
March 2004 Research Institute for National Health, Japan. Organized meeting of five UCSF faculty with group of physicians interested in the study of medicine and social science.
April 2004 Dr. Annette J Lankshear, Department of Health Sciences, University of York, England. Day-long meeting held at UCSF.
May 2006 United Kingdom House of Commons Committee on Health, Inquiry into Workforce Needs and Planning for the Health Service. Organized meeting of three UCSF faculty with 11-person Committee.
June 2006 Dr. Alvisa Palese, Professor, Udine University, Italy. One-hour meeting held at UCSF.
Nov 2006 Dr. Toon Keng Wong, Principal Assistant Secretary at the Ministry of Health of Malaysia Training Division in Kuala Lumpur. One-month sponsorship of WHO Fellow in Health Workforce Planning and Development.
Mar 2014 Lisa Smith, RN, Director, Nursing Education and Workforce, Whittington Health, National Health Service, London, England. One-week visitor via a Florence Nightingale Fellowship.
Mar-Sep 2014 Jia Guo, Assistant Professor, Central South University, School of Nursing. Six-month visiting fellowship through a faculty development award from the China Medical Board.
Aug 2018 Korean Ministry of Health and Welfare and Korea Institute for Health and Social Affairs, visiting delegation to support development of a national health workforce policy plan.

University of California

2017 UCOP Nursing School Budget Advisory Group (Member)

School of Nursing

2006 Lunch Discussion with Clinical Faculty on compensation issues
2009 Task Force on Data for Doctoral Program Committee (Member)

Departmental Service: Philip R. Lee Institute for Health Policy Studies

2008-2013 Health Policy Seminar Planning Committee (Member)

2011-2012	Ad-hoc Planning Committee for Advisory Board Meeting (Member)
2012	Ad-hoc Committee for Faculty Appointments (Member)
2013-present	Faculty Appointment Committee (Chair)
2015	Faculty Search Committee (Chair)

Departmental Service: Healthforce Center at UCSF

2001-2011	Project Directors/Managers Committee (Member)
2004-2007	Research Working Group (Organizer)
2006-2011	Research Team Task Force (Member)
2011-2012	Transition Team Co-Chair
2012-present	Executive Committee (Member)
2013-present	Research Faculty Group (Chair)

Departmental Service: Other Departments

2003-2011	Community Health Systems	Merit Review Committees (Member)
2004-2007	Community Health Systems	Administration Program Strategy Committee (Member)
2005-2009	Community Health Systems	Comprehensive Exam Grading
2014	Social & Behavioral Sciences	Faculty Search Committee (Member)
2014	Dept. of Emergency Medicine	Faculty Search Committee (Member)
2016	Dept. of Family & Comm. Med.	Faculty Search Committee (Member)
2017	Dept. of Preventive & Restorative Dentistry	Faculty Search Committee (Member)
2017	School of Pharmacy	Faculty Search Committee (Member)

Other Universities

1992-1993	Economics Graduate Policy Committee, Stanford University (Member)
1993	Stanford in Government Health Policy Internship, Selection Committee (Member)
2002, 2004	UC Berkeley, School of Public Health, Summer Internship Program (Intern Sponsor)
2002-present	Massachusetts Institute of Technology Externship Program, Extern Sponsor at UCSF