House Bill 191 – PROPONENT TESTIMONY
Ohio House Health Committee
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Lynn Reede, DNP, MBA, CRNA, FNAP

Good morning, Chairman Huffman, Vice Chair Gavarone, Ranking Member Antonio, and members of the House Health Committee. My name is Lynn Reede. I am a CRNA and Senior Director of Professional Practice with the American Association of Nurse Anesthetists. I practiced anesthesia for 30 years in the same 500 bed community hospital in Canton, Ohio, and for 10 of those years, managed the anesthesia department with 17 anesthesiologists, 58 CRNAs who provided 25,000 anesthetics and related procedures annually. I have been blessed to serve as an Army Nurse Corps reservist. In each of those settings, I shared the same practice standards, outcome expectations, liability insurance limits, and requirements for facility credentialing and quality reporting as my physician colleagues. I am most grateful for the opportunity to speak with you today regarding anesthesia service excellence that patients deserve and that healthcare facilities seek in this rapidly evolving healthcare market.

When a patient stops breathing, seconds count. A CRNA and RN are right there, trained, educated, expected and ready to respond to the emergency. A CRNA, who is an airway expert, is ready to place a breathing tube to save the patients life. The CRNA asks a Registered Nurse for help to administer a medication that he selected to facilitate placement of the breathing tube. However, according to the Ohio Revised Code, the CRNA cannot give this order. The RN is not allowed to follow the order, the law requires the RN to get an order from another physician, advanced practice nurse or other "ordering provider". Though protocols or order sets have value, point of care decision-making plays a critical role in determining the correct protocol to address the patient's needs.

CRNAs are educated and prepared for autonomous practice and do not require physician supervision to provide anesthesia services. Like our anesthesiologist colleagues, we consult with physicians and other specialists when appropriate. CRNAs always work with the patient and their team of healthcare providers that include one or many physicians. For the many hours of the day when physicians are engaged elsewhere, nurses and advanced practice professionals, such as CRNAs make critical decisions regarding complex patient's care at the patient's bedside. CRNAs make decision after decision each day to determine medications used to administer anesthesia, manage the patient's health status in the perioperative period, and when necessary interventions for resuscitation. Yet in Ohio, different than many states and the military, the CRNA cannot order another to administer what they are permitted to administer themselves.

The current anesthesia workforce is shrinking with retirement of both CRNAs and anesthesiologists. National physician lead anesthesia management companies such as Team Health, North American Partners in Anesthesia, US Anesthesia Partners and many others are having difficulty recruiting and retaining CRNAs in multiple markets due to increasing demand for a high quality anesthesia delivery model at a lower cost with fewer or no anesthesiologists. Full scope of practice of advanced

practice professionals allows our physician colleagues to focus their skills wherever they are most needed.

CRNAs and anesthesiologists share the same evidence based standards and guidelines. Courts found in 1917, 2007 and again in 2012 that anesthesia is the practice of medicine when practiced by a physician and the practice of nursing when practiced by a CRNA. Patients receive the same medications, monitoring, management, and expectation for best outcome whether care is provided by a CRNA or anesthesiologist. In a court of law, the expectation and liability is the same for each professional.

Anesthesia is 50 times safer today than in the 1980s when monitoring standards were implemented and anesthesia medications entered the market with shorter durations of action and fewer side effects. Malpractice premiums for nurse anesthetists are less today than in the 1980s even in the face of more complex patients and procedures. From AANA Insurance services, "on a nationwide basis, the average 2016 malpractice liability insurance premium for self-employed CRNAs was 33% less than it was in 1988. When trended for inflation through 2016, the reduction in premiums was even greater (67%)." The factors for malpractice premiums for CRNAs are 1) the location of service 2) the limits of liability coverage the CRNA chooses and 3) the amount of hours the CRNA works on an annual basis. The facility where a CRNA works, the types of procedures the CRNA provides anesthesia for, how long a CRNA has been working and whether a CRNA is supervised or medically directed have **no impact** on malpractice premiums for CRNAs.

Ladies and gentlemen, together, we have the opportunity through statute to remove barriers to practice models that offer the best patient outcomes. HB 191 is permissive and will allow facilities choices to meet the needs of their community through affordable, high quality care. In the face of increased demand for healthcare and a shrinking anesthesia workforce there is plenty of work for all anesthesia providers. Remove unnecessary restrictions that allow the surgeon, anesthesiologist and CRNA to focus on what is important, the patient's immediate and changing needs. Thank you for considering my testimony. I look forward to answering any questions that you may have.