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PROPONENT TESTIMONY – HB 224

Chairman Merrin, Vice Chair Manning, Ranking Member Boyd and members of the House Health Committee, thank you for the opportunity to provide proponent testimony on HB 224. My name is Dr. Michael Sarap and I have been in practice as a General Surgeon in rural southeastern Ohio for 32 years. I currently serve as Chairperson of the American College of Surgeons National Advisory Council on Rural Surgery and Chairperson of the Commission on Cancer Program in Ohio. Sixty million Americans reside in rural areas of the United States and the vast majority of surgical patients in rural America receive their anesthetic care solely from Certified Registered Nurse Anesthetists (CRNAs). In Ohio alone, over 150 facilities use CRNAs as the sole anesthesia providers. Ohio is only one of two states that statutorily require direct supervision, immediate presence or care under the direction of a physician, podiatrist or dentist for the CRNA provider. CRNAs are the oldest and most educated (double the pharmacology contact hours and 4 times the clinical hours) of all Advanced Practice Registered Nurses in Ohio, yet have the least authority and CRNAs are the only group with NO ordering or prescriptive authority.

There are significant differences in the systems of care of surgical patients in rural America compared to academic and metropolitan settings. Often times, the patient in a rural facility is cared for by a single surgeon without the support of a cadre of

anesthesiologists, critical care specialists, residents or other surgical trainees. Rural and small-town surgeons depend on CNRAs as an integral part of the team caring for peri-operative patients. The inability of a CRNA to order a medication, blood test or an x-ray for a patient, either in the immediate pre-operative or post-operative period, presents a significant burden for the attending surgeon and, in some instances, a real patient safety issue.

One very common scenario occurs when the surgeon is in the middle of a surgery and a previously operated patient in the Post Anesthesia Care Unit (PACU) develops a problem that requires the administration of a medication. Under the current law, the surgeon has to step away from the patient he or she is operating on and go to the phone and give a direct order to the recovery room nurse, even though a CRNA is standing at the patient's bedside. It makes no sense that the CRNA at the bedside is not allowed to give the recovery room nurse medication orders to help care for the patient, especially when Nurse Practitioners and Physicians Assistants without anesthesia training give these orders every day in Ohio.

Currently, every surgeon in my small facility is expected to enter post-operative orders on each surgical patient, but since 2013, we have the additional burden of entering all the post-anesthetic orders for these patients as well, even though the CRNAs are really the experts in the post-anesthetic setting. We work very closely with our CRNA team and develop an order set, which we collaborate on, to deliver the best care for each patient. This will not change if CRNAs become authorized to

enter orders. The attending surgeon is ultimately responsible for each of our patients, but the inability of CRNAs to help provide needed care for which they are well trained, presents real patient safety and quality issues.

Academic and metropolitan hospitals and surgeons may not experience the scenarios mentioned above. Physicians working in these settings have delivered most of the historical opposition testimony. The proposed legislation would allow these facilities to continue to limit the scope of practice of CRNAs if they choose to do so. This proposed legislation is permissive and would allow smaller facilities, like mine, to allow CRNAs to do the job that they are trained to do to support patients in the pre- and post-operative areas, as they do in an unrestricted manner inside of the operating suite.

Rural Americans, including large segments of Ohioans, have higher rates of many common illnesses, and they die at higher rates from those same maladies. Reasons include less access to care, lower quality of care, less specialized care and lack of opportunities for health education and preventive care. Through my work with the American College of Surgeons, the American Cancer Society, the Commission on Cancer, my local hospital and my surgical practice, I have strived to improve those disparities of care for rural patients locally and on a national level. This legislation is an additional tool for rural providers to improve rural surgical care.

Lastly, as a physician and surgeon, I am always skeptical about legislation attempting to expand the scope of practice for advanced practice providers and non-physician groups. In this instance however, I believe this piece of legislation offers immediate and real benefits for patients and surgeons in the rural areas of Ohio by allowing CRNAs to practice to the top of their education, training and national certification.

Thank you for the opportunity to share my perspective on this important piece of legislation with you today. I am happy to answer any questions you may have.