MERCYHEALTH

Proponent Testimony before Ohio House Health Committee

HB 224

B. Lynn Detterman
President – Toledo Rural Market
Mercy Health – Tiffin Hospital, Tiffin, OH
Mercy Health – Defiance Hospital, Defiance, OH
Mercy Health – Willard Hospital, Willard, OH

Chairman Merrin, Vice Chairman Manning, Ranking Member Boyd, and members of the House Health Committee, my name is Lynn Detterman. I am the President of the Mercy Health - Toledo Rural Market, which includes Defiance, Tiffin, and Willard hospitals, all located in Northwest Ohio. I appreciate the opportunity to address the committee as a proponent of House Bill 224.

I have served the Defiance, Tiffin, Willard, and surrounding communities for 17 years, and I am also a life-long resident of the area. Our CRNAs have given anesthesia care to me and my family members. Their safety record is impeccable. CRNAs provide access to anesthesia care to facilities in my community, and are the backbone of anesthesia care in many rural communities like ours, throughout Ohio and the U.S. We need the ability to utilize these health care professionals to the fullest extent of their training in order to deliver safe, high quality, cost efficient healthcare that continues to meet the increasing demand for anesthesia services.

Over the last two decades, continued advancement in the recognition in scopes of practice of three out of the four Ohio APRNs has helped to address the changing landscape of health care in Ohio and the utilization of these necessary health care providers. However, the scope of practice for CRNA's has not been addressed in this same time period. The evolution of APRN scopes has resulted in increased access to cost effective, high quality, and safe patient outcomes, especially in underserved populations, including rural Ohio. Utilizing these highly educated and trained health care providers to their fullest potential helps us meet the growing demand for medical services in Ohio. Clarification of a CRNAs scope of practice by the legislature is overdue.

Patients present to our facility with needs ranging from surgical anesthesia, specialized venous access, pain management, emergency room procedures, trauma stabilization, resuscitation, and maternity care. CRNAs have safely provided these services exclusively, for over 35 years in 2 out of 3 of Mercy Health rural market hospitals, without an anesthesiologist. Over four years ago, the 3rd rural market hospital converted to an all CRNA model of anesthesia as well. The results of this conversion are significant:

- We improved safety metrics in every category as compared to that of the former model which was comprised of 2 anesthesiologists;
- This one facility saved $1,000,000 per year in costs to patients and the overall health care system;
- We added 3 full time CRNA providers allowing us to significantly increase the amount of services that we can offer and provide access to these services to patients in our community that otherwise would simply not be available.

It is imperative for the General Assembly to understand that we provide the full scope of anesthesia services to our patients solely through the use of CRNAs. We do not employ a model of care that includes an anesthesiologist. While CRNAs are expected to, and do, meet the same anesthesia care standards that physicians meet, they do so with their hands tied behind their backs due to the way current Ohio law has been interpreted as a result of its ambiguity. In our communities, patient outcomes, safety records and access to the highest quality anesthesia services to our community speak for themselves. We are ultimately responsible for safe patient outcomes and need clarity around CRNA scope of practice to enhance efficiency in our facilities.

Our physicians call on our CRNAs to manage more aspects of patient care than just administering anesthesia, including some critical clinical functions that are outlined in HB 224. Our physicians fully support allowing CRNAs to manage their patients according to their training and education during the entire peri-anesthesia period, and when performing clinical functions related to anesthesia, such as epidurals, nerve blocks, and emergency breathing tube placement. CRNAs obtain training for these clinical functions in their programs and are documented requirements. The ability of a CRNA to perform "clinical support functions" is language that has been in statute (ORC 4723.43 (B)) for nearly two decades, recognizing CRNAs ability to provide these vital functions. Furthermore, they are always performed upon consult of a physician.

Recognizing the education, training and certification of a CRNA and clarifying their scope of practice in statute does not give them the authority to actually practice that scope. Each facility maintains a demanding and rigorous credentialing and privileging process that both recognizes and verifies a provider's licensing, education, training, certifications, adverse clinical occurrences, personal character, and clinical judgment, etc. It also specifically defines the scope of practice and clinical services each individual may provide at that facility. CRNAs are credentialed and privileged using the exact same process as the physician members of our medical staff.

I've outlined below, but won't read aloud, the steps our CRNAs would go through if we were to grant any additional privileges at our facilities as a result of the passage of HB 224. This process must be followed to grant any health care provider initial and/or additional credentials or privileges, and it is each facility that ultimately decides the extent to which they will utilize a CRNA. There is no provision of HB 224 that mandates a facility to change anything regarding the way it allows a CRNA to practice. The bill will, however, allow facilities like mine to utilize

the credentialing and privileging process – directed by our medical staff – to better employ the much-needed talents of CRNAs.

1.) CRNAs would need to request additional privileges though a completed application to the Central Credentials Department.
2.) The Central Credentials Department would then acquire both administrative and clinical references to verify competence and substantiate character and judgement.
3.) Documentation of the applicant's past clinical experience, along with a procedure log is obtained and reviewed, then compared to those privileges being requested to make sure each individual practitioner is qualified to perform the privileges requested.
4.) A verification of licensure status is done to ensure the applicant is current and that there are no actions pending or settled against them. For example, an applicant that has had a prior license revocation based on a disciplinary action would cause concern and would be reviewed on a case by case basis.
5.) Next, verification of education, board certification, and/or any sanctions are obtained.
6.) The National Practitioner Data Bank is queried and any unexplained gaps in history are reviewed.
7.) A physician reviewer obtains the applicant's file, completes a review, and refers it to the credentials committee and medical executive committee with a recommendation.
8.) Each committee reviews the application and information to make a recommendation to the appropriate Subcommittee delegated to act on behalf of the Mercy Health - Toledo Regional Board for final approval.
9.) Final action must be taken by the board to fully approve, approve with conditions, disapprove or send back to the medical executive committee for further information.

I, along with our medical staff, am hopeful for the passage of HB 224, so that the anesthesia experts at our facilities can provide that care efficiently. My three facilities, and the patients we serve, would greatly benefit from untying the hands of these trained anesthesia professionals, as most other states have done. My job is to put patients first and HB 224 will help to accomplish this goal.

I would appreciate your support of HB 224, and am happy to answer any questions that you might have.