**Ohio House Health Committee**
**HB 318**
**Proponent Testimony**
**March 1, 2022**

Good morning, Chairman Lipps, Vice Chair Holmes and Ranking Minority Member Liston. I my name is Carie Twichell, and I am a Certified Anesthesiologist Assistant and member of the Ohio Academy of Anesthesiologist Assistants (OAAA).I have been a practicing CAA in Ohio for over 20 years. Thank you for the opportunity to testify before you today in support of HB 318, and more specifically to speak to the changes made in Sub HB 318.

For those of you who may not have been here during the last General Assembly, the OAAA successfully sought an amendment in this committee to Senate Bill 236, which would have allowed CAA's to practice at a level consistent with their education and training. Unfortunately, an unrelated amendment was added to SB 236 and it did not receive the support to get over the finish line before the end of the last GA. House Bill 318 is our attempt to seek approval this GA of a change to the statutes governing the practice of CAAs, and to ensure we are able to fully participate as members of the Anesthesia Care Team.

The changes in the sub bill clarify that CAAs are, and will continue to be, required to practice under the direct supervision and in the immediate presence of a physician anesthesiologist. This change is consistent with the training and education of CAAs and the intent of the as introduce version of the legislation. In addition, the sub-bill establishes a definition of "in the immediate presence of" that is generally consistent with the definition currently in the Ohio Admisntrative Code, though it does update the definition to reflect current practices. Under this definition, the supervising anesthesiologist still needs to be available within the hospital or ambulatory surgical center.

Sub HB 318 is a workforce initiative. The bill provides mid-level providers uniformity and consistency in the scope of their practice in hospital and ambulatory surgical settings, and will allow for the more efficient and effective delivery of the Anesthesia Care Team model as described by the American Society of Anesthesiologists (ASA). Enacting Sub HB 318 will equip hospitals and ambulatory surgical centers to serve patients more effectively and efficiently by increasing access to care. If the pandemic has demonstrated anything, it is that mid-level providers must be able to practice to the fullest extent of their training due to the shortage of health care workers and the level of burnout.

Consistent with this purpose, the bill will also ensure parity among CAAs and CRNAs who work interchangeably within the Anesthesia Care Team model. Last General Assembly, CRNAs were successful in having their scope of practice bill, HB 224, amended into the Covid-19 response bill, HB 197. This is why OAAA sought the amendment in the last GA as I mentioned earlier in my testimony.

The relationship between the scope of practice of CRNAs and CAAs is central to the Anesthesia Care Team model. Within critical care settings, CRNAs and CAAs work shoulder to shoulder, and

interchangeably. If they do not have equivalent authority in the pre and post-opt settings, confusion and uncertainty is created as to who can do what, which we have seen manifest itself in CRNAs not being able to take advantage of the changes in HB 197. And, given that one of the goals of this legislation is to ensure consistency and conformity within the Anesthesia Care Team, the CAAs have worked with the CRNAs to respond to some of their concerns with the as introduced version. Specifically, when the CRNAs raised concerns at an interested party meeting and in legal analysis about changes to "direct supervision" language, we responded by adding that language back in and providing a statutory definition.

I'd also like to address some concerns or questions that have been asked in prior hearings. Some members have asked about the education and training of a CAA compared to a CRNA. CAAs have a long standing history in Ohio. Case Western Reserve University offered one of the first AA programs in the country in an effort by anesthesiologists to help avoid a shortage of anesthesiologists in the United States in the 1960s. The CAA practice was developed as a career pathway to support and extend the ability of the anesthesiologist in their care for their patients. This history is important to recognize, because CAAs are only seeking to support the anesthesiologist in the ACT, they are not seeking independent practice or a change to their fundamental requirement that they only practice under the supervision of physician anesthesiologist.

Finally, in terms of educational and training requirements, CAAs and CRNAs are subject to comparable pathways. A CAA must complete 56-132 hours of didactic education whereas CRNAs are subject to 35-80 hours. CAAs receive a master's degree requiring 24-28 months to complete, while the doctorate of nursing required for a CRNA takes 24-30 months. CAAs must also complete 600 clinical case rotations and 2000 clinical hours. In order to maintain certification, a CAA must complete 40 hours of CMEs biennially and sit for an exam every 6 years, though a 10 year exam requirement is being implemented.

Thank you for the opportunity to testify before you today. I respectfully ask for your support of Sub HB 318. I am available if you have any questions.