Dr. Thomas Mark, MD
OPPONENT TESTIMONY – Sub. HB 318
Ohio House Health Committee

Chairman Lipps, Vice Chair Holmes, Ranking Member Dr. Liston, and members of the House Health Committee, thank you for the opportunity to testify in opposition to Sub. HB 318 in front of you today. My name is Thomas Mark. I am a MD board certified Anesthesiologist. I completed my residency training at the Cleveland Clinic Foundation in Cleveland Ohio and am currently working both as an anesthesia clinician and as the Chairman of the Department of Anesthesiology at Summa Health System along with being the facility medical director for TeamHealth at the Summa site. I am the CMO at Talis Clinical and serve as the Medical Director of Process Improvement for Surgical Services at Summa Health Systems as well.

I work in an innovative and progressive supervision-based team model of MDs, CRNAs, NPs and RNs daily. We currently have the clinical responsibility for two CRNA training programs (University of Akron and Case Western Reserve) at Summa. I personally have a lot of experience with anesthesia providers including physician anesthesiologists, CRNAs, and anesthesiologist assistants (AAs). Our practice recently declined being a teaching site for AAs, and declined to bring any AAs onto our team at Summa because the lesser level of training and experience of an AA does not fit clinically into our system.

With regard to Sub. HB 318, I would like to address two critical issues around the practice of AAs. The first is the fact that an AA is required by CMS to be medically directed by an anesthesiologist anywhere an AA practices. Outside of the legal and logistical issues of the legislation, the major concern is that the culture and work environment of an AA is limited to the medical direction model, and rightly so. Working only in a medical direction model does not provide or allow the experience and training necessary to function with a high degree of autonomy. It is a model that necessitates the expertise of a MD anesthesiologist for all critical portions and medical management of a patient's anesthesia care. Under Sub. HB 318, there is a shift from a medical direction model to a supervision model, with much more autonomy and ownership of the outcome. This type of transition should begin with education, training, and clinical experience rather than the legislative process.

The second critical issue concerns training and education. At a minimum, a supervision model of care requires foundational training, education, and direct experience in this type of model before such a drastic scope expansion should occur. The primary reason a CRNA can evolve to work in an autonomous supervision model is the education, experience and training that underpins their now entry level Doctoral degree. CRNAs are first nurses with a degree in that discipline. They also are required to work in an ICU setting as a nurse for at least a year, which is very close to the surgical services environment, before they even begin an anesthesia program. In addition, CNRAs have the opportunity to work legally and functionally in a supervision or autonomous model. AAs on the other hand need no formal medical education and can go straight from college to an AA training program without any related work experience. Their training and education program totals 2 years and simply is not geared toward, nor provides experience in, autonomous care or the care provided in a supervision model.

In addition, the proposed language poses the direct risk of Medicare fraud. Under 42 CFR 415.110, Medicare will pay for an anesthesiologist's medical direction of anesthesia services, if and only if, the anesthesiologist: (1) performs a pre-anesthetic examination and evaluation; (2) prescribes the anesthesia plan; (3) personally participates in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence; (4) ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual as defined in operating instructions; (5) monitors the course of anesthesia administration at frequent intervals; (6) remains physically present and available for immediate diagnosis and treatment of emergencies; and (7) provides indicated post-anesthesia care. Turning the Anesthesia Care Team into a supervision model is simply inconsistent with these federal requirements and the standard of care for AAs.

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I am not trying to disparage any provider, or any group of providers, and I am sure there are very talented and competent individuals with AA degrees. However, what is germaine to this discussion is that shifting responsibility of patient care to a more autonomous model for AAs is not supported either by the level of education and training they receive or the fact that the model AAs have practiced in to this point has only provided for a highly, MD managed model of medical direction where the autonomy and ownership of any one case is not functionally allowed or encouraged. These facts make it very hard for me to see a successful and safe path forward regarding Sub. HB 318.

I believe in a team model and practicing at the top of ones' license. I believe in a model that asks individuals to be autonomous to the level of their education and training - and take ownership of what it is they do. However, when dealing with patient safety and patient outcomes, that model must have an underpinning of proper education, experience and functional culture to be successful - not to mention have an assurance of safety and high quality outcomes. Thank you for allowing me to speak with you.