

Chair Schmidt, Vice Chair Deeter, Ranking Member Somani, and members of the Ohio House Health Committee:

Thank you for the opportunity to testify today as a proponent of Substitute House Bill 52. My name is Dr. Gerald Szelagowski, and I am a board-certified anesthesiologist and the Chief of Anesthesia at the Institute of Orthopedic Surgery (IOS) in Lima, Ohio.

IOS is a state-of-the-art surgical hospital that specializes in comprehensive musculoskeletal care. We perform a wide range of orthopedic procedures including joint replacements, arthroscopy, spine surgeries, and sports medicine. We serve a diverse patient population from Lima and the surrounding northwest Ohio region performing nearly 8,500 surgeries per year.

At IOS, we hold all anesthesia providers to a single, high standard of care—regardless of license type. In our fast-paced, high-volume environment, CRNAs work at the top of their license. In collaboration with the patient's physician, they manage the entire anesthetic continuum: from pre-operative evaluation and anesthesia planning to induction, maintenance, emergence, and post-operative care. This is exactly what they are trained and certified to do. Sub. HB 52 defines and requires this type of collaboration, aligning the statute with how anesthesia care is delivered, and with training, education, and certification.

IOS is proud of our high patient satisfaction and consistently excellent quality ratings. We are committed to enhanced recovery protocols, and a key part of this is minimizing hospital stay through effective pain control—especially using non-opioid regional anesthesia techniques. These nerve blocks require our CRNAs to integrate anatomical knowledge and ultrasound guidance to accurately inject anesthetic near sensory nerves, significantly reducing pain and opioid use.

They perform thousands of these procedures annually at our hospital. The orders related to this procedure can be given to a nurse assisting them when they are done immediately before or after surgery, but if one is needed after the patient leaves the recovery room, while the CRNA can still perform it, they can no longer ask the nurse to assist them. This is due to an arbitrary timeline in the code currently surrounding this authority. Sub HB 52 addresses this inefficiency by putting this specific ordering authority into the scope section of the code, and tying that to collaboration, requiring the physician to request them to do it.

We support Sub. HB 52 because while it modernizes CRNA statutes, it preserves regulatory authority at the facility and physician level. The legislation strikes the right balance: it clarifies the law without expanding the scope of a CRNA, or mandating a specific model of care, allowing flexibility based on what works best for each institution.

Importantly, the bill clearly defines the collaborative relationship between CRNAs and physicians, dentists, and podiatrists—a reflection of the real-world, team-based care model used today, where every provider operates at the top of their license under physician-led leadership. Anesthesia is never delivered in a vacuum. It is a team effort. Collaboration among CRNAs, anesthesiologists, surgeons, and nurses is not only standard practice—it's essential for achieving the best patient outcomes.

In summary, Sub. HB 52 is a commonsense and much-needed update. It provides clarity, supports safe and efficient care, and reflects the reality of how modern anesthesia services are delivered. It will allow us to continue to meet the needs of our patients with excellence.

Thank you for your time and consideration. I would be happy to answer any questions.