

Thank you Chairman Lipps and committee members for your time and consideration of House Bill 318. My name is Zach Barsman. I've been working as a certified anesthesiologist assistant at University Hospitals Cleveland Medical Center for 10 years. I am testifying today as the immediate past president of the Ohio Academy of Anesthesiologist Assistants, and I'm the director of didactic education at Case Western Reserve University's Master of Science in Anesthesia program. This program has been training certified anesthesiologist assistants (or CAAs) in Ohio for 50 years. CAAs are midlevel providers who work under the medical direction of a physician anesthesiologist as part of the anesthesia care team model. Currently, this means that an anesthesiologist can supervise up to four CAAs or CRNAs interchangeably at any given time. While each CAA or CRNA cares for a patient in the operating room; this allows the anesthesiologist to attend to preoperative and postoperative care, while remaining immediately available for any support needed in the operating room.

I'm here today to humbly ask that you consider House Bill 318. I'd like to provide a brief history of why this bill is vital to the hundreds of CAAs practicing in Ohio as well as the countless patients we graciously care for every day. In 2020, house bill 197 was passed as an emergency relief bill in response to the Covid pandemic. Included in this bill was language adopted from the previously proposed house bill 224, a scope expansion bill for nurse anesthetists. The exclusion of CAAs from this bill has set up a clear disparity between CAAs and CRNAs, despite the Centers for Medicare and Medicaid Services and the American Society of Anesthesiologists deeming both groups to be equivalent providers. When working in the anesthesia care team model, CAAs and CRNAs work side by side in an equal capacity with identical clinical privileges. In fact, at University Hospitals where I work, there are about 100 anesthetists, roughly half CAA, half CRNA. If you toured our operating rooms, you wouldn't be able to tell a difference between the CAAs and CRNAs. But since the passage of this bill, CAAs have become a third tier of anesthesia provider in the state. This has resulted in confusion by hospitals in how to utilize and privilege two groups which have always been considered equivalent when working under an anesthesiologist's supervision. Safe, compassionate and cost-effective patient care is our ultimate goal and where CAAs and CRNAs work together, it is important that our patients don't suffer because of this disparity.

With the latest rise in Covid cases, the need for this bill is more important than ever. CAAs across Ohio have provided anesthesia care both in the operating room and out. Elective surgeries were cancelled for most of January to free up staff in order to assist the growing inpatient Covid population. Many CAAs were deployed to ICUs and patient floors to offload the pressures seen by critical nursing shortages. Because CAAs were not included in the original Covid relief bill, we are not able to function as effectively as our CRNA colleagues. For example, we can't order medications and tests which are within our scope of practice. Imagine that we are called to a code blue, a patient is in extremis and needs to be intubated and ventilated. We are the airway experts, but sometimes the patient needs medications to facilitate intubation. I cannot order the nurse to give the medication which I need to intubate this patient, even though the medications I would order are ones I've given literally tens of thousands of times. I cannot order the respiratory therapist to give breathing treatments which the patient might need, despite the fact that I am trained and licensed to give these medications in the operating

room. I cannot order a chest xray to confirm placement of the endotracheal tube following intubation. These are real problems which will be fixed with the passage of this bill and facilitate more consistent, expeditious access to safe anesthesia care.

Consider a laboring woman who asks for an epidural. We are typically called by the patient's nurse to come place the epidural. It is standard practice to give extra IV fluid prior to this procedure to reduce the risk of low blood pressure and nausea. I am currently not allowed to ask the nurse to start giving that fluid bolus. This patient will either have to wait longer to receive her epidural until I get there to start the fluid bolus myself, or be at risk if we choose not to wait to give that fluid bolus because of performance pressures and other patients needing our attention. Passage of this bill would allow me to order the patient's nurse to administer that fluid immediately, reducing time wasted and risk to the patient.

Consider an elderly patient having surgery. As I'm giving report to the recovery room nurse, the patient starts exhibiting signs of emergence delirium. This can be characterized by thrashing and dissociative speech and actions. The patient is a risk to himself and others. Currently, I'd have to restrain the patient and call my attending anesthesiologist and wait for his or her medication order. If I could restrain the patient and order the nurse to draw up and administer Haldol or physostigmine or precedex or any other number of drugs which would resolve this dangerous situation, everyone involved would be safer for it. Passage of this bill would result in safer and more direct access to quality care.

CAAs are a small group relative to the CRNAs in Ohio. But we have faithfully served patients in Ohio for over 50 years. CRNAs wanted in HB197 to be able to practice to the fullest extent of their licensure and training. That's all we're looking to accomplish as well, for the good of our patients and for the benefit of our healthcare system. Without the passage of this bill, we will continue to be at a distinct disadvantage in the job market at facilities which utilize both CAAs and CRNAs. Additionally, it is confusing for the hospital to parse out different privileges and responsibilities for two groups which are universally treated as equivalent under the anesthesia care team model. It is needlessly complicated to have a physician anesthesiologist directing a CAA and a CRNAs at the same time, and to be expected to keep straight who can do what, as currently exists after the passage of HB 197 without any consideration given to CAAs. As a group, we CAAs understood the importance of the Covid emergency relief bill which facilitated getting patients the care they needed. The OAAA felt the same level of urgency in passing our own form of this bill. Therefore we proposed this legislation in the form of an amendment, which was voted out of this committee, passed on the house floor, voted out of Senate committee, and only failed at the 11th hour on the Senate floor, not getting a vote on the last day of the general assembly. Now we're back here more than a year later, to make sure for our members that this bill, which is vital to the continued sustainability of our profession, can finally become law. The Ohio Society of Anesthesiologists and the Ohio State Medical Association understand the importance of our concerns and have no objections to this bill. We have had no legislation to update the language of our licensure since it was adopted over twenty years ago. Medicine has changed greatly in that time, and we desperately need this bill to bring our

statute up to date with the demanding and dynamic aspects of our profession. Thank you again for your time and consideration of passing house bill 318.