**House Bill 191 – PROPONENT TESTIMONY**
**Ohio House Health Committee**
**Wednesday, December 13th**
**Dr. Juan F. Quintana DNP, MHS, CRNA**

*RE: Elimination of statutory supervision requirements for Certified Registered Nurse Anesthetists (CRNA) and clarification of scope of practice in Ohio.*

Good morning, Chairman Huffman, Vice Chair Gavarone, Ranking Member Antonio, and members of the House Health Committee. The healthcare landscape in the United States is changing, and professionals whose services result in cost-effective, efficient, high-quality, safe outcomes will be needed more than ever. Nurse Anesthetists play a critical role in meeting that challenge by providing safe, quality anesthesia care efficiently at a cost that ensures access to anesthesia for millions of Americans.

My name is Dr. Juan F. Quintana DNP, MHS, CRNA and I come before you today as a former President for the American Association of Nurse Anesthetists speaking in favor of HB 191 and the elimination of barriers like supervision and limitations on providing the full scope of practice for patients during their care. I am humbled to appear before you and bring a national perspective of Nurse Anesthesia here to Ohio. I come to you with 21 years of practice as a CRNA, a veteran and a business owner. In Gallop polls, nursing has been voted the most honest and ethical healthcare profession 16 years running. CRNAs have been providing anesthesia care to patients in the United States for more than 150 years. CRNAs provide anesthesia in collaboration with surgeons, anesthesiologists, dentists, podiatrists, and other healthcare professionals. They practice in every setting in which anesthesia is delivered: traditional hospital surgical suites and obstetrical delivery rooms; critical access hospitals; ambulatory surgical centers; the offices of dentists, podiatrists, ophthalmologists, plastic surgeons, and pain management specialists; Public Health Services, and Department of Veterans Affairs facilities and the U.S. military where CRNAs provide anesthesia services for front line combatants in forward surgical teams (FSTs).

CRNAs are also the primary providers of anesthesia care in rural America, enabling healthcare facilities in these medically underserved areas to offer obstetrical, surgical, and trauma stabilization services. In some states, CRNAs are the sole providers in nearly 100 percent of rural hospitals. A recent study[i] published in the September/October 2015 Nursing Economic$ found that CRNAs are providing the majority of anesthesia care in U.S. counties with lower-income populations and populations that are more likely to be uninsured or unemployed. Interestingly, the number of CRNAs is higher in states with less-restrictive practice regulations where more rural counties exist[ii].

HB 191 adds much needed clarity to a CRNA's scope of practice in the State of Ohio. I hope this committee understands that the data and evidence supporting the utilization of CRNAs functioning to the full scope of their training is overwhelming. CRNAs outcomes in the practice of anesthesia are well documented and outstanding.

Important findings from the Institute of Medicine (IOM) in 2010 note that anesthesia is 50 times safer than 30 years ago and assert that expanding the role of nurses in the U.S. healthcare system will help meet the growing demand for medical services. The IOM report urged and continues to urge policymakers to remove policy barriers that hinder nurses—particularly advanced practice registered nurses such as CRNAs—from practicing to the full extent of their education and training. While Ohio has advanced the scope of practice for 3 out of 4 Ohio APRNs over the last two decades, CRNA practice simply has not been addressed. The current Ohio Revised Code describing their scope of practice does not adequately identify the scope CRNAs are educated, trained and certified to provide. HB 191 clarifies the CRNAs scope of practice and will align Ohio with the majority of states concerning their practice and ability to care for patients.

3 Studies, 2 from the Lewin Group and one from the Research Triangle Institute starting in 2010 and the last in 2016 found; A CRNA acting as the sole anesthesia provider is the most cost-effective model of anesthesia delivery (Lewin 2016), noted that there are no differences in patient outcomes when anesthesia services are provided by CRNAs, physician anesthesiologists, or CRNAs supervised by physicians (RTI 2010), and noted when CRNAs practice to their full authority, there was no measurable impact on anesthesia-related complications (2016). The results show that CRNAs acting as the sole anesthesia provider cost 25 percent less. This is significant, as a recent survey conducted by the Ohio State Association of Nurse Anesthetists (OSANA) identified over 150 facilities in the State of Ohio including hospitals that utilize this model of anesthesia care. The results of the Lewin studies are particularly compelling for people living in rural and other areas of the United States where anesthesiologists often choose not to practice for economic reasons.[iii]

Hospital administrators, health care facilities of all types, policymakers and healthcare providers must find ways to improve patient access to safe, quality care without further burdening the healthcare system. CRNAs align with the needs of today's healthcare system because they deliver the same safe, high-quality anesthesia care as other anesthesia professionals, to the exact same standards, but at a lower cost, helping to control rising healthcare costs.[iv] Health care facilities should be allowed to choose the right provider for the right patient at the right time and not be forced through regulation to employ costly alternatives. HB 191 will allow Ohio health care professionals and facilities to do just that by removing outdated statutory supervision requirements.

Nationally, the average 2014 malpractice premium for self-employed CRNAs was 33 percent lower than in 1988 (66 percent lower when adjusted for inflation). Working with CRNAs does not increase the liability of other health care providers and managed care plans recognize CRNAs for providing high-quality anesthesia care with reduced expense to patients and insurance companies. The cost efficiency of CRNAs helps control escalating healthcare costs.[v]

In closing I would like you all to keep in mind that regardless of any legislation that is passed CRNAs must still adhere to national certification and accreditation standards, hospital and facility bylaws. CRNAs never have and never will function in a vacuum. It is entirely appropriate for CRNAs to work with all physicians. CRNAs, like anesthesiologists, are experts in administering anesthesia and responding to emergency situations that require airway management, administration of emergency fluids and drugs, and basic or advanced life-support techniques. A CRNA's anesthesia expertise complements a surgeon's surgical expertise. When emergencies arise, standard operating procedures (including those pertaining to Advanced Cardiac Life Support, or ACLS) for responding are identical for anesthesiologists and CRNAs. In fact, in an operative setting, an observer would have difficulty determining whether an anesthetist was a nurse anesthetist or an anesthesiologist.

The healthcare landscape in the United States is changing. Overlap in care provided by healthcare providers will continue to occur. Professionals whose services result in cost-effective, high-quality, safe outcomes will be needed more than ever. CRNAs play a critical role in meeting that challenge by providing safe, quality anesthesia care at a cost that ensures access to anesthesia for millions of Americans.[vi] I urge you to support HB 191 and I would be happy to answer any questions from the committee.

Thank You,

Juan F. Quintana DNP, MHS, CRNA

Additional research sources:

A 2008 study titled, “Anesthesia Provider Model, Hospital Resources, and Maternal Outcomes.” That study, led by Drs. Jack Needleman, PhD, MS and Ann Minnick, PhD, RN, FAAN, concluded that obstetrical anesthesia is equally safe in hospitals that use only CRNAs or a combination of CRNAs and anesthesiologists, compared with hospitals that use only anesthesiologists.[vii]
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2677049/

A 2007 study titled, “Anesthesia Staffing and Anesthetic Complications During Cesarean Delivery.” That study, led by Daniel Simonson, CRNA, MHPA, concluded there is no difference in complication rates or mortality rates between hospitals that use only CRNAs compared with hospitals that use only anesthesiologists.[viii]
https://www.ncbi.nlm.nih.gov/pubmed/17179869

A 2003 study titled, “Surgical Mortality and Type of Anesthesia Provider.” The study, led by Dr. Michael Pine, a board-certified cardiologist, concluded that patients are just as safe receiving their anesthesia care from CRNAs or anesthesiologists working individually as from CRNAs and anesthesiologists working together.[ix]
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*Source*: AANA Insurance Services analysis of CRNA malpractice premiums, comparing 1988 premium information from the St. Paul Fire and Marine Insurance Company (which at the time was the country's largest insurer of CRNAs, but which no longer offers liability insurance for healthcare professionals) to 2014 data from the CNA Insurance Company (currently the country's largest insurer of CRNAs).

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[vi] Quintana, J. "Answering today's need for high-quality anesthesia care at a lower cost," *Becker's Hospital Review,*, January 20, 2016, available at http://www.beckershospitalreview.com/hospital-physician-relationships/answering-today-s-need-for-high-quality-anesthesia-care-at-a-lower-cost.html.

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