Proponent Testimony - Ohio House Health committee
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Good Morning, Chairman Huffman, Vice Chair Gavarone, Ranking Member Antonio, and members of the House Health Committee. My name is Kellie Deeter and I am a Certified Registered Nurse Anesthetist, or CRNA. I also chair the State Government Relations Committee for the Ohio State Association of Nurse Anesthetists (OSANA). I appear before you today representing Ohio's 2,074 CRNA members and 326 student nurse anesthetist members.

CRNAs are anesthesia professionals that provide every type of anesthesia, for every type of patient, in every practice setting, and for every type of surgery or procedure. There are several pathways to becoming a CRNA but all require state licensure and registration as a nurse, full time critical care work experience, graduate level education from an accredited program, and board certification from the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA). Maintenance of licensure and certification are required, including 25 continuing education hours per year, completion of core competencies every 4 years in airway management, applied clinical pharmacology, human physiology and pathophysiology, and anesthesia technology, as well as a recertification examination every eight years.

I have been a CRNA for over ten years and also hold certifications in neonatal resuscitation instruction and basic and advanced life support for both pediatric and adult patients. I am an ultrasound guided nerve block instructor providing training to CRNAs, Nurse Practitioners, and Physicians, in the performance of nerve blocks for use in both surgery and pain management. I am a small business owner. I own two anesthesia groups and personally provide anesthesia in six facilities in Ohio. Two of these facilities are rural hospitals where CRNAs are the only providers of anesthesia care, two are community hospitals where CRNAs are the only providers of anesthesia care in labor and delivery, and one is a hospital and a free-standing surgery center where anesthesia is provided by both CRNAs and anesthesiologists. Each facility utilizes a different anesthesia model. Each has an impeccable safety record and each demonstrates a need for the clarification in our scope of practice that HB 191 seeks.

The education, training, and certifications a CRNA receives does not limit or dictate the model of anesthesia care in which we work. We are prepared to offer the full scope of anesthesia care, independently, wherever anesthesia is required and in all anesthesia models. This includes reviewing and interpreting diagnostic studies for surgical patients, interviewing and examining patients prior to anesthesia, deeming patients fit for anesthesia based on their health status, selecting and administering all types of anesthesia, as well as providing patient management before and after surgery as it relates to anesthesia. (E.g. the prevention and/or treatment of surgical pain, anesthesia related nausea and vomiting, and respiratory and/or hydration concerns.) Additionally, CRNAs provide clinical functions that occur outside of the operating room, such as the placement of epidurals, nerve blocks, emergency breathing tubes in critically ill patients and/or central intravenous catheters. The extent that a CRNA is directed by a physician depends on the anesthesia model. Surgeons do not direct any part of a CRNAs anesthetic or clinical function. Anesthesiologists direct CRNAs to the extent that they opt to bill for these services. Direction is a billable service for an anesthesiologist but not for a surgeon.

Regardless of the anesthesia model utilized, patients are presented to CRNAs upon consult by a physician for either anesthesia care or one of the aforementioned clinical functions. This consult often requires evaluation, testing, and/or medications associated with performing these functions, many of which require orders, but as you know CRNAs are limited in this regard. I will give you several examples within my facilities, that without ordering, result in a weak continuum of care for patients before and after surgery as it relates to the services that I provide. While these examples are certainly more frequent in my rural facilities where there are no anesthesiologists and the surgeon is the only ordering provider on the team, they occur in all six of my facilities and anesthesia models, causing unnecessary delays, inefficient patient management, and conflicts with the current statute.

1. I have just finished giving an anesthetic to a patient with a history of tobacco use resulting in the need for oxygen administration in the recovery room beyond the time that I am personally available to stay with the patient. I cannot ask the nurse to continue the nasal oxygen use despite having personally managed the patient on a ventilator the three previous hours during their surgery. When this happens, I will delay seeing my next patient, stay with the patient until there is no longer a need for oxygen, or until the nurse finds the surgeon for the order that is needed to administer the oxygen. Usually, by the time the surgeon is available to provide the order, there is no longer a need for the oxygen.
2. Similarly, patients in recovery room often complain of nausea after anesthesia. Twenty feet away in the operating room, I provided these patients with an anesthetic where I was educated, certified, and privileged to personally select and directly administer the very medication they need to treat the nausea. However, once a patient crosses the threshold into recovery, an order is required for any medication to be dispensed and for the patient's nurse to legally administer it. I can still personally retrieve the medication from the operating room and personally administer it, but I may or may not be available to do so when the patient has the complaint. This is the ORDERING ability that we seek to clarify in our scope of practice, not prescribing. Surgeons are often unavailable to give timely orders in this situation, and if they are operating on another patient, they have no way of knowing what medications I have already given the patient during their anesthetic. This is why anesthesia providers normally write recovery room orders that relate to anesthesia and are the most appropriate practitioners to do so.
3. I am often consulted by intensive care physicians and emergency room physicians to insert breathing tubes in critically ill patients that they were unable to themselves insert. CRNAs are experts in airway management. This procedure requires assistance from nurses and/or respiratory therapists in giving needed medications and ventilation to the patient. These are the same medications and treatments that I select and administer to patients having surgery in whom I insert breathing tubes. Both of my hands are being utilized to provide my patient with the oxygenation desperately needed to stay alive. In this example, seconds literally count and logistically more than two hands are needed, but CRNAs are prevented from directing other qualified providers to literally administer a medication or treatment that is within our scopes of practice. Working through who can direct, order, administer, and properly sign off, in the correct order, results in critical delays. This is not efficient use of the team that is utilized in four of my six anesthesia practices.

4. I work as the only anesthesia provider in two busy labor and delivery units. There is one CRNA physically present on the unit 24 hours a day, 7 days a week, but there is not an Obstetrician on the unit 24 hours a day, 7 days a week. We have multiple mothers and their babies who are dependent on one CRNA. When we are limited by having to personally perform every function that may be needed, there are innumerable examples in this setting, all potentially detrimental. When a pregnant patient who is profusely bleeding presents at one o'clock in the morning, the patient comes directly from the emergency room to my operating room for an emergency cesarean section. The nurses and I have to manage this patient until the surgeon arrives from home. This could mean the need for life-saving fluid and/or blood administration, to the need for IV's, and/or medications that could now save two lives. Regardless, neither the patient nor their baby can wait for the physical presence of the surgeon before that management occurs. CRNAs are trained to handle this situation and this management is currently expected to occur. The right decision is in conflict with an unclear statute, and we are asking the legislature to clarify your intent.
5. This last example occurs in every facility where I provide anesthesia. CRNAs are the only providers in all six of my practices that are trained to perform nerve blocks, including the models with anesthesiologists. Nerve blocks temporarily reduce or eliminate the sensation of pain using local anesthetic allowing us to significantly reduce or eliminate the use of opioids during and after surgical procedures. Given the opioid epidemic, CRNAs feel strongly about obtaining and utilizing this training. In one of my practices, CRNAs performed over 700 nerve blocks last year. The logistics of nerve block placement require a needle in one hand and an ultrasound probe in the other. I personally select and prepare the local anesthetic, but a third hand is required by a nurse to push the syringe of medication upon my direction. This assists us in surrounding the nerve structure with local anesthetic while we visualize it. CRNAs are unable to direct nurses in this task without the surgeon, who is unable to perform said block, writing an order for them to do so. If the surgeon is unavailable to write the order, the patient technically can't receive the block. Also, if surgeons have to be "immediately present" for block insertion, they have to arrive much earlier than normal if CRNAs are to be "supervised" in this task. This also results in fewer patients receiving nerve blocks because surgeons simply cannot always accommodate this requirement and are unsupportive in causing patient delays.

Of note, all other Advanced Practice Registered Nurses (APRNs) in Ohio with training in non-anesthesia specialties such as family practice, midwifery, and clinical nursing, are currently authorized to order anesthesia and write anesthesia related orders. Their scopes of practice have been expanded and refined over the last two decades to recognize their education, training, and value to the delivery of patient centered health care. The scope of practice for a CRNA, the APRN who specializes in anesthesia, has not been addressed by the General Assembly during this time. We feel that HB 191 modernizes the current statute to reflect our scope of practice as outlined by our education and national accrediting organization for training and certification. This bill protects CRNAs, our patients, other licensed staff members, and surgeons who work with CRNAs as the sole anesthesia provider. It could also make models where CRNAs aren't the sole anesthesia providers significantly more efficient and patient centered as well. I sincerely ask for your support and would be happy to answer any questions.