Proponent Testimony before Ohio House of Representatives
Health Committee

HB 191
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Good morning, Chairman Huffman and members of the House Health Committee, my name is Kelly Leahy. I am a health care partner in the law firm of Shumaker, Loop & Kendrick, LLP. I have been practicing health care law for more than 25 years and we represent the Ohio State Association of Nurse Anesthetists (OSANA). I appreciate the opportunity to address the committee as a proponent of House Bill 191. My main goal here today is to provide background and information about why HB 191 is important and necessary for CRNAs practicing in Ohio.

CRNAs have been providing anesthesia care to patients in the United States for more than 150 years. CRNAs administer anesthesia safely in the exact same way that anesthesiologists do. When anesthesia is administered by a CRNA it is considered the practice of nursing. When it is administered by an anesthesiologist it is considered the practice of medicine. Nurse and physician anesthesia professionals give anesthesia in the same exact way. Despite this, Ohio is one of just 10 states that have a supervision requirement in its state nursing statutes.

You will hear from opponents of HB 191 that there is no evidence that the current supervisory model adversely affects patient care. Not only is the supervisory model obsolete, we submit that the training, education and safety record of CRNAs makes the supervisory model unnecessary and burdensome. Research confirms that anesthesia care is equally safe regardless of whether it is provided by a CRNA working alone, an anesthesiologist working alone or a CRNA and an anesthesiologist working together. As you will hear in more detail from

another proponent this morning, the safety of CRNA practice has resulted in significant decreases in professional liability premiums over the last two decades. No one can assess safety better than an actuary.

Additionally, the physician supervision standard contained in RC 4723.43(B) is ambiguous at best. The current language says that a CRNA "....with the supervision" and "in the immediate presence of a physician, podiatrist, or dentist..." may administer anesthesia. It is not clear what kind of "supervision" is required of a podiatrist, dentist or non-anesthesiologist physician. Non-anesthesiologist supervising professionals do not develop, direct, or administer any part of the CRNA's anesthesia care plan. In these situations the CRNA is THE ANESTHESIA EXPERT in the room. They are better trained and far more expert in anesthesiology than any of the non-anesthesiologist "supervisors" provided for under current Ohio law. Further, does "with supervision" and "in the immediate presence" mean the supervising professional must be available by phone? Does it mean the supervising professional must be in the same room at all times when the CRNA is providing anesthesia care? Can the supervising professional be in another room if immediately available to provide assistance and direction? Is "immediate" measured in time or distance (for example 3 minutes or 250 feet)? Must the supervising professional have sufficient anesthesia knowledge and training to furnish actual assistance and direction or is mere ability to assist in an emergency sufficient? This language is not just a problem in facilities that operate with a CRNA only model. In a large tertiary care hospital under reimbursement rules an anesthesiologist may medically supervise up to 4 concurrent anesthesia procedures. In this scenario, state law "immediate presence" language creates the same ambiguity. Must the anesthesiologist be "interruptable" to tend to one of the other three patients to be considered "immediately available"? May the anesthesiologist take short breaks to check on patients in the recovery room or meet with patients and their families? Without definition, these questions cast doubt as to who is responsible for the anesthesia care provided by CRNAs. Recall that CRNAs and anesthesiologists provide anesthesia in the exact same way and if an anesthesiologist is the provider of anesthesia there is no question about who bears responsibility for an anesthesia care error. The supervisory language is not

only antiquated, it does not reflect the relationship between a supervising professional and a CRNA, especially in the models of anesthesia care that do not include an anesthesiologist. We are aware of a noteworthy number of non-anesthesiologist supervising professionals who have concerns about whether the supervision language in current Ohio law may lead to professional liability on their part.

The supervisory language is just one example of the way that the current CRNA scope of practice statute is vague. In sponsor testimony before this committee, State Representative Anne Gonzales skillfully illustrated the confluence of events leading to the need for HB 191. Over the last two decades, continued evolution in the scope of practice of three out of the four Ohio Advance Practice Registered Nurse (APRN) categories (Nurse Practitioners, Clinical Nurse Specialists, and Certified Nurse-midwives), including full prescriptive authority, has helped to address the changing landscape of health care in Ohio and the utilization of these necessary health care providers. This evolution has resulted in increased access to high quality, cost-effective and safe patient care, especially in underserved urban areas and rural Ohio. Utilizing these highly educated and trained health care providers to their fullest potential helps meet the growing demand for medical services in Ohio. Unfortunately, efforts to clarify the scope of practice for CRNAs have lagged and HB 191 is a direct response to Ohio Board of Nursing (OBN) and Ohio Attorney General (OAG) opinions interpreting the scope of practice of a CRNA in the State of Ohio.

In 2000, in HB 241 (123rd General Assembly) the Ohio General Assembly granted explicit prescriptive authority to Nurse Practitioners, Clinical Nurse Specialists and Certified Nurse-midwives through a certificate to prescribe (CTP) granted by the OBN. Also in HB 241, language was added acknowledging that CRNAs did not need a CTP, or to be a prescribing provider at all, in order to provide anesthesia care pursuant to ORC 4723.43 (B). Additionally, HB 241 amended statutes related to LPN and RN practice which allowed them to administer prescriptions "authorized by an individual who is authorized to practice in this state and is acting within the course of the individual's

professional practice." This gave LPNs and RNs the ability to accept direction from APRNs.

Following this legislation, and from 2000 to 2008, CRNAs in hospitals across Ohio selected, ordered and administered necessary medications to provide anesthesia care to patients as routine and inherent functions of their scope of practice. They also ordered drugs related to their practice, such as anti-nausea medications, for other nurses to administer. To our knowledge no hospitals, ambulatory surgery centers (ASC), physician groups, health care professionals or administrators voiced any concerns about CRNAs performing these duties. Despite this, in 2008 the OBN took the position that writing medication orders related to anesthesia practice for others to administer was not within the scope of CRNA practice. In 2013, the OBN sought an Ohio Attorney General opinion on this point and the statute was interpreted by the OAG to restrict a CRNA from 'ordering' medications to be administered by others because the General Assembly did not grant CRNAs explicit prescriptive authority when it was granted to other APRNs. Further, when HB 216 was passed last year, the language in RC 4723.43(B) specifying that CRNAs did not need a CTP to practice anesthesia was deleted, as it should have been since OBN now issues a license rather than a CTP. While there was no legislative intent to modify the CRNA scope of practice this change contributes to the ambiguity of the statute and is another oversight that must be addressed for effective and efficient CRNA practice in Ohio.

We would like to be especially clear that CRNAs are not seeking prescriptive authority in HB 191, rather they seek to clarify that they may order medications in connection with CRNA practice. Under federal DEA rules the traditional practice of nurse anesthetists – ordering and administering controlled substances and other drugs before, during and after anesthesia is administered – does not constitute "prescribing". According to DEA definitions, a prescription is:

> "An order for medication which is dispensed to or for an ultimate user but does not include an order for medication which is dispensed for immediate administration to the ultimate user (e.g., an order to

dispense a drug to a bed patient for immediate administration in a hospital is not a prescription."

Consistent with this line of thinking HB 191 explicitly prohibits a CRNA from prescribing a drug for use outside the facility or other setting where the CRNA provides care. In lines 245 – 248 of HB 191 (as introduced) states:

HB 191 As Introduced:

This division does not authorize a certified registered	245
nurse anesthetist to prescribe a drug for use outside the	246
facility or other setting where the nurse provides anesthesia	247
care.	248

HB 191 through to the Current Working Draft:

Division (B) of this section does not authorize a	449
certified registered nurse anesthetist to prescribe a drug for	450
use outside the facility or other setting where the nurse	451
provides care.	452

CRNAs do **not** seek the ability to write prescriptions for patients to fill at the pharmacy and self-administer at home. Rather, the legislation restores their ability to place 'orders' for medications they already currently select and administer. The legislation will also allow a CRNA to direct other qualified and licensed providers to administer medications (within their scope of practice) ordered by a CRNA in connection with CRNA practice. (See graphic at the end of this testimony.)

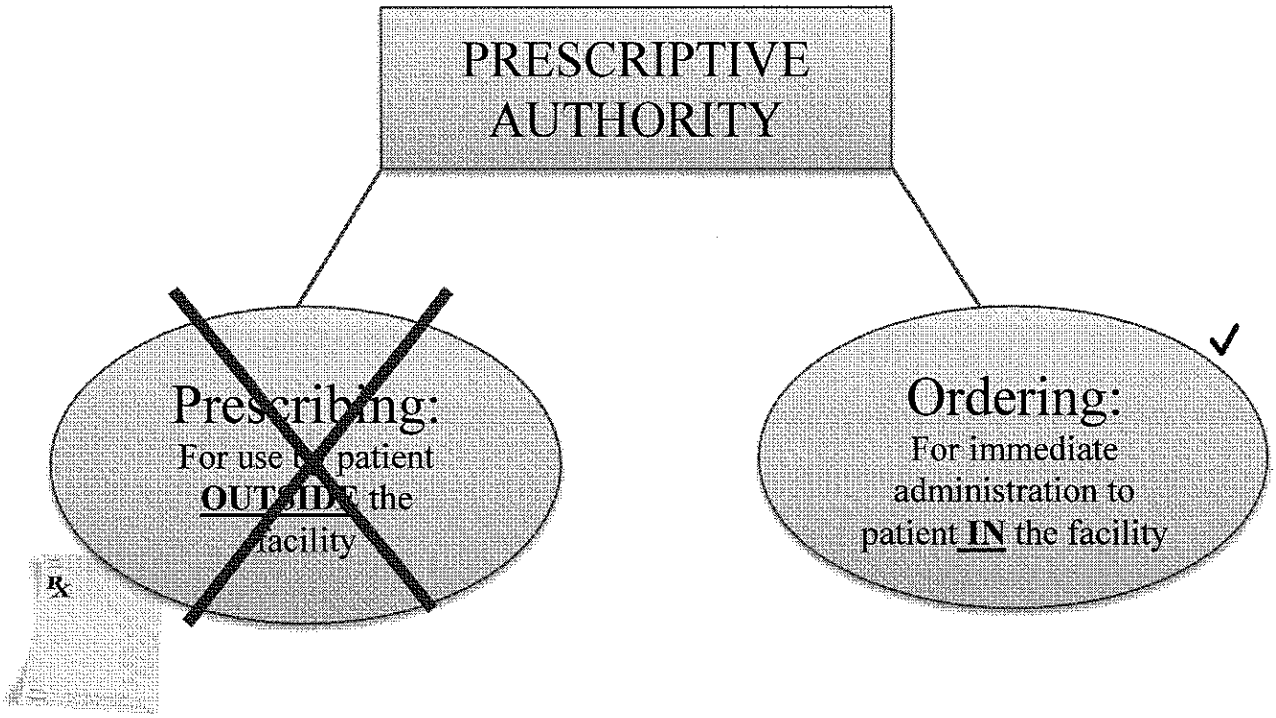
You will hear from opponents of HB 191 that it is an assault on the anesthesiologist-preferred and anesthesiologist-led "anesthesia care team" model in hospitals and ASCs. Clarifying CRNA scope of practice does not dismantle or mandate any specific anesthesia care model. As you will hear in more detail from other proponents, House Bill 191 is permissive. Clarifying the

scope of practice of CRNAs in statute by recognizing their education, training and certification gives them authority, but not permission or a right, to perform all of the functions they are trained to perform in a hospital or an ASC. In these locations the facilities conduct a process known as credentialing where CRNAs are granted permission, referred to as privileges, to perform certain functions. This process is performed by the Medical Staff of a facility, ultimately allowing physician control in these settings.

In closing, HB 191 seeks to clarify and modernize statutory language that is ambiguous and has been interpreted to restrict CRNAs from performing what they are educated, trained and nationally certified to do. It further seeks to remove outdated statutory supervision requirements that no longer serve a useful purpose and create confusion and concern regarding anesthesia liability for non-anesthesiologist supervising providers. The bill will allow CRNAs the ability to provide more efficient anesthesia care for their patients before, during, and after surgery.

I am happy to answer any questions that you might have.

HB 191 STRICTLY PROHIBITS A CRNA TO PRESCRIBE DRUGS FOR USE OUTSIDE OF A CARE SITE



HB 191 As Introduced:

This division does not authorize a certified registered nurse anesthetist to prescribe a drug for use outside the facility or other setting where the nurse provides anesthesia care.

HB 191 current working draft:

Division (B) of this section does not authorize a certified registered nurse anesthetist to prescribe a drug for use outside the facility or other setting where the nurse provides care.