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THE ACADEMY OF MEDICINE OF CLEVELAND & NORTHERN OHIO

Opponent Testimony
Before the
Ohio House of Representatives
Health Committee

HB 191-5
November 14, 2018

By

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Good morning, Chair Huffman; Vice Chair Gavarone, ranking member Antonio and members of the Health Committee, my name is Dr. John Bastulli, Vice President of Legislative Affairs of the Academy of Medicine of Cleveland and Northern Ohio (AMCNO). The Academy of Medicine of Cleveland and Northern Ohio represents a majority of the physicians in Northern Ohio and is the predominant physician organization in our region. I am also a member of the Ohio State Medical Association and the Ohio Society of Anesthesiologists. I am an anesthesiologist practicing at St. Vincent Charity Medical Center in Cleveland, Ohio. At St. Vincent's, I serve as the Medical Director of Surgical Services and the Director of the Division of Anesthesia. I would like to thank the Committee for providing me with the opportunity to testify here today in opposition to HB 191-5, legislation that would expand the scope of practice of certified registered nurse anesthetists or CRNAs.

The bill before you today greatly expands the scope of practice for CRNAs and will move away from the current anesthesia model of care in Ohio that works for patients in favor of a new model that will invite confusion, duplicative and unnecessary orders, increased health care costs and, most importantly, will compromise patient care.

I graduated from Case Western Reserve University with a Bachelor of Science in Health Science. A degree in health science allowed me to function as a non-physician anesthesia provider commonly referred to as an anesthesia assistant (AA). I was a member of the anesthesia care team consisting of an anesthesia assistant

and anesthesiologist. My job descriptions, duties and responsibilities were exactly the same as a nurse anesthetist.

I worked as an anesthesia assistant for one year prior to attending medical school and during my medical school education. During this time, I realized that while anesthesia assistants were well-trained, there were significant gaps in their education. Therefore, in order to function as a consultant in anesthesia, managing the continuum of care, it was imperative that I become a physician. I soon came to realize the difference in education between an anesthetist and an anesthesiologist; how much I learned and how much I didn't know. That view has been reinforced down through the years as I have been involved in the education of student nurse anesthetists, student anesthesiologist assistants, and physicians in training.

I understand that the proponents believe that their scope needs to be expanded so that patients can receive medications in a more timely fashion in the immediate preoperative and postoperative period, especially in rural areas. While patient safety is always the top priority, I am not aware of any verifiable data or evidence to support their claims that patients are not getting the medications they need in a timely manner. Are there any consumers or patient advocacy groups that believe Ohio's team-based model of anesthesia care is unsafe for patients or that patients are not receiving medications in a timely manner during the surgical period?

If there are ordering issues, they can easily be resolved with the use of standardized protocol order sets. At the healthcare facilities where I provide anesthesia services, these order sets exist electronically or on paper. They can be completed at any point prior to the surgical procedure and can address pre and postoperative orders on one form. This process is safe, efficient and user friendly. I have included an example of this document with my testimony.

In addition, it is important to point out that there is a reason I would hold off sedating a patient until the surgeon arrives - it comes down to what is safe for the patient. I want the patient alert and able to give their informed consent and to provide the surgeon with the opportunity to see the patient and mark the surgery site. If the patient has already been given medication prior to the physician being present to talk to the patient and mark the surgery site that could compromise patient safety. This is an issue of risk management. In my practice I do not sedate the patient prior to the surgeon coming to the hospital, and I explain to the patient that I cannot sedate them until they see their surgeon.

Patient safety mandates that the implementation of policies and procedures are based upon evidence and consensus based data that is accurate, verifiable and reproducible. The bill's provisions are problematic in that so many areas are undefined. The CRNAs seek to order drugs, diagnostic tests, treatments and fluids

for patients during the perianesthesia period and during the performance of clinical functions but these terms are not defined. But what is the perianesthesia period and how far does it extend pre and post-surgery? What are the clinical functions the CRNAs seek to perform in the facility where they want to order drugs, tests, treatments, and fluids while they perform them? And what are the drugs, diagnostic tests, treatments, and fluids the CRNA wants to order? Why can the CRNA order drugs, tests, and treatments for conditions that have nothing to do with the administration of anesthesia? The ambiguity and lack of specificity in the bill will create a system that should not be in place for something as important as anesthesia care. While we are all interested in reducing the cost of healthcare and improving access, adding another prescriber to the surgical team does not result in accomplishing either objective.

I recognize that the version of the bill before you (-5) re-inserts physician supervision; however, like so many other undefined provisions in the bill, supervision is not defined for the expanded scope of practice. The bill only requires the immediate presence of the physician when the CRNA is administering anesthesia or performing anesthesia induction, maintenance and emergence. Is the supervising physician required to be on-site or can supervision occur remotely for all of the other expanded scope functions? That question alone raises significant concerns as to why supervision of CRNAs can even be considered to be from afar. This bill is not about primary care, it is about surgical care and anesthesia care and all of the complications that surround it. If the supervising physician is not even required to be on site and CRNAs are given authority to order drugs and diagnostic tests for patients, if they are unnecessary or duplicative to the physician orders, health care costs will increase. More importantly, though, how is this safe for the patient and better than the current model of anesthesia care in Ohio?

I'm also concerned that the language can be interpreted to allow CRNAs to order drugs, tests, treatments, and fluids for patients from outside of the facility. There is no language requiring the CRNA to be with the patient or even in the facility when giving an order. How is this making patient care safer? I also noted there are no additional educational requirements in the bill to address the expanded authority to order drugs, diagnostic tests, treatments and fluids for patients. There are many significant issues that need to be resolved with this legislation.

At this point I would like to highlight a report that demonstrated evidence does not exist to support the claims made by proponents of the legislation. A research report sponsored by the Ohio Association of Advance Practice Nurses was conducted and published in 2015 by the RAND Corporation. The report was titled, "The Impact of Full Practice Authority for Nurse Practitioners and Other Advanced Practice Registered Nurses in Ohio," and concluded that there were no studies or evidence supporting the claims made by proponents of the

legislation. The report was unable to determine the impact of expansion of scope of practice for CRNAs with respect to access to care, quality and costs.

I appreciate the opportunity to testify before you today. While my colleagues and I value the role of CRNAs and respect their important contributions to the surgical team, this legislation adds an unnecessary layer of complexity to the surgical process and tries to address a problem that is not proven to exist. I am happy to answer any questions you may have either now or after others have had the opportunity to testify. Thank you.

ANESTHESIA PRE-OP and PACU ORDERS

Allergies: ☐ NKDA _____

Date	Time	PRE-OPERATIVE ORDERS
		☐ Blood Sugar (ALL diabetic patients)
		☐ Precision Pregnancy Test (females childbearing age) ☐ N/A
		☐ INITIATE IV THERAPY (check order): ☐ N/A
		☐ a. Lactated Ringers _____ 500ml _____ 1000ml at KVO
		☐ b. D5% Water _____ ml at KVO
		☐ c. D5% Lactated Ringers _____ ml at KVO
		☐ d. D5% ½ Normal Saline
		☐ e. Other
		☐ REGLAN (Metoclopramide) 10mg IVPB after admission to Pre-op
		☐ VERSED (Midazolam) _____ mg IV Pre-op
		☐ FENTANYL _____ mcg IV Pre-op
		☐ OTHER:
		☐ OTHER:
		☐ FOLLOW SURGEON'S ORDERS

Date	Time	POST OPERATIVE ORDERS FOR PACU
		☐ Admit patient to Post Anesthesia Care Unit: • Phase I • Phase II
		☐ Notify Anesthesiologist immediately for: Respiratory rate <10/min, or with distress; systolic BP<90 or >180; HR<50 or >120, rhythm changes or signs of ischemia; Temp. above 38.5°C.
		☐ If Physician not immediately available: Pulse less than 40 beats per minute give ATROPINE 0.5mg IVP; SaO2 < 90% for more than 30 seconds, start O2 therapy
		☐ Diabetic insulin Dependent Patient (obtain a blood sugar on admission to PACU) ☐ N/A
		☐ Other:
		A. Nausea
		☐ REGLAN 10mg IVPB for vomiting
		☐ ANZEMET 12.5 mg IV push every four hours PRN for nausea
		☐ ZOFRAN 4 mg IV push every four hours PRN for nausea
		☐ PHENERGAN 12.5 mg IV push may repeat after 15 min x 1
		☐ OTHER:
		B. Pain
		☐ MORPHINE SULFATE 2-4mg IV every 5 min PRN up to a total of 12 mg/hour
		☐ MORPHINE SULFATE _____ mg IM every 4 hours PRN
		☐ DILAUDID 1 mg IV every hour PRN
		☐ DILAUDID 2 mg IM every 4 hours PRN
		☐ DEMEROL 25 mg IV every 5 min PRN up to a total of 200 mg/hour
		☐ DEMEROL _____ mg IM every 4 hours PRN
		☐ TORADOL (Ketorolac) 30 mg IV PRN
		☐ TORADOL (Ketorolac) 30 mg IM PRN
		☐ EXTRA STRENGTH TYLENOL 500 mg one or two tablets PO every 4 hours PRN
		☐ PERCOCET 5mg/325mg one or two tablets PO every 4 hours PRN
		☐ VICODIN 5mg/500mg one or two tablets PO every 4 hours PRN
		☐ Other:
		☐ FOLLOW SURGEON'S ORDERS FOR MEDICATIONS

_____
Physician Signature

_____
Date

PATIENT LABEL