The Ohio Society of Anesthesiologists

Opponent Testimony
Ohio House of Representatives
Health Committee

House Bill 191-Expand Scope of Practice for Certified Registered Nurse Anesthetists

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Chairman Huffman, Vice-Chairwoman Gavarone, Ranking Minority Member Antonio and members of the House Health Committee, my name is Dr. Paul Wojciechowski. I am a current board member and past President of the Ohio Society of Anesthesiologists and a practicing physician anesthesiologist in Cincinnati, Ohio. Thank you for taking the time to listen to my testimony on House Bill 191, version 5. The Ohio Society of Anesthesiologists opposes House Bill 191 as it unnecessarily expands the scope of practice for nurse anesthetists and compromises patient safety.

I work with certified registered nurse anesthetists (CRNAs) and respect their role in providing anesthesia care to patients in the team-based of model of care. In the team-based model, CRNAs are supervised by a physician, who may or may not be an anesthesiologist, or they can be supervised by dentists or podiatrists in the appropriate setting. As patients are extremely vulnerable during the surgical period, it is important to have a team in place ready to respond to any situation that may arise. As the head of the surgical team, physicians are responsible for ordering the drugs, diagnostic tests, treatments and fluids for patients during this critical period.

I participated in an early interested party meeting on the bill as I share your interest in ensuring that Ohio has the best anesthesia care model in place for Ohioans. The first question asked was what is the problem for ***patients*** with the current model of anesthesia care in Ohio? What data shows that patient care is compromised by Ohio's current anesthesia model? A change in scope of practice should be driven by data and evidence of substandard patient care or delays in care, not personal opinion or a desire to increase scope of practice. No compelling evidence was shared or has been shared to-date showing that Ohio's model of anesthesia care is unsafe for patients or places a hardship upon them.

Passage of House Bill 191 in its current form will create confusion amongst health care professionals, result in duplicative or unnecessary orders, increase health care costs, and, most alarming, it will jeopardize patient care. The bill expands the scope of practice for CRNAs by authorizing them to order (prescribe) drugs, diagnostic tests, treatments and fluids for patients during two separate and distinct times: During the "perianesthesia period" and whenever the CRNA is performing a "clinical function" for a patient, whether related to surgery or not. Both are packed with problems and I will address each separately.

Perianesthesia Period: Lines 55-58 permit CRNAs to perform and document evaluations and assessments during the perianesthesia period which may include **ordering and evaluating one or more diagnostic tests** and consulting with one or more health professionals. Lines 76-79 further permit CRNAs, as necessary for patient management and care in the perianesthesia period, to **select, order and administer fluids, treatments and drugs for conditions related to the administration of anesthesia.** The bill goes on in lines 96-97 to permit CRNAs to **select, order and administer pain relief therapies during the perianesthesia period**.

The term perianesthesia is not defined by the bill nor is it defined in Ohio law. Is this considered during the surgical period or during some other time in the health care facility? If during surgery, how long does the period extend before surgery? How long does it extend beyond surgery? Does it end when the patient is transferred from the recovery area or can it extend through the patient's hospital stay? There are no answers to this question, yet the CRNA is granted broad authority to order drugs, tests, treatments and fluids for the patient during this perianesthesia period.

The bill also does not specify what drugs, diagnostic tests, treatments or fluids can be ordered by the CRNA. What drugs, tests, treatments and fluids will be ordered? Are there limits on what can be ordered? What are the conditions related to the administration of anesthesia for which the CRNA is ordering? And why is the bill silent on any additional education needed to prescribe for the patient?

The time before, during and after surgery can be treacherous for patients. Physician involvement during all phases of surgical and anesthesia care, especially when it comes to prescribing medications, is critical for maintaining patient safety and optimal outcomes. Patients come to surgery in all states of health. Physicians have the education and training needed to prescribe the medications needed to optimize a patient prior to surgery. Inhalers for breathing disorders and medications for heart disease are a few examples of the things prescribed by physicians prior to surgery. It is paramount that the physician anesthesiologist or supervising physician prescribe the medications given to a patient prior to surgery to maintain continuity and avoid dangerous medication interactions and errors. Physicians prescribe medications before surgery to impact the course of the patient during and after surgery and, as part of the care team approach, discuss the medications given

to patients with CRNAs and others involved in the care of the patient while monitoring the patient during surgery. When surgery is complete, the physician continues to follow the patient into the recovery room. Physicians provide patient specific orders from standardized order sets for recovery room nurses to utilize and are available to re-evaluate patients in the recovery room if needed. In addition, physicians will write orders for medications or other therapies that are not included on the standardized order set and will address unforeseen medical issues that arise after surgery.

The ordering authority granted to CRNAs will disrupt the successful anesthesia model in place and create uncertainty when the CRNA gives duplicative, conflicting or unnecessary orders for the patient. Patients are vulnerable during this critical time and there is no room for uncertainty, lack of definition and conflicts that will be created by this expanded scope.

Clinical Functions: Even more alarming is the language in the bill permitting CRNAs to order drugs, diagnostic tests, treatments and fluids while performing clinical functions. Lines 66-72 of the bill states CRNAs may **perform clinical functions that are either specified in clinical standards established for nurse anesthetist education programs by a national accreditation organization or completed pursuant to a physician consultation.** Lines 73-75 go on to state that the **CRNA can order drugs, treatments, fluids and one or more diagnostic tests and evaluate the results of such tests**. Interestingly, ordering drugs, tests, treatments and fluids for the patient is **not** tied to any conditions related to the administration of anesthesia. This begs the question as to what exactly the CRNAs are trying to accomplish through the broad prescribing authority and what areas of practice they are trying to enter through this language. This section of the bill will create significant confusion in the facility and amongst health care professionals as clinical functions are vaguely defined, or defined by national accreditation organizations, and the prescribing authority granted while performing these unspecified clinical functions is incredibly broad and open-ended.

I also turn your attention to the language in lines 98-101 of the bill which states that CRNAs cannot prescribe a drug for use outside of the facility or other setting where the CRNA provides care. While this language applies to prescribing drugs for patients within the facility, it is silent on tests and treatments which opens the door for CRNAs to order diagnostic tests and treatments for patients who are not patients in the health care facility. Since the CRNAs have not answered the question as to what diagnostic tests or treatments they want to order for patients, this can be interpreted to be any test or treatment they want to order and will lead to duplicative and unnecessary tests ordered for patients who are not even in the hospital setting. I think it is also important to point out that while the CRNA can prescribe drugs for patients in the facility, the CRNA is not required to even be with the patient or in the facility when prescribing drugs, tests, treatments or fluids for the patient. The bill can certainly be interpreted to permit the CRNA to call in drug, test, treatment or fluid orders for patients from outside the facility. Given that the

CRNAs indicated in an interested party meeting that they want this flexibility, there is nothing in the bill preventing them from doing so. I cannot stress enough that the vagueness and breadth of this bill does not enhance patient care or improve the model of anesthesia care for patients in Ohio. The lack of definition, specificity and clarity will create confusion and will jeopardize patient care.

I have barely scratched the surface with problems in this bill or even touched upon the lack of definition around supervision or any of the other scope provisions in the bill that are unnecessary for improved patient care. However, I want to spend the remainder of my testimony on the compromise language the OSA, along with OSMA, provided to the CRNAs 7 months ago in April.

Our organizations did not take compromise lightly and there are admittedly some physicians who are uncomfortable with the language we put forward. However, in an attempt to address problems proponents claim arise in some settings, we suggested the following:

The medical director, nursing director and pharmacy director of a health care facility can establish a drug protocol allowing the CRNA to select, order and administer drugs from the protocol for the patient and can direct another health care professional to administer the drug. The CRNA can order the drug for the patient in the immediate post operative period, which does not include the period of time in which a patient has moved from a post-anesthesia care unit to another part of the facility. The CRNA cannot order a controlled substance and the drugs ordered from the protocol shall treat nausea, pain or respiratory conditions related to the administration of anesthesia. If directing another person to administer a drug ordered by the CRNA, the CRNA shall be available to evaluate the patient and in the facility. If the supervising physician determines it is not in the patient's best interest for the CRNA to order drugs pursuant to the protocol, the CRNA is not permitted to do so and the patient's medical record shall reflect that.

We believe this compromise significantly moves CRNA practice forward by allowing them to order drugs to treat specific conditions related to the administration of anesthesia and to allow them to direct others to administer drugs. The fact that CRNAs did not respond to this proposal, were not willing to dialogue on it and rejected it in favor of the bill before you calls into question exactly what they are trying to accomplish through such broad prescribing ability with such lack of specificity and detail.

In closing, I question how this bill will improve patient care in Ohio. While it may allow the CRNAs to practice in areas we can only imagine, it does nothing to improve anesthesia care in this state.

Thank you for your consideration. I will be happy to answer any questions you may have.