Proponent Testimony – Sub. S.B. 301
Ohio Senate Health, Human Services & Medicaid Committee
Kellie Deeter MSN, CRNA
Firelands Anesthesia – Owner, Northern Ohio Anesthesia Ltd. – Owner

Good afternoon, Chairman Burke, Vice Chair Beagle, Ranking Member Tavares and members of the Senate Health, Human Services & Medicaid Committee. My name is Kellie Deeter and I am a Certified Registered Nurse Anesthetist, or CRNA. I chair the State Government Relations Committee for the Ohio State Association of Nurse Anesthetists (OSANA) and serve on the board of directors. I appreciate the opportunity to appear today representing over 2,000 Ohio CRNA members and 340 student members.

As nurse anesthetists, we provide every type of anesthesia, for every type of patient, in every practice setting, and for every type of surgery or procedure. Ohio, like all states, utilizes several different models of anesthesia care depending on the needs of facilities and their respective communities. Large medical centers generally utilize a care team of CRNAs and anesthesiologists. Rural hospitals generally utilize an all CRNA model of care. Community hospitals generally utilize a hybrid model of CRNAs and/or anesthesiologists that may work separately or together. In each of these settings, CRNAs almost exclusively staff anesthesia for labor and delivery units.

I am fortunate to be the business owner of two anesthesia groups. I personally provide anesthesia at 5 facilities across Ohio and staff several of them as well. Each of these facilities utilize different anesthesia models, each has impeccable safety, and each demonstrates a need for the clarification in our scope of practice that Sub. SB 301 seeks. While all anesthesia models can benefit from Sub. S.B. 301, those that utilize CRNAs as the sole anesthesia providers, and those using hybrid anesthesia models experience the most acute need for the legislation. In practice, this bill adds nothing to what we currently do, other than to clarify that we CAN write anesthesia related orders for our patients.

The majority of my practices are rural and community hospitals that do not utilize an anesthesiologist. The expectation in the provision of anesthesia care, however, is EXACTLY the same. There is only one standard in anesthesia care regardless of model or the provider. Since the Ohio Attorney General opinion, the settings that I staff have faced challenges related to the strict interpretation regarding ordering. Placing orders is an inherent part of anesthesia and is completely consistent with our education, training, certification, and licensure. I can personally speak to having routinely performed this function along with every CRNA that I know in the state of Ohio. My business partner wrote orders for his patients for 30 years of his practice. Since 2013, not one surgeon that I work with at my 5 facilities has adopted customarily writing anesthesia order sets for our patients. These surgeons STILL want to defer to the anesthetist for these orders since we provide the anesthesia.

CRNAs enable healthcare facilities across the state and country to provide access to quality surgical and obstetrical anesthesia care, along with trauma stabilization services, vascular access services, and airway and resuscitation services. We are the only anesthesia provider on my facility's surgical teams, working with surgeons, obstetricians, dentists, and podiatrists, yet our hands have been tied by the narrow interpretation of the currently vague scope of practice. This restriction was not done by an outcry from any physicians, nurses, or administrators, or by an act of the legislature, and is why we seek clarification, not only of the ordering but of the entire scope.

A CRNAs services are always at the request of a physician, to provide either anesthesia or to perform a clinical function, such as a nerve block or intubation. This consult ALWAYS requires patient evaluation, and sometimes requires testing and/or medications associated with safely performing the anesthesia or clinical function. These require ORDERS, but as you know CRNAs are now limited in this regard. I have several examples within my facilities that without ordering authority, have resulted in a weak continuum of care, unnecessary delays, unsafe and inefficient patient management, and conflicts with the current ORC.

Some routine examples of the need for CRNAs to place orders when we are performing "pre-anesthetic preparation and evaluation" for our patients as currently described in the code include: prior to placing spinals or epidurals, certain patients need routine blood tests checking their coagulation status in order to safely receive these anesthetics. There are also routine blood tests that can apply to safely receiving general anesthesia. The surgeons who consult us don't always anticipate the anesthesia to be provided because they do not choose or delegate the anesthesia. The anesthetic is decided by the patient and the anesthetist, therefore, not every patient that presents to us has been adequately prepared. Our ability to ensure that the patient is prepared for the anesthetic that we administer is both logical and practical and is expected by all physicians who consult me. Additionally, CRNAs need the ability to delegate aspects of care to nurses during the placement of nerve blocks. We routinely perform these blocks before surgery by placing local anesthetic around nerves in an effort to eliminate pain. These blocks are vital to pain control and significantly decrease the use of opioids after surgery.

Routine examples of the need for CRNAs to place orders when providing "post-anesthesia care" as currently described in the code include: after personally managing patients' ventilation and oxygenation during anesthesia, just twenty feet away in recovering room, we no longer have the authority to ask nurses to continue the use of oxygen if needed. When this happens, I delay seeing my next patient to stay and personally administer the oxygen since outside of the operating room, oxygen administered by any other provider needs an order. Oxygen administration is a routine ANESTHESIA order during this phase of care.

Similarly, patients often complain of pain or nausea after anesthesia and surgery. This is a common complication that CRNAs have always managed as part of the "post-operative care" described in the current code. We are now limited to personally selecting and administering those medications and treatments, rather than providing orders for the nurse assuming care of the patient to administer them. Once a patient crosses the threshold into recovery room, an order is required for any medication to be dispensed and for the patient's nurse to legally administer. This is the ORDERING ability that we seek to clarify in our scope, not writing prescriptions. Surgeons are often unavailable to give timely orders in this situation. Additionally, surgeons have no knowledge of what medications were given during a patient's anesthetic, or how the patient responded to them. This is why anesthesia providers normally write recovery room orders that relate to anesthesia and are the most appropriate practitioners to do so.

An example of the need for CRNAs to place orders when "performing clinical functions" as currently described in the code include: being consulted by physicians to insert breathing tubes in critically ill patients that they were unable to themselves insert. This situation is life-threatening and requires assistance from nurses and/or respiratory therapists in giving needed medications and ventilation to patients, because logistically more than two hands are needed. These are the same medications and treatments that I select and administer to patients having surgery in whom I insert breathing tubes. CRNAs are now prevented from directing other providers to assist in administering medications or treatments in this situation.

CRNAs are the sole provider of anesthesia care in nearly every labor and delivery unit in Ohio and across the country. I personally 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 only a supervising physician present a fraction of that time. Multiple patients and their unborn babies are dependent on one CRNA who is no longer an ordering provider. CRNAs in this setting are now limited to personally performing every function that may be needed. There are innumerable examples in this setting, all potentially detrimental.

When a pregnant patient begins bleeding to death from a uterine rupture at one o'clock in the morning, the patient goes directly to the operating room for an emergency cesarean section. The nurses and the CRNA have to manage the patient until the obstetrician arrives. This could mean the need for lifesaving fluids, blood administration, additional IV's, and/or medications that could now save TWO lives. Because the CRNA is not recognized as an ordering provider, the obstetrician must be called for "verbal orders" for all interventions despite CRNAs being trained, educated, and certified to order and provide these exact services. If the obstetrician is not available or does not immediately respond, both the mother and the baby are in jeopardy. The right decisions for all providers in this situation are in conflict with an unclear statute that we are asking the legislature to clarify.

All of the other Advanced Practice Registered Nurses (APRNs) in Ohio with training in non-anesthesia specialties are currently authorized to place ALL 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 does specialize in anesthesia, has not been addressed by the General Assembly during this time.

Sub. S.B. 301 modernizes the current statute to reflect our scope of practice as outlined by our education and nationally accredited certification. This bill protects CRNAs, our patients, other licensed staff members, surgeons, dentists, and podiatrists who work with CRNAs as the sole anesthesia provider. It could also make models where CRNAs are not 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.