# Proponent Testimony before Ohio Senate, Human Services & Medicaid Health Committee

## Sub. SB 301
## November 27, 2018


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Good afternoon, Chairman Burke, Vice Chairman Beagle, Ranking Member Tavares, and members of the Senate Health, Human Services, and Medicaid Committee. My name is Kelly Leahy and 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 Sub. Senate Bill 301. My main goal today is to provide background and information about why the bill is important and necessary for CRNAs practicing in Ohio.

Historically, CRNAs have been providing anesthesia care to patients in the United States for more than 150 years and they were the first providers of anesthesia care. It is important to note that 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. It bears repeating: *Nurse and physician anesthesia professionals give anesthesia in the same exact way*. There are ***no*** different anesthesia standards for CRNAs compared to anesthesiologists.

**What Sub. SB 301 Does**

The primary goal of Sub. SB 301 is simple: to clarify that in Ohio CRNAs' scope of practice recognizes and is consistent with their education, training and certification. Sub. SB 301 is not a "drastic expansion of scope" as the House companion bill, Sub. H.B. 191, was characterized in opponent testimony. Ohio Revised Code Section 4723.43(B) currently describes five (5) basic functions that comprise the CRNA scope of practice: 1) administer anesthesia and perform anesthesia induction, maintenance and emergence, 2) perform preanesthetic preparation and evaluation, 3) perform post anesthesia care, and 4) perform clinical support functions.

Sub. SB 301 adds clarity about what each of these four (4) basic functions includes. It also sets forth the care CRNAs provide to patients today, at the request of and with the supervision of physicians. The bill does not expand the CRNA's scope of practice; it clarifies and codifies what any anesthesia provider is qualified to perform as a result of their education, training and national certification standards. The chart below compares the current language with the proposed language.

| CURRENT ORC 4723.43(B) | SUB. SB 301 ORC 4723.43 (B) |
|---|---|
| May perform pre-anesthetic preparation and evaluation | (a) Perform and document perianesthesia preparation and evaluation, which may include ordering and evaluating one or more diagnostic tests, consulting with one or more health professionals; |
| | (b) Establish anesthesia care plans; |
| | (c) Determine whether planned anesthesia is appropriate; |
| | (d) Obtain informed consent for anesthesia care; |
| And, may administer anesthesia and perform anesthesia induction, maintenance, and emergence | (e) Select and order anesthesia; |
| | (f) In the immediate presence of a physician, podiatrist, or dentist, administer anesthesia and perform anesthesia induction, maintenance, and emergence |
| | (i) As necessary for patient management and care in the perianesthesia period, select, order, and administer fluids, treatments, and drugs for conditions related to the administration of anesthesia; |
| | (j) Direct Registered Nurses, Licensed Practical Nurses, and respiratory therapists to do any of the following that they are authorized by law to do for patient management and care in the perianesthesia period:<br>a) Provide supportive care as necessary for patient management care, including monitoring vital signs, conducting EKGs, and intravenous therapy;<br>b) Administer fluids, treatments, and drugs to treat conditions related to the administration of anesthesia. |
| | (m) Select, order, and administer pain relief therapies during the perianesthesia period; |
| And, may perform postanesthesia care | (k) Perform and document post-anesthesia care and evaluation; |

| | |
|---|---|
| | |
| | (l) Perform post-anesthesia care assessments, including on admission to or release or discharge from recovery areas; |
| And, may perform clinical support functions | (g) May perform clinical functions as specified in the clinical experience standards established for nurse anesthetist education programs by a national accreditation organization, selected by the Board of Nursing, or pursuant to physician consultation consistent with the nurse's education and certification; including ordering fluids, treatments, drugs, and diagnostic tests, and evaluating the results of such tests;<br>(h) When performing clinical functions as provided in this section, order fluids, treatments drugs, and one or more diagnostic tests and evaluate the results of the such tests; |

I would like to draw your attention in particular to lines 66-72 dealing with clinical functions (referred to as "clinical support functions" in current law). Opponents of the House companion bill claim that this language, which has been in current law for nearly two decades, is ambiguous and vague and that the clinical functions are not specified. In fact, this historical language is clarified in the bill. As one of the many accommodations made to physician interests during IP meetings, the bill specifically ties the authorized clinical functions to either: 1) those specified in the clinical experience standards established for nurse anesthetist education programs by a national accreditation organization selected by the Ohio Board of Nursing, or 2) those completed pursuant to a physician consultation. The national accreditation standards, which are an objective third party standard, and are attached for your information, leave little doubt about what clinical experiences are required for accredited programs and have been provided to the OSMA and OSA on multiple occasions (See Attachment 1). We have a hard time understanding the assertion that the language is ambiguous and vague.

**Why Sub. SB 301 is Needed**

The need for this bill is very clear and very important to those who serve constituents in rural and underserved areas. Until the Ohio Attorney General issued a 2013 opinion interpreting current Ohio law to restrict a CRNA from ordering medications to be administered by others because the General Assembly did not grant CRNAs explicit prescriptive authority, it was uniformly recognized that ordering during the peri-anesthesia period is an inherent function of CRNA practice.

Additionally, until the passage of HB 216 in 2016, explicit language in the CRNA scope of practice statute stated that a CRNA did not need a certificate to prescribe (CTP) to practice anesthesia. This is because CRNAs do not write prescriptions to practice anesthesia, rather they select and administer necessary medications directly for patient use. However, A CTP was required for all other APRNs with full prescriptive authority. HB 216 removed the CTP requirement for APRNs and the OBN now issues a license, rather than a CTP. In harmonizing the language in HB 216, LSC deleted the language that said CRNAs did not need a CPT to practice anesthesia. This change contributes to the ambiguity of the statute and is an oversight that must be addressed for effective and efficient CRNA practice in Ohio.

Historically, 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), anesthesiologists, physician groups, health care professionals, health care administrators or patient advocacy groups voiced any concerns about CRNAs performing these duties.

As a result, the OAG opinion greatly impacted hospitals, ambulatory surgery centers, endoscopy centers, and other outpatient care sites where patients need anesthesia for surgery, procedures or other conditions such as labor epidurals. CRNAs are *primary providers of anesthesia* and the *only* anesthetists in over 150 facilities throughout Ohio. Ordering pre- and post-operative medications, such as nausea and pain medication, in connection with anesthesia is integral to being an anesthetist -- whether the anesthetist is a physician or a nurse. It is critical to providing high quality patient care. CRNAs are trained, educated and certified to perform all of the tasks specified in Sub. S.B. 301 and it's a disservice to patients, hospitals, and surgical teams to handcuff CRNAs and surgeons in these facilities and elsewhere.

**How Does SB 301 Address Need?**

In addition to specifically clarifying CRNA scope of practice as outlined above, Sub. SB 301 adds CRNAs to the list of "prescribers" under Ohio's pharmacy laws to clarify that they can place orders necessary to perform the full scope of anesthesia services for patients including pre-anesthesia preparation and management of post-anesthesia complications, as described in their current scope of practice. This is not "broad prescriptive authority" as opponents claim. No health care professional is confused by the different concepts of prescribing and ordering, and any doubt about this distinction can be addressed directly by the Ohio Board of Pharmacy or the Drug Enforcement Agency, which both recognize ordering as inherent to CRNAs' scope of authority. Please see Attachment 2 attached illustrates the current list of ordering providers under Ohio law.

**Limitations in SB 301**

**1. No Prescriptive Authority**

Reiterating what I just spoke about we would like to be especially clear that CRNAs are not seeking prescriptive authority in Sub. SB 301, 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***."

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. Sub. SB 301 explicitly prohibits a CRNA from prescribing a drug for use outside the facility or other setting where the CRNA provides care (lines 98-101). Please see Attachment 3 illustrating this point.

**2. Supervision Restored.**

At the request of physician interests, CRNA supervision by a physician, dentist or podiatrist has been restored in the bill. Every aspect of the proposed scope of practice of CRNAs will be directly supervised by a physician, dentist or podiatrist.

**3. Permissive Nature.**

As you will hear in more detail from other proponents, Sub. SB 301 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. Sub. SB 301 makes no mandates on hospitals and does not require change to the way any facility currently functions.

**Physician Liability**

The suggestion by physician opponents that CRNAs create liability for surgeons and other non-anesthesiologist CRNA supervisors is a red herring that the committee should disregard. In 1982, the Ohio Supreme Court held in *Baird v. Sickler* that if a surgeon exercises control over the anesthesia process the physician can be held liable for a bad outcome under the doctrine of respondeat superior. In this case, a physician exercised control over the CRNA during intubation directing the CRNA (who inserted the tube) and assisting in positioning the patient before and after intubation. The patient was paralyzed as a result of the intubation and the physician was held liable because he was directly involved in the anesthesia care. If the anesthetist had been an anesthesiologist instead of a CRNA, the surgeon would have been similarly responsible for his actions. Despite being decided in 1982, *Baird v Sickler* is established law in Ohio and has been followed by at least two lower appellate courts, most recently in 2013. Surgeons and other physicians currently determine the extent to which they participate in the administration of anesthesia and exert control over anesthetists. Sub. S.B. 301 changes nothing in this regard.

In closing, Sub. SB 301 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. The bill will allow CRNAs the ability to provide more efficient anesthesia care for their patients before, during, and after surgery.

Mr. Chairman, members of the committee, OSANA respectfully requests your support of Sub. SB 301. I am happy to answer any questions that you might have.

# STANDARDS FOR ACCREDITATION OF NURSE ANESTHESIA EDUCATIONAL PROGRAMS

## COUNCIL ON ACCREDITATION OF NURSE ANESTHESIA EDUCATIONAL PROGRAMS

Revised January 2018

# Appendix (--)

**Applies to students matriculating into anesthesia programs prior to January 1, 2015**

The minimum number of anesthesia cases is 550.

| CLINICAL EXPERIENCES | Minimum Required Cases | Preferred Number of Cases |
|---|---|---|
| **PATIENT PHYSICAL STATUS** | | |
| Class I | | |
| Class II | | |
| Classes III & IV | 100 | |
| Class V | | 5 |
| TOTAL CASES | 550 | 650 |
| **SPECIAL CASES** | | |
| Geriatric 65 + years | 50 | 100 |
| Pediatric | | |
| Pediatric 2 to 12 years | 25 | 75 |
| Pediatric (less than 2 years) | 10 | 25 |
| Neonate (less than 4 weeks) | | 5 |
| Trauma/Emergency (E) | 30 | 50 |
| Ambulatory/Outpatient | 100 | |
| Obstetrical management | 30 | 40 |
| Cesarean delivery | 10 | 15 |
| Analgesia for labor | 10 | 15 |

| CLINICAL EXPERIENCES | Minimum Required Cases | Preferred Number of Cases |
|---|---|---|
| **POSITION CATEGORIES** | | |
| Prone | 20 | |
| Lithotomy | 25 | |
| Lateral | 5 | |
| Sitting | 5 | |
| **ANATOMICAL CATEGORIES[1]** | | |
| Intra-abdominal | 75 | |
| Extrathoracic | 15 | |
| Extremities | 50 | |
| Perineal | 15 | |
| Extracranial | 15 | |
| Intracranial | 5 | 20 |
| Oropharyngeal | 20 | |
| Intrathoracic | 15 | 40 |
| Heart | 5 | 10 |
| Lung | 5 | |
| Neck | 5 | 10 |
| Neuroskeletal | 20 | |
| Vascular | 10 | 20 |

[1] Count all that apply.

| CLINICAL EXPERIENCES | Minimum Required Cases | Preferred Number of Cases |
|---|---|---|
| METHODS OF ANESTHESIA | | |
| General anesthesia | 350 | |
| Induction, maintenance, and emergence | | |
| Intravenous induction | 200 | |
| Inhalation induction | 10 | 25 |
| Mask management | 25 | 40 |
| Laryngeal mask airways (or similar devices) | 25 | 40 |
| Tracheal intubation | | |
| a. Oral | 200 | |
| b. Nasal | | 10 |
| Total intravenous anesthesia | 10 | 25 |
| Emergence from anesthesia | 200 | |
| Regional techniques | | |
| Management | 30 | |
| Administration[2] (total of a, b & c) | 25 | |
| a. Spinal | | 50 |
| b. Epidural | | 50 |
| c. Peripheral | | 40 |
| Monitored anesthesia care | 25 | 50 |

[2] Students must have experience in each category.

| CLINICAL EXPERIENCES | Minimum Required Cases | Preferred Number of Cases |
|---|---|---|
| **PHARMACOLOGICAL AGENTS** | | |
| Inhalation agents | 200 | |
| Intravenous induction agents | 200 | |
| Intravenous agent - muscle relaxants | 200 | |
| Intravenous agent - opioids | 200 | |
| **ARTERIAL TECHNIQUE** | | |
| Arterial puncture/catheter insertion | 25 | |
| Intra-arterial BP monitoring | 25 | |
| **CENTRAL VENOUS PRESSURE CATHETER** | | |
| Placement[3] (total of a & b) | 5 | 10 |
| a. Actual | | |
| b. Simulated | | |
| Monitoring | 15 | |
| **PULMONARY ARTERY CATHETER** | | |
| Placement | | 5 |
| Monitoring | | 10 |

[3] Simple models and simulated experiences may be used to satisfy this requirement.

| CLINICAL EXPERIENCES | Minimum Required Cases | Preferred Number of Cases |
|---|---|---|
| OTHER | | |
| Intravenous catheter placement | 100 | |
| Mechanical ventilation | 200 | |
| Pain management (acute/chronic) | | 10 |
| Alternative airway management techniques (total of 1 & 2)<br>(see Glossary: alternative airway management techniques) | 10 | 40 |
| 1) Fiberoptic techniques[3] (total of a, b & c) | 5 | 15 |
| a) Actual placement | | |
| b) Simulated placement | | |
| c) Airway assessment | | |
| 2) Other techniques | 5 | 25 |

(--) Effective for students matriculating into anesthesia programs prior to January 1, 2015. For all students matriculating into programs on or after January 1, 2015, the clinical case experience requirements will be identical for all programs regardless of degree.

[3] Simple models and simulated experiences may be used to satisfy this requirement.

## Appendix (+)

**Applies to students matriculating into anesthesia programs on or after January 1, 2015**

The minimum number of clinical hours is 2000 (See Glossary: Clinical hours).

| CLINICAL EXPERIENCES | Minimum Required Cases | Preferred Number of Cases |
|---|---|---|
| **PATIENT PHYSICAL STATUS** | | |
| Class I | | |
| Class II | | |
| Classes III – VI (total of a, b, c, & d) | 200 | 300 |
| a. Class III | 50 | 100 |
| b. Class IV | 10 | 100 |
| c. Class V | 0 | 5 |
| d. Class VI | | |
| Total Cases | 600 | 700 |
| **SPECIAL CASES** | | |
| Geriatric 65+ years | 100 | 200 |
| Pediatric | | |
| Pediatric 2 to 12 years | 30 | 75 |
| Pediatric (less than 2 years) | 10 | 25 |
| Neonate (less than 4 weeks) | | 5 |
| Trauma/Emergency (E) | 30 | 50 |
| Obstetrical management (total of a & b) | 30 | 40 |
| a. Cesarean delivery | 10 | 15 |
| b. Analgesia for labor | 10 | 15 |
| Pain management encounters (see Glossary: Pain management encounters) | 15 | 50 |

| CLINICAL EXPERIENCES | Minimum Required Cases | Preferred Number of Cases |
|---|---|---|
| ANATOMICAL CATEGORIES[4] | | |
| Intra-abdominal | 75 | |
| Intracranial (total of a & b) | 5 | 20 |
| a. Open | 3 | 10 |
| b. Closed | | |
| Oropharyngeal | 20 | |
| Intrathoracic (total of a, b, & c) | 15 | 40 |
| a. Heart | | |
| 1. Open heart cases (total of a & b) | 5 | 10 |
| a) With cardiopulmonary bypass | | |
| b) Without cardiopulmonary bypass | | |
| 2. Closed heart cases | | 10 |
| b. Lung | 5 | |
| c. Other | | |
| Neck | 5 | 10 |
| Neuroskeletal | 20 | |
| Vascular | 10 | 30 |

[4] Count all that apply

| CLINICAL EXPERIENCES | Minimum Required Cases | Preferred Number of Cases |
|---|---|---|
| **METHODS OF ANESTHESIA** | | |
| General anesthesia | 400 | |
| Inhalation induction | 25 | 40 |
| Mask management[5] | 25 | 35 |
| Supraglottic airway devices (total of a & b) | 35 | 50 |
| a. Laryngeal mask | | |
| b. Other | | |
| Tracheal intubation (total of a & b) | 250 | |
| a. Oral | | |
| b. Nasal | | 5 |
| Alternative tracheal intubation/endoscopic techniques[6] (total of a & b ) (see Glossary: Alternative tracheal intubation techniques) | 25 | 50 |
| a. Endoscopic techniques[7] (total of 1 & 2) | 5 | 15 |
| 1. Actual tracheal tube placement | | |
| 2. Simulated tracheal tube placement | | |
| 3. Airway assessment | | |
| b. Other techniques | 5 | 25 |
| Emergence from anesthesia | 300 | |

[5] A general anesthetic that is administered by mask, exclusive of induction.

[6] Tracheal intubations accomplished via alternative techniques should be counted in both tracheal intubation and the alternative tracheal intubation categories.

[7] Simple models and simulated experiences may be used to satisfy part of this requirement. No clinical experiences can be obtained by simulation alone.

| CLINICAL EXPERIENCES | Minimum Required Cases | Preferred Number of Cases |
|---|---|---|
| Regional techniques | | |
| Actual administration (total of a, b, c, & d) | 35 | |
| a. Spinal (total of 1 & 2) | 10 | 50 |
| 1. Anesthesia | | |
| 2. Pain management | | |
| b. Epidural (total of 1 & 2) | 10 | 50 |
| 1. Anesthesia | | |
| 2. Pain management | | |
| c. Peripheral[8] (total of 1 & 2) | 10 | 50 |
| 1. Anesthesia | | |
| Upper | | |
| Lower | | |
| 2. Pain management | | |
| Upper | | |
| Lower | | |
| d. Other[9] (total of 1 & 2) | | |
| 1. Anesthesia | | |
| 2. Pain Management | | |
| Management (total of 1 & 2) | 35 | 50 |
| 1. Anesthesia | | |
| 2. Pain management | | |
| Moderate/deep sedation | 25 | 50 |

[8] Simple models and simulated experiences may be used to satisfy part of this requirement. No clinical experiences can be obtained by simulation alone.

[9] Examples include truncal, cutaneous, head, and neck blocks (e.g., transversus abdominis plane, rectus sheath, ilioinguinal, iliohypogastric, oral, and maxillofacial blocks).

| CLINICAL EXPERIENCES | Minimum Required Cases | Preferred Number of Cases |
|---|---|---|
| **ARTERIAL TECHNIQUE** | | |
| Arterial puncture/catheter insertion | 25 | |
| Intra-arterial blood pressure monitoring | 30 | |
| **CENTRAL VENOUS CATHETER** | | |
| Placement[10] – Non PICC (total of a & b) | 10 | 15 |
| a. Actual | | 5 |
| b. Simulated | | |
| Placement – PICC (total of a & b) | | |
| a. Actual | | |
| b. Simulated | | |
| Monitoring | 15 | |
| **PULMONARY ARTERY CATHETER** | | |
| Placement | | 5 |
| Monitoring | | 10 |
| **OTHER** | | |
| Ultrasound guided techniques (total of a & b) | | 10 |
| a. Regional | | |
| b. Vascular | | |
| Intravenous catheter placement | 100 | |
| Advanced noninvasive hemodynamic monitoring | | |

[10] Simple models and simulated experiences may be used to satisfy this requirement. For students enrolled on or after January 1, 2020, no clinical experiences can be obtained by simulation alone. Insertion of peripherally inserted central catheters (PICC) does not meet the requirements for central line placement.

OSANA Ohio State Association of Nurse Anesthetists

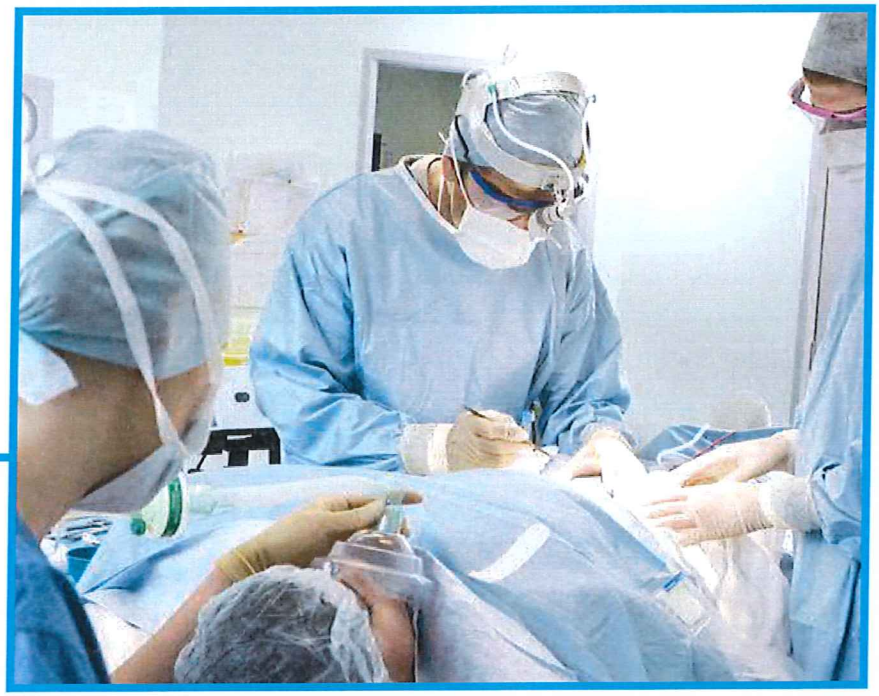
# HB 191/SB 301 EXPAND THE DEFINITION OF PRESCRIBERS TO INCLUDE CRNA'S BUT LIMITS THEIR AUTHORITY TO ORDERING ONLY

| PRESCRIBER | ORDERING<br>Administer medicine IN the care setting | PRESCRIPTIONS<br>Prescription pad to be administered outside of the care setting | AUTHORITY |
|---|---|---|---|
| **DOCTORS** | | | |
| Physicians | ✓ | ✓ | Current Law |
| Dentists | ✓ | ✓ | Current Law |
| Optometrists | ✓ | ✓ | Current Law |
| Veterinarians | ✓ | ✓ | Current Law |
| **ADVANCED PRACTICE NURSES** | | | |
| Certified Nurse Practitioners | ✓ | ✓ | Current Law |
| Clinical Nurse Specialists | ✓ | ✓ | Current Law |
| Certified Nurse Midwives | ✓ | ✓ | Current Law |
| CRNA's | ✓ | X | HB191/SB301 |
| **NON-DOCTOR/NON-NURSE** | | | |
| Physician Assistants | ✓ | ✓ | Current Law |

CRNA's are added to the definition of prescribers, "but only to the extent of the nurse's authority under division (B) of section 4723.43 of the Revised Code."—Lines 284-285.

Section 4723.43 (B)(2) states, "Division (B)(1) 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 certified registered nurse anesthetist provides care."—Lines 98-101.

# HB 191/SB 301 includes CRNA's in the list of PRESCRIBERS, but limits their authority to ORDERING. They are prohibited from writing PRESCRIPTIONS.



## ORDERS - YES

For immediate administration to patient IN the facility


## PRESCRIPTIONS - NO

For use by patient OUTSIDE the facility

Sec. 4723.43 (B)(2) states, "Division (B) (1) 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 certified registered nurse anesthetist provides care."

OSANA Ohio State Association of Nurse Anesthetists