Chairman Lipps, Vice Chair Holmes, Ranking Member Liston, and members of the House Health Committee, thank you for the opportunity to present written opposition testimony to Sub. HB 318 on behalf of the Ohio State Association of Nurse Anesthetists and over 2,600 members. With one business days' notice over a holiday weekend, it would have required the cancelation of surgeries and closed operating rooms to appear in person today. As you can imagine the stress to patients, delay in treatment, and the financial impact on hospitals took precedent. We respectfully request through the Chairman, and to the members of the committee, to have the opportunity to present an expanded version of our opposition testimony and answer committee questions in-person at a future date with ample notification.

OSANA opposes Sub. HB 318 because it lowers the standard of anesthesia care for Ohio patients. **The proposed legislation transforms the practice of an anesthesiologist assistant (AA) from a provider that assists an anesthesiologist - to a primary provider of anesthesia care.** HB 318 dramatically and unprecedentedly expands the AA scope of practice and eliminates the medical direction standard of care that currently governs AA practice; essentially collapsing the difference between the AA and the anesthesiologist they are assisting. Further, Sub. HB 318 permits the entire continuum of anesthesia care to be delegated to an AA through a supervision model, rather than medical direction model of care, further distancing Ohio anesthesia patients from their primary anesthesia care provider. We find no reason this new model of care or separation, in any portion of the anesthesia continuum, would improve patient care, safety, or patient outcomes. In both our clinical practice and ethical professional standards, we are required to advocate on behalf of our patients and to put their best interests first, without exception.

Modifying a standard of care or scope of practice, especially regarding patients' anesthesia care, demands the highest possible burden of proof. To date, proponents of Sub. HB 318 have presented no verifiable and accurate data, peer reviewed clinical research, or qualified evidence from unassailable sources that suggests changing the current anesthesia standard of care or dramatically increasing the AA scope of practice would provide better anesthesia patient care, higher quality outcomes, and ensure patient safety.

MEDICAL DIRECTION

Currently, ORC 4760.01(B) defines an anesthesiologist assistant as "an individual who assists an anesthesiologist in developing and implementing anesthesia care plans for patients" and ORC 4706.09 delineates a limited AA scope of practice and specific tasks and services an anesthesiologist may utilize to assist him or her with the administration anesthesia care. The standard of care for AA practice is medical direction requiring substantial direct patient contact from a physician anesthesiologist who directs all

patient care after a physical examination by prescribing the anesthesia plan and engaging with the patient to discuss the plan and obtain informed consent. To accomplish this, the anesthesiologist performs preanesthetic preparation and subsequently prescribes or orders the necessary drugs and treatments and diagnostic tests specific to that individualized patient's plan. This plan continues with the anesthesiologist personally participating in anesthesia induction and emergence, monitoring the anesthetic, and providing the post anesthesia care.

This model, referred to as the "Anesthesia Care Team", is the only model permitting the utilization of an AA in the 15 states where they are licensed. Established by CMS as the only practice and billing delivery model for AAs, the medical direction standard and model of care does not permit any level of autonomous patient care by an AA or provide the AA with any level of autonomy to manage any aspect of patient care or directly control the treatment of a patient. AAs simply do not receive the education or training that is commensurate with, or essential for, any health care provider that can directly control patient care or autonomously manage aspects of a patient's anesthesia care.

Additional degradation of the current anesthesia standard of care through Sub. HB 318 is accomplished by eliminating statutory language (lines 481-482) that restricts AA practice to any location other than a hospital or ambulatory surgical facility - allowing AAs to practice outside of the hospitals and ASCs in which they are exclusively trained. Sub. HB 318 also eliminates current State Medical Board of Ohio rules that require enhanced supervision of anesthesiologist assistants during the first four years of practice (lines 506-508) - eliminating quality assurance measures meant to protect a patient's safety. We do not find this type of oversight or location restriction as a problem in current anesthesia care delivery.

We oppose Sub. HB 318 because it eliminates the medical direction standard of care regarding AA practice. The legislation creates a new form of a supervised standard and model of care that would consist of the availability of the "supervising anesthesiologist" (with exceptions) (lines 474-481), through individual written practice protocols defining the manner of supervision and scopes of practice for each individual AA, with no established statutory medical direction standard or practical limitations (lines 488-506). A supervision model of care does not require substantial direct patient care participation of an anesthesiologist, provides AAs with substantial practice autonomy, and significantly lowers the current anesthesia standard of care – further distancing patients from their primary anesthesia provider of care. We can identify no reason the new model and standard of care would provide better anesthesia patient care, higher quality outcomes, and ensure patient safety.

SCOPE OF PRACTICE EXPANSION

The impact of eliminating the medical direction standard of care, providing greater autonomy of AA practice in a supervised model and substantially less participation in direct patient care from the physician anesthesiologist is magnified when coupled with a massive and unprecedented scope of practice increase. **OSANA opposes the AA scope of practice proposed in Sub. HB 318.** The new scope of practice provides AAs with prescriptive authority to order drugs, treatments, and fluids to be directly administered to patients (lines 334-338 & lines 580-583). This includes the authority to order and evaluate diagnostic tests (lines 576-579), and to direct the practice of RNs, LPNs, and RTs to provide supportive care including administering drugs, treatments, and fluids prescribed or ordered by the AA (lines 584-595). The new scope of practice provides AAs with the authority to directly engage, rather than assist an anesthesiologist, by performing anesthesia induction, maintenance, and emergence (lines 543-545). The AA may obtain informed consent for anesthesia patient care (line 570); and perform preanesthetic preparation and evaluation, postanesthetic preparation and evaluation, post anesthesia care – and incredibly - any other function described in a written practice protocol (lines 571-575). The AA scope of practice will not be limited by statute.

The tremendous increase in breadth and depth of the proposed scope of practice provides an AA with full anesthesia practice authority and greater autonomy in a supervised model of care. The elimination of the medical direction standard of care provides that an AA may be delegated the entire continuum of anesthesia care. Also of note, Sub. HB 318 contains no corresponding additional education, training or licensing requirements that substantiate full anesthesia practice authority. Without addressing the lack of appropriate education, training, and direct clinical patient care experience that does not include substantial medical direction from a physician anesthesiologist, we find no reason the proposed expansion of AAs scope of practice and new practice paradigm would provide better anesthesia patient care, higher quality outcomes, and ensure patient safety.

Anesthesia and anesthesia care demand the highest possible standard of care. Patients deserve the highest possible standard of care. Sub. HB 318 lowers the current anesthesia standard of care, without merit or sufficient reason. The proposed Sub. HB 318 does not address any of the issues outlined in this testimony. For over 100 years in the state of Ohio, anesthesia has been recognized as the practice of both medicine and advanced practice nursing. Both anesthesiologists and Certified Registered Nurse Anesthetists (CRNAs) meet that standard every day. Anesthesia is not recognized as the practice of anesthesiologist assistants in Ohio or anywhere in country. For this reason and those described above, the Ohio State Association Nurse Anesthetists (OSANA) asks that you oppose Sub. HB 318, and not lower the current, proven, and safe anesthesia standard of care.

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