MINUTES OF THE
SENATE COMMITTEE ON COMMERCE AND LABOR

Eighty-second Session
May 12, 2023

The Senate Committee on Commerce and Labor was called to order by Vice Chair Roberta Lange at 8:06 a.m. on Friday, May 12, 2023, in Room 2134 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Roberta Lange, Vice Chair
Senator Melanie Scheible
Senator Skip Daly
Senator Julie Pazina
Senator Scott Hammond
Senator Carrie A. Buck
Senator Jeff Stone

COMMITTEE MEMBERS ABSENT/EXCUSED:

Senator Pat Spearman, Chair (Excused)

GUEST LEGISLATORS PRESENT:

Assemblyman Gregory T. Hafen, Assembly District No. 36
Assemblyman David Orentlicher, Assembly District No. 20

STAFF MEMBERS PRESENT:

Cesar Melgarejo, Policy Analyst
Bryan Fernley, Counsel
Lynn Hendricks, Committee Secretary

OTHERS PRESENT:

Susan Fisher, State Board of Osteopathic Medicine; Nevada State Society of Anesthesiologists; Nevada Orthopaedic Society
Sarah Adler, Healthy Communities Coalition of Lyon and Storey Counties; Nevada Advanced Practice Nurses Association; American Association of Nurse Practiioners
Blayne Osborn, Nevada Rural Hospital Partners
Paige Barnes, Nevada Nurses Association
Mari Nakashima Nielsen, Nevada State Medical Association
Trevor Parrish, Vegas Chamber
Wiselet Rouzard, Deputy State Director, Americans for Prosperity
Miranda Hoover, CRNA
Arthur Savignac, CRNA, President, Nevada Association of Nurse Anesthetists
Landon Mouritsen, CRNA, Humboldt General Hospital
Allison Lofton, CRNA
Jennifer Brown, CRNA
Jeffrey Meter, M.D., Chief of Surgery, Humboldt General Hospital
Matt Robinson, Carson Tahoe Health System
Morgan McCarroll, M.D., Chief of Anesthesiology, Carson Tahoe Hospital
Shaina Richardson, M.D.
Jerry Matsumura, M.D.
Elliot Malin, Nevada Osteopathic Medical Association
Michael Hillerby, State Board of Nursing; State Board of Pharmacy
Yvette Williams, Clark County Black Caucus

VICE CHAIR LANGE:
I will open the hearing on Assembly Bill (A.B.) 120.

ASSEMBLY BILL 120 (1st Reprint): Revises certain provisions governing voluntary health care service. (BDR 54-177)

ASSEMBLYMAN GREGORY T. HAFEN (Assembly District No. 36):
Existing law under *Nevada Revised Statutes* (NRS) 629.450 prohibits healthcare providers who have not actively practiced their profession continuously for the immediately preceding three years from volunteering their services. This statute prohibits recent graduates of health care from volunteering to provide essential medical, dental, vision and other services to underserved areas such as rural Nevada. This means that before you graduate, you can volunteer your time; but

after you graduate, you are no longer allowed to volunteer your time for three years. The intent of this bill is to change this situation so that recent graduates can volunteer their time.

This prohibition has negatively impacted healthcare services in Nevada. One example of this is a dental student from the University of Nevada, Las Vegas (UNLV), who was a volunteer for the remote area medical (RAM) program. After graduation, he wanted to continue his volunteer service, but because of this provision, the Nevada Department of Health and Human Services had to decline his services.

Residents throughout Nevada, especially in rural Nevada, benefit extremely from the free pop-up clinics provided by the RAM program. Both Pahrump and Tonopah recently had these pop-up clinics come to the communities and provide services. A few years back, the RAM program brought a dentist to Pahrump to provide dental services to a woman in kidney failure. She needed a kidney transplant, but before that could be done, she needed to have multiple teeth removed. The RAM pop-up clinic was able to do that for her, and she was then able to proceed with the transplant. Had we not had these volunteer healthcare workers available, I do not know that she would have ever been able to afford to have her teeth removed and be able to proceed with the transplant.

I want to touch on the bill itself. Section 1, subsection 2, paragraph (c) amends the restriction that a provider of health care who has not actively practiced his or her profession continuously for the immediately preceding three years may not volunteer to provide healthcare services. Removing this restriction will allow recently graduated qualified healthcare providers to continue their volunteer service in association with sponsored organizations. With these volunteers, Nevada residents, especially in the poorest of our communities, have an opportunity to receive the care that they desperately need to live a healthier life.

SENATOR SCHEIBLE:
I am trying to understand the significance of the three-year timeline. Is it related to their residency, or is it just a number? Why three years?

ASSEMBLYMAN HAFEN:
I have spent the last four or five years trying to get an answer to why we even have this restriction in statute, and I have not been able to find out. I have had some conversations with previous Legislators, who said it came from a concern

that retirees who are not keeping up their skills should not be volunteering. This bill does not change that part of the statute. It just allows recent graduates, who are the cream of the crop, to volunteer their time. After all, we are investing hundreds of millions of dollars in our medical and dental schools in Nevada. We want these individuals to volunteer their services, especially considering Nevada's desperate shortage of medical professionals.

SUSAN FISHER (State Board of Osteopathic Medicine):
We fully support A.B. 120. We thank Assemblyman Hafen for bringing this bill, which corrects a nonsensical omission.

SARAH ADLER (Healthy Communities Coalition of Lyon and Storey Counties):
We support A.B. 120.

I have a personal connection to this statute. Many years ago, I joined the board of the Healthy Communities Coalition of Lyon and Storey Counties. Ernie Adler drafted the original language to create access to volunteer healthcare professionals. Tom Grady, our Assemblyman at the time, carried the bill.

The pop-up clinics Assemblyman Hafen referred to are clinics organized and run by the RAM project. After months of planning, they bring semitrucks full of equipment to an isolated community and set up dental or vision clinics. I have attended these clinics in Silver Springs and supported them many times by helping people fill out paperwork, since I have no other healthcare ability. These clinics have made a huge difference to people, and we have all been brought to tears by the impact these clinics have.

We support A.B. 120 and urge your support.

BLAYNE OSBORN (Nevada Rural Hospital Partners):
We are here in support of A.B. 120.

PAIGE BARNES (Nevada Nurses Association):
We support A.B. 120. We think of this bill as one tool in our tool kit to help bring more providers to Nevada patients, especially to our most rural communities.

MARI NAKASHIMA NIELSEN (Nevada State Medical Association):
We are here in support of A.B. 120 and want to thank the sponsor for his work on this bill.

TREVOR PARRISH (Vegas Chamber):
The Chamber is in support of A.B. 120. This will be another important tool to help address our doctor shortage here in Nevada and will assist us in providing services to medically underrepresented communities. We urge your support of A.B. 120.

WISELET ROUZARD (Deputy State Director, Americans for Prosperity):
I am in support of A.B. 120. I echo the sentiments of the previous speakers. We greatly appreciate Assemblyman Hafen for bringing this bill and giving Nevada doctors the ability to contribute to their communities.

ASSEMBLYMAN HAFEN:
If I may, I would like to explain the process of the pop-up clinics a little more. Organizations like the RAM project spend months getting everybody fully vetted and licensed and with the proper insurance in place. As Ms. Adler stated, these clinics are not just a tent in somebody's backyard. The equipment is brought in semitrucks from all over the Country. In our most recent clinic in Pahrump, they took over the entire high school. They set up clinics in every room and had different stations throughout the school for different services. The clinics are very well organized and provide desperately needed services throughout Nevada.

VICE CHAIR LANGE:
I will close the hearing on A.B. 120 and open the hearing on A.B. 198.

ASSEMBLY BILL 198 (1st Reprint): Revises provisions governing health care. (BDR 54-446)

ASSEMBLYMAN DAVID ORENTLICHER (Assembly District No. 20):
The goal of A.B. 198 is to address one element in the shortage of healthcare professionals in Nevada, specifically certified registered nurse anesthetists (CRNA). Under current law, they are not able to practice within their full scope of authority and do what they are trained to do. This is a particular concern in rural areas. In Reno and Las Vegas, CRNAs and anesthesiologists practice together as a team. In some rural hospitals, there are no anesthesiologists. If

you do not have a CRNA deliver anesthesia services, you cannot do the procedures. That is why we have this proposal in A.B. 198.

MIRANDA HOOVER, CRNA:
I am here today representing all CRNAs who practice in Nevada. We CRNAs have been passionately and safely providing care to patients for more than 150 years in the United States. We are educated and trained to work without physician supervision and to exercise independent judgment, especially when having to respond quickly to emergencies. This bill brings merit to the highly educated, trained and licensed professionals that CRNAs are and will help Nevada to attract additional CRNAs, which in turn will work to combat our anesthesia provider shortage.

I will dive into the language of the bill. Sections 2 and 3 codify language that has been part of the CRNA's scope of practice for their entire history. This bill allows CRNAs to continue providing safe care in all settings where they are licensed to practice and defines their service capability in statute for services they have been providing since the Civil War. All CRNAs will continue to be licensed and regulated under the State Board of Nursing. They will also now be added to the State Board of Pharmacy's definition of "practitioner" and be required to pay an additional annual $300 fee to the State Board of Pharmacy. This will mean that CRNAs will be able to order, prescribe, possess and administer controlled substances, poisons, dangerous drugs and devices to treat a patient under the care of a licensed physician, a licensed dentist or a licensed podiatric physician.

Based on their education, licensure and certification, CRNAs are qualified to make independent judgments regarding all aspects of anesthesia care. They practice with a high degree of autonomy and are comfortable doing so because graduates of nurse anesthesia programs have an average of 9,369 hours, which equates to 390 24-hour days of clinical experience.

The remainder of this bill is cleanup language to include CRNAs in the prescribing chapters of NRS. Over the last several years, CRNAs have run into issues in Nevada not being able to successfully administer care because this language has not been codified in statute. Their scope is currently only spelled out in the *Nevada Administrative Code* (NAC). The intention here is to simply add prescriptive authority to the scope-of-practice language that CRNAs have currently in the NAC and codify it into modern law so they can continue

providing quality patient care in Nevada. This will alleviate the question from regulatory entities about who has jurisdiction over CRNAs. It will also ensure CRNAs can continue providing safe care throughout the entire State.

ARTHUR SAVIGNAC, CRNA (President, Nevada Association of Nurse Anesthetists): Thank you for allowing me the opportunity to speak today as a representative of 125 nurse anesthetists in Nevada who provide anesthesia care both in the cities and in the rural areas of the State. We provide anesthesia care 24/7 for 365 days a year in operating rooms, obstetrics suites, magnetic resonance imaging offices, dental offices, plastic surgery clinics and emergency rooms in the vast majority of the facilities in Nevada.

I have been a nurse for 40 years and a CRNA for 33 years, and I spent 15 years in the U.S. Army. During that time, I provided anesthesia care around the world for soldiers and their families. Like other CRNAs, I have covered many cases, including middle-of-the-night emergencies and the like. These are the types of circumstances we are trained for. During the COVID-19 pandemic, CRNAs were pressed into service in the ICUs because there was such a dire need.

The Association of Nurse Anesthetists has been around since the 1910s. We have been ardent supporters of safe anesthesia care. There are approximately 58,000 CRNAs in this Country. We provide approximately 60 percent of the anesthetics given on a daily basis in the U.S. I have also been part of a four-person CRNA group in Elko, where we provided anesthesia care around the clock for the entire facility.

Anesthesia providers are trained in pharmacology, pathology, physiology and anesthesia. One of the components of this bill is prescriptive authority. When you are called in at 3 a.m. to provide anesthesia care for a patient who will die if immediate measures are not taken, you do not have time to hunt down a physician to write orders for the medications you need. That is why we would like to have codified into law that we can use the types of medications we need on a daily basis. This is why we fully support A.B. 198.

I implore you to give these dedicated providers the tools they need to continue to provide safe and timely anesthesia care every day in this State.

SENATOR STONE:
Could you describe the relationship between CRNA, anesthesiologist and physician and the steps that have to be taken to put somebody on anesthesia? I assume CNRAs can recommend certain anesthesia. Is the provision of services collaborated with a physician?

MR. SAVIGNAC:
There are three different practice models. The medically directed model is where a physician tells a CRNA or other anesthesia provider how to conduct the anesthesia. The anesthesia care team model is where an anesthesiologist works with a cohort of CRNAs. The third model is the situation where CRNAs practice by themselves, which is what we primarily see in the rural areas.

Using an anesthetic involves a preoperative evaluation where you review the history, lab results and the patient's past experiences with anesthesia, if any. From that, you formulate a plan to provide anesthetic for that patient. The CRNA also manages the postoperative recovery as the patient comes back to consciousness.

SENATOR STONE:
Who officially writes the order for the anesthesia or pharmaceuticals?

MR. SAVIGNAC:
Typically, it is not so much one order as a whole plan. That plan includes preoperative medications, such as antiemetics to prevent vomiting and medications for pain. If the patient has breathing issues, they may include a breathing treatment. Whoever the anesthesia provider is for that patient that day would write those orders.

SENATOR STONE:
Is that based on a collaborative relationship with a physician? That is, have these orders been approved by a physician to be administered under certain cases?

MR. SAVIGNAC:
They are approved on an individual basis rather than being based on a case type. Some facilities do have order sets. For example, if a patient is a diabetic, there will be some types of medication you do not want to administer. You

might start with a standard order set and draw from that. Typically, the CRNA or the anesthesiologist will be the one to write the actual orders.

SENATOR STONE:
You have certainly demonstrated in your testimony that CRNAs are well trained. What are their limitations? Under what circumstances would an anesthesiologist need to step in because a CRNA was facing circumstances he or she was not prepared or trained to handle? Every anesthesia patient is different, and there is always the possibility that something can happen. There is also a certain percentage of people who do not make it out of anesthesia, whether physicians or CRNAs are providing the care.

MR. SAVIGNAC:
The limitations are more facility-based, in that some facilities will not allow CRNAs to perform certain procedures. Some of my friends who are CRNAs routinely provide anesthesia for the most demanding cases involving neurosurgery or cardiothoracic issues. Not every CRNA wants to do those, and it is not a requirement that you handle cases like that the day after you graduate. Many CRNAs do not want to do those cases because of the demands and the liability involved. For that matter, many anesthesiologists do not want to do those cases either. It is down to the experience and skill level of the individual CRNA.

SENATOR STONE:
Do Medicare and Medicaid put restrictions on what CRNAs can do or mandate they be overseen by anesthesiologists?

MR. SAVIGNAC:
I am not sure. I will have to get back to you.

One of the bones of contention with A.B. 198 is the idea that it would allow CRNAs to prescribe. We are not looking to prescribe medications outside of a healthcare facility. We are looking to use our expertise and knowledge to provide patients within a facility with the medications they need for a specific procedure. We need to be able to do this when we are working by ourselves in an isolated setting like Pahrump. If a patient comes in with significant medical problems that I need to look at, my experience tells me what medications I can and cannot use. If I have a question, I have somebody I can call.

SENATOR STONE:
There was some talk of an amendment regarding telehealth. Can you talk about that?

VICE CHAIR LANGE:
Counsel has advised us that the amendment is not germane to the bill, and it will not be considered.

SENATOR BUCK:
I am a little naive to the whole medical field. What is the education difference between an anesthesiologist and a CRNA?

MR. SAVIGNAC:
Typically, CRNAs are registered nurses to begin with, so we have four years of nursing school. Most CRNA programs require a minimum of two to four years of experience in critical care, which can be cardiothoracic coronary care, medical ICUs or surgical ICUs, where you are managing one critically ill patient with multiple medications. Before you even start the CRNA program, you have a base in pharmacology, monitoring and caring for critically ill patients.

When I was in the U.S. Army, I taught nurse anesthetists for four years. The Army program was 17 months of classroom work followed by clinical work: doing anesthesia in the operating room and learning airway and fluid line management.

An anesthesiologist starts with four years of undergraduate work in a hard science, four years of medical school, one year of internship and three years in anesthesia residency.

SENATOR BUCK:
Was your experience in the military different than it would be for a civilian?

MR. SAVIGNAC:
One difference is that military training emphasizes that from the day you graduate, you may well be on a battlefield caring for a critically ill soldier. Civilian programs do not tend to have that emphasis. Military CRNAs are a minority of the CRNAs that practice in this Country. Civilian CRNA training involves all of the things the Army training does. Graduation in both cases is contingent on the number of cases they have handled. There is a minimum

standard number of cases they are required to perform in order to graduate. This includes the amount of lines they place and the amount of different case types they perform, including thoracic, neurosurgery, cardiac, obstetric, epidurals, spinals and all the things we do on a daily basis.

Some facilities may not allow CRNAs to perform spinals or epidurals, and the CRNA goes into that job understanding that this is going to be a limitation of their practice.

SENATOR SCHEIBLE:
Here is what I am struggling with. The goal of this bill is to increase the number of providers available, especially in rural areas; however, I do not see how this bill will do that. The problem is clearly not that CRNAs are not allowed in the operating room or in the hospitals; it sounds like there are more CRNAs than doctors already. So I am not sure how this bill gets us more providers than we already have.

Secondly, I do not understand why the answer to the problem is to remove all supervision and allow CRNAs to operate independently instead of modifying that relationship so supervision can be done in a less prescriptive manner. Help me understand how this solves the problem and why this is the answer.

MS. HOOVER:
I will try to answer your question in small chunks. First, this bill does not remove or add any additional physician supervision.

Second, if I may give a little bit of history, a few years ago we were told who actually has jurisdiction over CRNAs. They are nurses first, yes, but they also have the ability to prescribe dangerous poisons and controlled substances. In the past, CRNAs worked under the U.S. Drug Enforcement Administration (DEA) number of either a hospital or a physician.

Some of the regulatory boards have asked whether CRNAs can actually prescribe and why is it part of their scope of practice, even though it is currently in the NAC and not in the NRS. We have been running into numerous issues across Nevada with healthcare facilities and hospitals telling CRNAs they can no longer practice within their scope. Instead, they are requiring that a physician with a DEA number write the order, after which the CRNA can do their job.

This bill alleviates that issue and puts the CRNA's full scope of practice into law. It is taken from the NAC almost word for word. It clarifies for both the State Board of Nursing and the State Board of Pharmacy who has jurisdiction over what and ensures that CRNAs are now part of that whole DEA process.

LANDON MOURITSEN, CRNA (Humboldt General Hospital):
I am the director of anesthesia services at Humboldt General Hospital in Winnemucca, which is a rural and underserved community where CRNAs have been the sole providers of anesthesia for almost 30 years. Without CRNAs, we would not have the ability to do emergency or preventative surgeries or provide medical services. People would have to travel hours to receive those services elsewhere.

We CRNAs do much more than that, though. We are the ones that the doctors in the community turn to when they encounter difficult airways, challenging vascular access and other emergencies. They rely on us because we are highly trained individuals who are experts at what we do. I have put breathing tubes in babies when others could not. I have provided pain relief to distressed mothers. I have helped save the lives of many of my fellow community members.

We spent years becoming nurses, years working as nurses and years in anesthesia school. I trained for ten years to become a CRNA. What we are asking for in this bill is not unreasonable or dangerous. It is what we were trained to do. I know of no other state that has restricted CRNA practice as much as Nevada. Research shows that anesthesia care provided by CRNAs is equally as safe as that provided by physician anesthesiologists. We are the ones in the operating room standing by the patient's side, making critical decisions for the vast majority of surgeries in the United States.

I am baffled that with the high level of training we have and the safe care we provide, we are not allowed to do what we have been trained to do. Nevada is in dire need of anesthesia services. We are here, we are qualified, and we want to serve. My kids, my wife and my community members deserve access to anesthesia care. Please help us provide that care in a manner that makes sense.

SARAH ADLER (Nevada Advanced Practice Nurses Association; American Association of Nurse Practitioners):
The groups I represent are in full support of A.B. 198.

In more than 40 states, CRNAs are recognized as advanced practice nurses. We are all acutely aware of Nevada's shortage of healthcare providers, and we are at risk of losing our newly trained CRNAs. As they complete the extensive training you have just heard about, they are going to choose to practice in some other state where they can use the full scope of their abilities.

How we got into the situation A.B. 198 is seeking to remedy is understandable. We are in a time and an environment that is looking at medical liability. It is understandable that licensing boards want absolute clarity on the authority of practitioners to do what they are proposing to do.

This bill is appropriate and necessary. I have worked in rural Nevada most of my career, and I know these hospitals. To think that people might have to go without care because they lack access to a highly trained anesthesia professional is something we do not want. We do not need to have it if we move forward with A.B. 198.

ALLISON LOFTON, CRNA:
I am a full-time nurse anesthetist at Carson Tahoe Hospital. I have been a CRNA for eight years, and I came here this morning from a 24-hour labor and delivery call shift. This means that for 24 hours, I was available to be called in day or night to perform epidurals and other anesthesia necessary for emergency C-sections.

Prior to becoming a CRNA, I was an ICU nurse for seven years. I have eight years of autonomous nurse anesthesia practice in Washington State and the U.S. territory of Guam. I particularly enjoyed providing epidurals and spinals for pregnant women, helping them through the painful hours of labor. I am taking more call shifts because we are distressingly short on CRNAs who are willing to provide labor and delivery care here in Nevada. We are trained and educated to perform specialized services, but we are not able to fulfill the scope of practice in Nevada.

This bill is a step in the right direction to rectify this shortage of anesthesia providers.

JENNIFER BROWN, CRNA:
I am the chief CRNA at Carson Tahoe Hospital. I have been a nurse for 20 years and a CRNA for 14 years. I hold licenses in Alaska, Maine and Hawaii, and I also hold a DEA license in Alaska.

I am reminded again and again that CRNAs are one of the best-kept secrets in health care. Many people have no idea that we even exist, yet nurses have been delivering anesthesia independently since before anesthesiology was a specialty of physicians.

Today, there are 44,000 CRNAs and 31,000 anesthesiologists practicing in the United States. That is 13,000 more CRNAs than anesthesiologists. At Carson Tahoe, our staff consists of ten CRNAs and three anesthesiologists. Studies have shown that CRNAs and physicians provide the same quality of anesthesia care. That is why in every state, anesthesia teams consist of a mix of CRNAs and physicians. In Nevada, our rural hospitals have only CRNAs. We cannot provide anesthesiologists in our rural communities because they are just not going there.

Sometimes, bills come up that are intended to fix the language of previous bills that were not perfectly written. This is one of those times. The purpose of this bill is to codify language and align Nevada laws. Everyone knows that we need more healthcare workers. This bill will fix confusing language that keeps providers away. If this bill does not pass, I, along with many CRNAs, will have to leave Nevada. Please pass A.B. 198.

JEFFREY METER, M.D. (Chief of Surgery, Humboldt General Hospital):
The CRNAs I work with are excellent, and I am always comfortable with their care. However, the way the law is written right now, I need to supervise the care and medications they give, and I do not have the training or experience that my CRNA partners have in giving those medications. To me, it is a bit insane that I should be supervising people outside of my expertise. We would need to hire two or three anesthesiologists to supervise the CRNAs around the clock, and that is just not possible.

I can foresee that if we do not change this, we would not be able to provide surgery in Winnemucca. If we cannot provide surgery, we will not have the revenue needed to keep the hospital open. One more critical access hospital

would disappear. Recruiting surgeons who are willing to supervise anesthesia care is going to be very difficult.

MR. OSBORN:
I am happy to support A.B. 198.

MATT ROBINSON (Carson Tahoe Health System):
We are here in support of A.B. 198. As we all look to address the healthcare provider shortage in Nevada, allowing these providers to practice to the fullest extent of their training is a great and easy-to-access tool. We urge your support of this important measure as we all work together to increase good patient outcomes.

MORGAN MCCARROLL (Chief of Anesthesiology, Carson Tahoe Hospital):
Our rural hospitals provide excellent care for rural Nevadans. When those patients need care beyond what the rural hospitals can provide, they often get transported to one of the city hospitals, like Carson Tahoe or Renown in Reno. These hospitals are more likely to have care team models or anesthesiologist models of care.

The point is that it is not necessarily a CRNA limitation that prevents CRNAs from practicing in rural environments. It is the individual hospital that is not able to take care of complicated cases. As the complexity of the case increases, patients are more likely to go to a more well-equipped facility.

Nurse anesthetists do a fantastic job. My experience with them started more than 25 years ago when I was in my residency. I worked side by side with CRNAs in New Jersey during the COVID-19 pandemic. There and in Elko, CRNAs played a critical role in managing COVID-19 patients in intensive care settings.

I believe strongly that A.B. 198 is in the best interests of nursing practice. I have had people tell me that the restrictions of practice in Nevada are preventing them from working in Nevada. Removing some of these restrictions will improve access to care in Nevada.

SHAINA RICHARDSON, M.D.:
I am opposed to A.B. 198. I am a practicing physician anesthesiologist, primarily in northern Nevada. I too am just coming off of a 24-hour shift. I apologize if I have to gather my words a few times. It is my third one this week.

First, let me point out that there is no independent practice of CRNAs in Nevada. This is per federal guidelines. Title 42 of the *Code of Federal Regulations* (CFR) states that CRNAs need to practice under the supervision of a physician unless the state has opted out. Nevada is not one of the few states that opts out of that requirement. The vast majority of the anesthetics provided in the U.S. are done under the team care model and supervised by a physician.

A question was asked about the level of education. No one doubts the amazing work experience that anesthesia providers of all types get while working. However, there is a significant difference in the level of education. A physician receives two to three times the education of a nurse anesthetist. I received 13 years of higher education, which included science, research, critical care and pharmacology. This is the foundation upon which our experience is built and evolves.

I do not want to discount the amazing services provided by anesthesiologist assistants and CRNAs in the care team model. At the same time, providing that care under the direction of a physician is the safest way to provide anesthesia. This has been shown in multiple studies that were not industry-funded. The largest of these studies was one that looked at over 25 million anesthetics and found that when a physician was specifically involved in the care and delivery of that anesthesia, there was a better outcome in 2.5 per 1,000 complicated cases. That is not an insignificant number We provide a service that is extremely safe because we have gotten so good over the years at providing safe anesthesia care. If we can save 2.5 more patients per 1,000 complicated cases by having a physician involved, that is something that we deserve. And I do not believe that those in rural Nevada deserve any less care than those in the cities.

I appreciate the passionate testimony given by everybody here. We all have lots of stories to tell about intubating babies and crashing C-sections. But I oppose this amendment because Nevadans deserve to have the safest care possible.

SUSAN FISHER (State Board of Osteopathic Medicine; Nevada State Society of Anesthesiologists; Nevada Orthopaedic Society):
The three groups I represent are all opposed to A.B. 198. The federal code that was referenced by Dr. Richardson is Title 42 CFR 482.52 (Exhibit C). We also have submitted one letter of opposition (Exhibit D) from the American Medical Association (AMA) and another letter of opposition (Exhibit E) from the American Society of Anesthesiologists.

The AMA strongly supports a physician-led care team with all members of the team working together to ensure patients receive the full spectrum of high-quality care. However, A.B. 198 effectively removes physicians from managing key aspects of patient care. The AMA believes A.B. 198 is not the right approach to expanding access to care and may have devastating effects on patient safety. A recent study published in the *Journal of Internal Medicine* compared the prescribing patterns of physicians to nurse practitioners and physician assistants. The study found that nonphysicians are more likely to prescribe opioids compared to physicians. In fact, 6.3 percent of nurse practitioners and 8.4 percent of physician assistants prescribed opioids to more than 50 percent of their patients, compared to just 1.3 percent of physicians. Nurse practitioners are 20 times more likely to overprescribe opioids than those in prescription-restricted states.

We know that CRNAs are highly trained physician extenders, as are physician assistants. However, in this Legislative Session, we have seen quite a bit of scope creep attempting to remove the physician from the physician assistant model and now removing the physician from the CRNA anesthesia delivery model.

We are adamantly opposed to this bill.

MS. NAKASHIMA NIELSEN:
We want to echo the importance of CRNAs across Nevada in a comprehensive care team. However, we want to call attention to a few concerns in the measure. The NAC section the presenters are referring to, which is NAC 449.388, still requires physician supervision. We believe this bill goes beyond codifying the existing code.

The bill is written as though the patient being under the care of a physician and the supervision requirement of a CRNA are two different things. Subsection 2,

paragraph (d) of the NAC specifically states that anesthesia may be offered by a CRNA "who is under the direction of the operating practitioner or of an anesthesiologist who is immediately available if needed."

As to the 44 states mentioned earlier, CNRAs may have prescriptive authority, but they do not have independent practice. That is where we have concerns with this measure.

JERRY MATSUMURA, M.D.:
I am calling in to testify in opposition to A.B. 198. I am a board-certified anesthesiologist.

I echo the testimony of previous speakers, but I would like to add to the discussion about education. Ms. Hoover stated that CNRAs get 9,369 hours of training. Mr. Savignac confirmed that a lot of that is two to four years of critical care nursing. While that is certainly important experience and highly educational, it is not anesthesia experience. Anesthesiologists have a bachelor's degree in a hard science; four years of medical school, the last two years of which are clinical, which amounts to about 6,000 hours; and four years of anesthesia residency, which amounts to about 20,000 hours. That is quite a difference in education.

I would also like to agree with Senator Scheible's point that A.B. 198 will not add providers to the rural areas. It just expands the scope of practice of one category of provider. I have previously given testimony to the Legislature that we do have a shortage of anesthesia providers in Nevada. However, changing State regulations and statutes to provide a lower standard of care will not fix the problem.

ELLIOT MALIN (Nevada Osteopathic Medical Association):
We are in opposition and echo the statements made by previous speakers.

MICHAEL HILLERBY (State Board of Nursing; State Board of Pharmacy):
At the risk of further muddying the waters, I will do my best to answer questions about this bill. The decision on the scope of practice of any provider is yours to make, and the two boards I represent take no position on that.

It should be noted that there is some confusion regarding the NAC section quoted earlier. In addition to NAC 449.388, there is similar language in

NAC 632.500. These sections have language that is similar but not identical, and the two sections need to be reconciled. The second section cited says nothing about supervision, for example. Some of these regulations date back to 1969. Some clarification will be helpful for the boards, especially considering those regulations that use the words "select," "order" and "administer."

If you want CRNAs to be included in the Board of Pharmacy's list of practitioners who can prescribe, possess and administer, you may want to put that in NRS 453 and NRS 454 to make it clear, particularly the prescription part. That would clarify things and be very helpful.

You will also need to take a look at S.B. 336, which covers some of these same issues. Some clarification would certainly be helpful for the two boards so that we can enact a clear policy as determined by the Legislature.

SENATE BILL 336 (1st Reprint): Revises provisions relating to the regulation of certain healing arts. (BDR 54-886)

SENATOR BUCK:
For the record, this bill is not asking for CRNAs to practice independently. Is that correct?

MR. HILLERBY:
I do not believe that is the boards' interpretation. A CRNA works with a patient who is under the care of a physician, podiatric physician or dentist. The question is what level of discretion the CRNA has. An amendment may be presented on the bill in the Assembly side that will say, "under supervision." It is not independent practice; they are not initiating the care of a patient starting from scratch the way an advanced practice registered nurse or physician might do. It still has to be done in the appropriate setting and with a patient who is under the care of one of those two types of physicians or a dentist. I rely on the Committee's counsel to provide any clarification.

BRYAN FERNLEY (Counsel):
As Mr. Hillerby mentioned, the bill does require the patient to be under the care of a licensed physician, podiatric physician or dentist. What exactly that means in particular settings is left to the licensing boards to define.

VICE CHAIR LANGE:
Which boards would be interpreting this?

MR. HILLERBY:
The scope-of-practice issues would be decided by the State Board of Nursing. The issues regarding access to drugs and how those can be possessed and administered would be with the State Board of Pharmacy. Those boards are willing to work together to update any of their regulations.

YVETTE WILLIAMS (Clark County Black Caucus):
We are neutral on A.B. 198.

SENATOR BUCK:
It sounds like "under the care of a physician" means something other than "supervision of a CRNA." Could you describe both?

ASSEMBLYMAN ORENTLICHER:
As Mr. Fernley indicated, the language is under NRS 632.014, the nursing statute. This section states the CRNA may practice under the care of a licensed physician or other provider. Assembly Bill 198 uses the current statutory language.

MS. HOOVER:
We included the provision that the patient must be under the care of a licensed physician, dentist and so on because facilities across Nevada work in different care teams, as previously mentioned. This allows for CRNAs who are not working in tandem with an anesthesiologist per se, especially in the rural areas, and also for CRNAs who work in a direct care model team in the urban areas.

MR. SAVIGNAC:
I would like to refute the statement from a previous speaker that CRNAs deliver a lesser standard of care. That is both insulting and incorrect. I have provided anesthesia care to anesthesiologists, surgeons, CRNAs, their families, generals, admirals, corporals, sergeants and captains, and they were all provided the same level of high-quality care with the same high-quality outcome.

MS. HOOVER:
I appreciate Mr. Hillerby coming forward. This bill does not seek independent practice for CRNAs. It is simply intended to clarify the language regarding the

CRNA's scope of practice. We all know that health care and healthcare policy can be muddy and confusing with a lot of weird word choices. We are not seeking to change the regulations or opt out. That is not what we want, and it muddies the water on this conversation.

It should be noted that UNLV's School of Medicine is going to be starting a CRNA school, the first one in Nevada. Without A.B. 198, there is no point in having such a school. We want to be able to tell those students that Nevada truly cares about CRNAs and allows them to practice within their scope.

ASSEMBLYMAN ORENTLICHER:
Passing this law will help us attract and retain CRNAs. I spent six and a half years at the AMA dealing with ethical and legal affairs. While I am proud of a lot of things the AMA did, when it comes to scope-of-authority issues the AMA has a history of erring too much on the side of limiting the authority of competitors under the guise of safety concerns. It defended a lot of lawsuits under Federal Trade Commission orders. Sometimes we err on the side of preventing legitimate competition by alternative providers. I hope we do not do that with this bill.

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VICE CHAIR LANGE:
I will close the hearing on A.B. 198. Is there any public comment? Hearing none, we are adjourned at 9:36 a.m.

RESPECTFULLY SUBMITTED:

Lynn Hendricks,
Committee Secretary

APPROVED BY:

Senator Roberta Lange, Vice Chair

DATE:

EXHIBIT SUMMARY				
Bill	**Exhibit Letter**	**Introduced on Minute Report Page No.**	**Witness / Entity**	**Description**
	A	1		Agenda
	B	1		Attendance Roster
A.B. 198	C	17	Susan Fisher	Title 42 CFR section 482.52
A.B. 198	D	17	Susan Fisher / American Medical Association	Letter of Opposition from James Madara
A.B. 198	E	17	Susan Fisher / American Society of Anesthesiologists	Letter of Opposition from Michael Champeau