AGENDA ITEM 11(e)

Review of Public Comments on, and Possible Adoption of, Proposed Amendment to NAC Chapter 630 as Contained in LCB File No. R069-23

PROPOSED REGULATION

PROPOSED REGULATION OF

THE BOARD OF MEDICAL EXAMINERS

LCB File No. R069-23

January 10, 2024

EXPLANATION – Matter in *italics* is new; matter in brackets [~~omitted material~~] is material to be omitted.

AUTHORITY: §§ 1-3, 6-10, 16-31, 33-36 and 38-41, NRS 630.130 and section 10 of Assembly Bill No. 270, chapter 247, Statutes of Nevada 2023, at page 1548; § 4, NRS 630.130 and 630.268, as amended by section 31 of Assembly Bill No. 270, chapter 247, Statutes of Nevada 2023, at page 1557, and section 10 of Assembly Bill No. 270, chapter 247, Statutes of Nevada 2023, at page 1548; § 5, NRS 622.530, 630.130 and 630.268, as amended by section 31 of Assembly Bill No. 270, chapter 247, Statutes of Nevada 2023, at page 1557, and section 10 of Assembly Bill No. 270, chapter 247, Statutes of Nevada 2023, at page 1548; § 11, NRS 630.130, 630.253, as amended by section 30 of Assembly Bill No. 270, chapter 247, Statutes of Nevada 2023, at page 1554, and NRS 630.268, as amended by section 31 of Assembly Bill No. 270, chapter 247, Statutes of Nevada 2023, at page 1557, and section 10 of Assembly Bill No. 270, chapter 247, Statutes of Nevada 2023, at page 1548; §§ 12-15, NRS 630.130 and 630.253, as amended by section 30 of Assembly Bill No. 270, chapter 247, Statutes of Nevada 2023, at page 1554, and section 10 of Assembly Bill No. 270, chapter 247, Statutes of Nevada 2023, at page 1548; § 32, NRS 630.130 and 630.275; § 37, NRS 630.130 and 630.298 and section 10 of Assembly Bill No. 270, chapter 247, Statutes of Nevada 2023, at page 1548.

A REGULATION relating to health care; prescribing requirements governing the issuance, renewal or change of status of a license as an anesthesiologist assistant; authorizing a student in a training program for anesthesiologist assistants to engage in certain supervised activity; prescribing requirements governing the practice and supervision of anesthesiologist assistants; setting forth grounds for disciplinary action against an anesthesiologist assistant; establishing certain procedures for the imposition of such disciplinary action; authorizing the Board of Medical Examiners to order the examination of an anesthesiologist assistant under certain circumstances; providing for the automatic suspension of the license of an anesthesiologist assistant under certain circumstances; authorizing an anesthesiologist assistant or a physician assistant whose practice has been limited or whose license has been suspended to petition for the removal of the limitation or suspension; providing for the appointment of an advisory committee concerning anesthesiologist assistants; prohibiting a physician from failing to adequately supervise an anesthesiologist assistant; providing for the confidentiality

of certain information relating to an anesthesiologist assistant; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law provides for the licensure and regulation of physicians, physician assistants, perfusionists, practitioners of respiratory care and anesthesiologist assistants by the Board of Medical Examiners. (Chapter 630 of NRS) Assembly Bill No. 270 (A.B. 270) of the 2023 Legislative Session similarly provides for the licensure of anesthesiologist assistants and requires the Board to adopt regulations establishing the requirements for such licensure. (Sections 2-39 of Assembly Bill No. 270, chapter 247, Statutes of Nevada 2023, at pages 1545-1562)

A.B. 270 prescribes certain qualifications for licensure as an anesthesiologist assistant. (Section 8 of Assembly Bill No. 270, chapter 247, Statutes of Nevada 2023, at page 1547) **Section 3** of this regulation prescribes the qualifications for licensure as an anesthesiologist assistant, in addition to the qualifications required by A.B. 270. **Section 4** of this regulation establishes the required contents of an application for such licensure. **Section 5** of this regulation establishes the requirements and procedure for licensure by endorsement as an anesthesiologist assistant. **Section 6** of this regulation establishes grounds for the rejection of an application for the issuance or renewal of a license. **Section 7** of this regulation authorizes the Board to deny an application for the issuance or renewal of a license if the applicant has committed any act that would constitute grounds for disciplinary action against a person who is already licensed as an anesthesiologist assistant. **Section 8** of this regulation: (1) sets forth the qualifications required for temporary licensure as an anesthesiologist assistant; and (2) requires the holder of a temporary license to wear an identifying name badge. **Section 9** of this regulation sets forth the required contents of a license as an anesthesiologist assistant. **Section 10** of this regulation requires an anesthesiologist assistant to provide to the Board before practicing as an anesthesiologist assistant: (1) a physical, public address, which may be a location of practice of the anesthesiologist assistant; and (2) a mailing address at which he or she prefers to receive correspondence from the Board.

A.B. 270 requires the Board to prescribe by regulation requirements governing the continuing education that an anesthesiologist assistant must complete to renew his or her license. (NRS 630.253, as amended by section 30 of Assembly Bill No. 270, chapter 247, Statutes of Nevada 2023, at page 1554) **Section 11** of this regulation prescribes such requirements and sets forth certain procedures concerning the renewal of a license. **Section 12** of this regulation authorizes the Board to issue credit toward the required continuing education to an anesthesiologist assistant who performs a medical review for the Board. **Section 13** of this regulation requires an anesthesiologist assistant to complete a course of instruction relating to the medical consequences of an act of terrorism that involves the use of a weapon of mass destruction. **Section 14** of this regulation requires an anesthesiologist assistant to complete a single course of instruction relating to the screening, brief intervention and referral to treatment approach to substance use disorder. **Section 15** of this regulation entitles an anesthesiologist assistant who takes a continuing education course in certain matters relating to older persons to receive credit towards the continuing education required by **section 11** equal to twice the number of hours the anesthesiologist assistant spends in the course.

Section 16 of this regulation prescribes: (1) the authorized activities of a student in a training program for anesthesiologist assistants; and (2) the requirements governing the supervision and identification of such a student. **Section 17** of this regulation prescribes

requirements and limitations governing the scope of practice of an anesthesiologist assistant. **Section 18** of this regulation prescribes requirements governing the utilization of an anesthesiologist assistant by a supervising anesthesiologist. **Section 19** of this regulation requires at least one supervising anesthesiologist to conduct a biennial performance assessment of each anesthesiologist assistant. **Section 36** of this regulation prohibits a physician from failing to adequately supervise an anesthesiologist assistant.

Section 20 of this regulation prescribes standards of conduct for anesthesiologist assistants. **Section 21** of this regulation authorizes an anesthesiologist assistant to administer general anesthesia, conscious sedation, deep sedation, a regional anesthesia block or neuraxial anesthesia to patients only under certain circumstances. **Section 22** of this regulation requires an anesthesiologist assistant to make a note in the records of each patient concerning the services provided to the patient. **Section 31** of this regulation requires an anesthesiologist who is primarily responsible for the care of a patient after the patient is transferred from one anesthesiologist to another, or one anesthesiologist assistant or certified registered nurse anesthetist to another, to ensure that the transfer is clearly indicated in the medical records of the patient. **Section 2** of this regulation defines the term "certified registered nurse anesthetist," and **section 33** of this regulation makes a conforming change to indicate the proper placement of **section 2** in the Nevada Administrative Code.

Section 23 of this regulation prohibits certain actions by an anesthesiologist assistant. **Section 24** of this regulation sets forth grounds for disciplinary action by the Board against an anesthesiologist assistant, which include malpractice, and the procedure for initiating such disciplinary action. **Section 34** of this regulation includes within the definition of "malpractice" the failure of an anesthesiologist assistant, in treating a patient, to use the reasonable care, skill or knowledge ordinarily used under similar circumstances. **Section 25** of this regulation requires the Board to serve notice on an anesthesiologist assistant and his or her supervising anesthesiologist at least 21 days before a hearing relating to any disciplinary action. **Section 25** also provides that any investigation and subsequent disciplinary proceedings will be conducted in the same manner as provided by existing law for disciplinary actions against other licensees. **Section 29** of this regulation requires the Board to also deliver a copy to the supervising anesthesiologist of any letter of warning, letter of concern or nonpunitive admonishment issued to an anesthesiologist assistant.

Section 26 of this regulation authorizes the Board or an investigative committee thereof to order an anesthesiologist assistant to undergo a mental or physical examination or another examination testing his or her competence to practice if the conduct of the anesthesiologist assistant raises a reasonable question as to his or her competence to practice with reasonable skill and safety to patients. **Section 26** provides that, except in extraordinary circumstances, a refusal to submit to such an examination constitutes an admission of the charges against the anesthesiologist assistant.

Section 27 of this regulation provides for the automatic suspension of the license of an anesthesiologist assistant if he or she loses certification by the National Commission for Certification of Anesthesiologist Assistants or its successor organization.

Existing law: (1) authorizes a physician, perfusionist or practitioner of respiratory care whose practice has been limited or whose license has been suspended or revoked to petition the Board for removal of the limitation, suspension or revocation; and (2) sets forth procedures for the consideration of such a petition. (NRS 630.358) **Sections 28 and 32** of this regulation enact

similar provisions applicable to the limitation of the practice of or suspension of the license of anesthesiologist assistants and physician assistants, respectively.

Existing regulations provide for the appointment of advisory committees to advise the Board on matters relating to physician assistants, practitioners of respiratory care and perfusionists. (NAC 630.415, 630.560, 630.790) **Section 30** of this regulation provides for the appointment of a similar advisory committee to advise the Board on matters relating to anesthesiologist assistants.

Existing regulations require an original signature or authenticated electronic signature on certain documents submitted to the Board by licensees or applicants for any license to practice medicine or to practice as a physician assistant, practitioner of respiratory care or perfusionist. (NAC 630.045) Existing regulations prescribe procedures for the voluntary surrender of a license to practice medicine, perfusion or respiratory care while an investigation concerning the license or disciplinary proceedings concerning the licensee are pending. (NAC 630.240) Existing regulations require a committee conducting an investigation of a complaint against a physician, physician assistant, practitioner of respiratory care or perfusionist to appoint a group of specialists to review the practice of the licensee and make certain recommendations if the committee finds that the licensee tests positive for exposure to the human immunodeficiency virus. (NAC 630.243) Existing regulations require the Board to keep confidential certain records relating to a program established by the Board to enable a physician, physician assistant, practitioner of respiratory care or perfusionist to correct a dependence on alcohol or a controlled substance or certain other impairments. (NAC 630.275) Existing regulations prescribe procedures concerning prehearing conferences in proceedings relating to physicians, physician assistants, practitioners of respiratory care and perfusionists. (NAC 630.465) Existing regulations prescribe the criteria and procedure for placing a license to practice medicine, perfusion or respiratory care on retired status. (Section 1 of LCB File No. R118-21) **Sections 35 and 37-41** of this regulation make these provisions additionally applicable to anesthesiologist assistants.

Section 1. Chapter 630 of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 32, inclusive, of this regulation.

Sec. 2. ***"Certified registered nurse anesthetist" has the meaning ascribed to it in NRS 632.014, as amended by section 2.8 of Senate Bill No. 336, chapter 229, Statutes of Nevada 2023, at page 1445.***

Sec. 3. ***1. In addition to the qualifications required by section 8 of Assembly Bill No. 270, chapter 247, Statutes of Nevada 2023, at page 1547, an applicant for licensure as an anesthesiologist assistant must have the following qualifications:***

(a) Be able to communicate adequately orally and in writing in the English language.

(b) Be of good moral character and reputation.

(c) If the applicant submits the application at least 24 months after the applicant initially obtained the certification described in paragraph (c) of subsection 1 of section 8 of Assembly Bill No. 270, chapter 247, Statutes of Nevada 2023, at page 1547, and the applicant has not practiced as an anesthesiologist assistant for at least 24 months before the date on which the application is submitted, the applicant must, at the order of the Board:

(1) Take and pass a competency examination or other assessment designated by the Board; or

(2) Except as otherwise provided in subsection 2:

(I) Successfully complete a re-entry program approved by the Board; or

(II) Take and pass a competency examination or other assessment designated by the Board and successfully complete a re-entry program approved by the Board.

2. The Board will not require an applicant subject to the provisions of paragraph (c) of subsection 1 who successfully completed a re-entry program approved by the Board within the 24 months immediately preceding the date on which the application is submitted to complete another re-entry program.

Sec. 4. *1. An application for licensure as an anesthesiologist assistant must be made on a form supplied by the Board. The application must state:*

(a) The date and place of the applicant's birth and his or her sex;

(b) Information about the applicant's postsecondary education as an anesthesiologist assistant, including, without limitation, postsecondary institutions attended, the length of time in attendance at each institution and whether he or she is a graduate of those institutions;

(c) Whether the applicant has ever applied for a license or certificate as an anesthesiologist assistant in another state and, if so, when and where and the results of his or her application;

(d) The applicant's work experience for the 5 years immediately preceding the date of his or her application;

(e) Whether the applicant has ever been investigated for misconduct as an anesthesiologist assistant or had a license or certificate as an anesthesiologist assistant revoked, modified, limited or suspended or whether any disciplinary action or proceedings have ever been instituted against the applicant by a licensing body in any jurisdiction;

(f) Whether the applicant has ever been arrested for, investigated for, charged with, convicted of or pled guilty or nolo contendere to:

(1) Any offense or violation of any federal, state or local law, including, without limitation, the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony or similar offense in a foreign jurisdiction, excluding any minor traffic offense; or

(2) Any violation of the Uniform Code of Military Justice;

(g) Whether the applicant has ever been arrested for, investigated for, charged with, convicted of or pled guilty or nolo contendere to any offense which is related to the manufacture, distribution, prescribing or dispensing of controlled substances;

(h) Whether the applicant has a medical condition that may affect his or her ability to safely practice as an anesthesiologist assistant;

(i) Whether the applicant uses prescription drugs or other substances that may affect his or her ability to safely practice as an anesthesiologist assistant; and

(j) The various places of his or her residence for the 5 years immediately preceding the date of his or her application.

2. An applicant must submit to the Board:

(a) Proof of graduation from an anesthesiologist assistant program described in paragraph (a) of subsection 1 of section 8 of Assembly Bill No. 270, chapter 247, Statutes of Nevada 2023, at page 1547;

(b) Proof of passage of a certification examination administered by the National Commission for Certification of Anesthesiologist Assistants or its successor organization;

(c) Proof of certification issued by the National Commission for Certification of Anesthesiologist Assistants or its successor organization; and

(d) Such further evidence and other documents or proof of qualifications as required by the Board.

3. Each application must be signed by the applicant and accompanied by a signed affidavit indicating that:

(a) The applicant is the person named in the proof of graduation from an anesthesiologist assistant program as required by subsection 2;

(b) The proof of graduation from an anesthesiologist assistant program required by subsection 2 was obtained without fraud or misrepresentation or any mistake of which the applicant is aware; and

(c) All the information contained in the application and any accompanying material is complete and correct.

4. The application must be accompanied by the applicable fee.

5. An applicant shall pay the reasonable costs of any examination required for licensure.

Sec. 5. ***1. An application for licensure by endorsement as an anesthesiologist assistant must be made on a form supplied by the Board. An application must include:***

(a) All information required by section 4 of this regulation;

(b) Proof that the applicant meets the requirements of paragraphs (a) to (e), inclusive, of subsection 2 of NRS 622.530; and

(c) The documents described in paragraphs (g) and (h) of subsection 2 of NRS 622.530.

2. Unless the Board denies the application for good cause, the Board will approve the application and issue a license by endorsement to practice as an anesthesiologist assistant to the applicant within the time required by subsection 4 of NRS 622.530.

3. A license by endorsement to practice as an anesthesiologist assistant issued pursuant to this section may be issued at a meeting of the Board or outside a meeting of Board by the President of the Board and the Executive Director of the Board. If the license is issued outside a meeting of the Board pursuant to this subsection, such an action shall be deemed to be an action of the Board.

4. In addition to the grounds set forth in this chapter and chapter 630 of NRS, the Board may deny an application for licensure by endorsement pursuant to this section:

(a) If the applicant does not meet the requirements of paragraphs (a) to (e), inclusive, of subsection 2 of NRS 622.530; or

(b) For the reasons set forth in subsection 6 of NRS 622.530.

5. If an applicant seeking licensure by endorsement pursuant to this section is an active member of or the surviving spouse of an active member of the Armed Forces of the United States, a veteran or the surviving spouse of a veteran, the Board will charge not more than one-half of the fee established pursuant to NRS 630.268, as amended by section 31 of Assembly Bill No. 270, chapter 247, Statutes of Nevada 2023, at page 1557, for the initial issuance of the license.

Sec. 6. ***The Board may reject an application for licensure as an anesthesiologist assistant if the Board determines that:***

1. The applicant is not qualified or is not of good moral character or reputation;

2. The applicant has submitted a false credential; or

3. The application is not made in proper form or is otherwise deficient.

Sec. 7. ***The Board may deny an application for the issuance or renewal of a license to practice as an anesthesiologist assistant if the applicant has committed any of the acts described in subsection 1 of section 24 of this regulation.***

Sec. 8. ***1. The Board will issue a temporary license as an anesthesiologist assistant to any qualified applicant who:***

(a) Meets the requirements of subsections 1 and 2 of section 9 of Assembly Bill No. 270, chapter 247, Statutes of Nevada 2023, at page 1548; and

(b) Pursuant to subsection 3 of section 9 of Assembly Bill No. 270, chapter 247, Statutes of Nevada 2023, at page 1548, submits proof of registration for a certification examination required by paragraph (b) of subsection 1 of section 8 of Assembly Bill No. 270, chapter 247, Statutes of Nevada 2023, at page 1547.

2. The holder of a temporary license shall wear at all times while on duty a name badge that identifies the holder as a "Graduate Anesthesiologist Assistant" or "Anesthesiologist Assistant Graduate."

3. The holder of a temporary license may apply to the Board to renew the temporary license in the same manner as the original application. The Board may, upon the applicant's compliance with the provisions of this section and subsection 3 of section 9 of Assembly Bill No. 270, chapter 247, Statutes of Nevada 2023, at page 1548, renew the temporary license

once for a period of 1 additional year. A temporary license may not be renewed more than once.

Sec. 9. ***The license issued by the Board to an anesthesiologist assistant must contain:***

1. The name of the anesthesiologist assistant;

2. The duration of the license; and

3. Any other limitations or requirements which the Board prescribes.

Sec. 10. ***1. Before practicing as an anesthesiologist assistant, an anesthesiologist assistant shall provide to the Board:***

(a) A physical, public address, which may be a location of practice of the anesthesiologist assistant; and

(b) A mailing address at which the anesthesiologist assistant prefers to receive correspondence from the Board.

2. Within 30 days after any change to the information provided to the Board pursuant to subsection 1, an anesthesiologist assistant shall provide updated information to the Board.

Sec. 11. ***1. The license of an anesthesiologist assistant must be renewed on or before June 30 or, if June 30 is a Saturday, Sunday or legal holiday, the next business day after June 30, of each odd-numbered year. The Board will not renew the license unless the anesthesiologist assistant provides satisfactory proof:***

(a) Of current certification issued by the National Commission for Certification of Anesthesiologist Assistants or its successor organization; and

(b) That he or she has completed the amount of continuing education required by subsection 2, which, except for credit issued pursuant to section 12 of this regulation, must be:

(1) Approved by the Board; or

(2) Recognized as Category 1 credits by the American Medical Association.

2. The following hours of continuing education are required to renew a license to practice as an anesthesiologist assistant:

(a) If licensed during the first 6 months of the biennial licensing period, 40 hours.

(b) If licensed during the second 6 months of the biennial licensing period, 30 hours.

(c) If licensed during the third 6 months of the biennial licensing period, 20 hours.

(d) If licensed during the fourth 6 months of the biennial licensing period, 10 hours.

3. To allow for the renewal of a license to practice as an anesthesiologist assistant by each person to whom a license was issued or renewed in the preceding biennial licensing period, the Board will make such reasonable attempts as are practicable to send:

(a) A renewal notice to the licensee at least 60 days before the expiration of the license; and

(b) Instructions for renewal to the last known electronic mail address of the licensee on record with the Board.

4. If a licensee fails to pay the fee for renewal after it becomes due or fails to submit proof that the licensee completed the number of hours of continuing education required by subsections 1 and 2, his or her license expires. Within 2 years after the date on which the license expires, the license may be reinstated if the holder:

(a) Pays twice the amount of the current fee for renewal to the Secretary-Treasurer of the Board;

(b) Submits proof that he or she completed the number of hours of continuing education required by subsections 1 and 2; and

(c) Is found to be in good standing and qualified pursuant to this chapter.

Sec. 12. ***The Board may issue not more than 10 hours of continuing education during a biennial licensing period to an anesthesiologist assistant who performs a medical review for the Board. The hours issued by the Board:***

1. May be credited against the hours of continuing education required for a biennial licensing period by section 11 of this regulation;

2. Except as otherwise provided in subsection 3, must be equal to the actual time involved in performing the medical review; and

3. May not exceed 10 hours per medical review.

Sec. 13. ***1. Pursuant to the provisions of NRS 630.253, as amended by section 30 of Assembly Bill No. 270, chapter 247, Statutes of Nevada 2023, at page 1554, an anesthesiologist assistant shall complete, within 2 years after initial licensure, a course of instruction relating to the medical consequences of an act of terrorism that involves the use of a weapon of mass destruction.***

2. In addition to the requirements set forth in NRS 630.253, as amended by section 30 of Assembly Bill No. 270, chapter 247, Statutes of Nevada 2023, at page 1554, a course of instruction relating to the medical consequences of an act of terrorism that involves the use of a weapon of mass destruction:

(a) Except as otherwise provided in subsection 3, must offer to the anesthesiologist assistant, upon successful completion of the course, a certificate of Category 1 credit as recognized by the American Medical Association; and

(b) Is in addition to the continuing education required by section 11 of this regulation.

3. A course of instruction relating to the medical consequences of an act of terrorism that involves the use of a weapon of mass destruction will be deemed to satisfy the requirements of paragraph (a) of subsection 2 if the course was provided to an anesthesiologist assistant:

(a) After January 1, 2002; and

(b) As a part of the training the anesthesiologist assistant received while serving:

(1) In the military; or

(2) As a public health officer.

Sec. 14. ***1. Pursuant to NRS 630.253, as amended by section 30 of Assembly Bill No. 270, chapter 247, Statutes of Nevada 2023, at page 1554, an anesthesiologist assistant shall complete at least 2 hours of training in the screening, brief intervention and referral to treatment approach to substance use disorder within 2 years after initial licensure.***

2. An anesthesiologist assistant is entitled to receive credit towards the continuing education required pursuant to subsection 2 of section 11 of this regulation for each hour of continuing education completed pursuant to subsection 1.

Sec. 15. ***1. Except as otherwise provided in subsections 3 and 4, if an anesthesiologist assistant takes a continuing education course on geriatrics and gerontology, the anesthesiologist assistant is entitled to receive credit towards the continuing education required by section 11 of this regulation equal to twice the number of hours the anesthesiologist assistant actually spends in the continuing education course on geriatrics and gerontology.***

2. Except as otherwise provided in subsections 3 and 4, if an anesthesiologist assistant takes a continuing education course on the recent developments, research and treatment of Alzheimer's disease or other forms of dementia, the anesthesiologist assistant is entitled to

receive credit towards the continuing education required by section 11 of this regulation equal to twice the number of hours the anesthesiologist assistant actually spends in the continuing education course on the recent developments, research and treatment of Alzheimer's disease or other forms of dementia.

3. During any biennial licensing period, an anesthesiologist assistant may receive a maximum credit pursuant to this section of 8 hours of continuing education for 4 hours of time spent in a continuing education course described in subsection 1 or 2, or both.

4. An anesthesiologist assistant is only entitled to receive the additional credit for a continuing education course pursuant to subsection 1 or 2, but not both.

Sec. 16. ***1. A student in a training program for anesthesiologist assistants:***

(a) May assist an anesthesiologist in the practice of medicine;

(b) May perform medical tasks delegated by such an anesthesiologist; and

(c) Shall not assist any person other than an anesthesiologist in the practice of medicine or perform medical tasks delegated by a person who is not an anesthesiologist.

2. An anesthesiologist may delegate the supervision of a student in a training program for anesthesiologist assistants only to a provider of anesthesia.

3. A student in a training program for anesthesiologist assistants shall wear at all times while on duty a name badge that identifies the student as a "Student Anesthesiologist Assistant" or "Anesthesiologist Assistant Student."

4. Nothing in this section limits the number of otherwise qualified providers of anesthesia whom an anesthesiologist may supervise.

5. As used in this section, "provider of anesthesia" means:

(a) An anesthesiologist;

(b) An anesthesiology fellow;

(c) An anesthesiology resident;

(d) An anesthesiologist assistant; or

(e) A certified registered nurse anesthetist determined by a supervising anesthesiologist to have received adequate clinical training in anesthesiology.

Sec. 17. *1. The tasks which an anesthesiologist assistant is authorized to perform must be commensurate with the education, training, experience and level of competence of the anesthesiologist assistant. An anesthesiologist assistant may not perform any tasks in the care of a patient that are outside the scope of practice of his or her supervising anesthesiologist. In addition to the activities authorized by section 7 of Assembly Bill No. 270, chapter 247, Statutes of Nevada 2023, at page 1546, a supervising anesthesiologist may authorize an anesthesiologist assistant to participate in administrative activities and clinical teaching activities if those activities are within the education, training, experience and level of competence of the anesthesiologist assistant.*

2. An anesthesiologist assistant shall wear at all times while on duty a placard, plate or insigne which identifies him or her as an "Anesthesiologist Assistant" or "Certified Anesthesiologist Assistant."

3. An anesthesiologist assistant shall not represent himself or herself in any manner which would tend to mislead the general public, the patients of the supervising anesthesiologist or other health professionals as to the training, skills, scope of practice or professional designation of the anesthesiologist assistant.

4. An anesthesiologist assistant shall comply with the regulations of the State Board of Pharmacy regarding controlled substances, poisons, dangerous drugs and devices.

5. An anesthesiologist assistant shall be deemed the agent of his or her supervising anesthesiologist with regard to tasks that the supervising anesthesiologist has delegated to the anesthesiologist assistant.

6. An anesthesiologist assistant shall not assist in the practice of medicine without supervision from his or her supervising anesthesiologist, except in:

(a) Life-threatening emergencies, including, without limitation, at the scene of an accident; or

(b) Emergency situations, including, without limitation, human-caused or natural disaster relief efforts.

7. When an anesthesiologist assistant assists in the practice of medicine in a situation described in subsection 6:

(a) The anesthesiologist assistant shall assist in the practice of medicine as he or she is able based on the need of the patient and the training, education and experience of the anesthesiologist assistant.

(b) If a licensed physician is available on-scene, the anesthesiologist assistant may take direction from the physician.

Sec. 18. *1. An anesthesiologist who utilizes the services of an anesthesiologist assistant shall provide notice of that fact to any patient of the anesthesiologist. If the anesthesiologist provides a patient with a form on which the patient may provide informed consent to treatment, such notice must be included on the form.*

2. Notice provided pursuant to subsection 1 must include, without limitation:

(a) An explanation of the role of the anesthesiologist assistant; and

(b) An explanation that the anesthesiologist assistant is not a physician and provides anesthesia care to a patient only under the constant medical direction of a supervising anesthesiologist.

3. The supervising anesthesiologist of an anesthesiologist assistant shall:

(a) Communicate with the anesthesiologist assistant regarding the care of all patients;

(b) Adopt a written protocol regarding the practice and supervision of anesthesiologist assistants that meets the requirements of subsection 4; and

(c) Provide a copy of the written protocol adopted pursuant to paragraph (b) to:

(1) Each anesthesiologist assistant that the supervising anesthesiologist supervises; and

(2) The Board, upon request of the Board.

4. A written protocol regarding the practice and supervision of anesthesiologist assistants adopted pursuant to paragraph (b) of subsection 3 must:

(a) Comply with the provisions of this chapter and chapter 630 of NRS with regard to the tasks that the anesthesiologist assistant may perform;

(b) Detail the tasks that the anesthesiologist assistant may perform and the manner in which the supervising anesthesiologist will supervise the anesthesiologist assistant in the performance of those tasks;

(c) Provide for regular review by the supervising anesthesiologist of the medical records of any patients delegated to the anesthesiologist assistant; and

(d) Be based upon consideration of relevant quality assurance standards.

5. A supervising anesthesiologist may not simultaneously supervise a greater number of anesthesiologist assistants than authorized by federal law or regulations governing Medicare and Medicaid, or any guidance adopted pursuant thereto.

Sec. 19. ***1. Every 2 years, at least one supervising anesthesiologist who has supervised or is supervising an anesthesiologist assistant shall conduct a performance assessment of the anesthesiologist assistant. To the greatest extent practicable, the assessment must be conducted by the supervising anesthesiologist with the most knowledge of the performance of the anesthesiologist assistant during the relevant biennium. A supervising anesthesiologist may gather information for a performance assessment conducted pursuant to this subsection through direct observation or review of available information, including, without limitation, a review of reports which evidence performance of the anesthesiologist assistant, or a combination of both. The performance assessment must include, without limitation:***

(a) An assessment of the medical competency of the anesthesiologist assistant;

(b) A review of selected charts, which may include, without limitation, electronic medical records; and

(c) An assessment of the ability of the anesthesiologist assistant to take a medical history from, and perform an examination of, patients who are representative of all patients to whom the anesthesiologist assistant provided care during the relevant biennium.

2. The requirements of subsection 1 shall be deemed to be satisfied for an anesthesiologist assistant working in a facility which is required by local, state or federal statutes or regulations to have a director of anesthesia services perform a review of the anesthesiologist assistant.

3. Except as otherwise provided in this subsection, a supervising anesthesiologist who conducts a performance assessment pursuant to subsection 1 or a review which is deemed by subsection 2 to satisfy the requirements of subsection 1 and an anesthesiologist assistant who is the subject of such a performance assessment or review shall maintain a record of the

performance assessment or review, as applicable, for not less than 6 years. A record which is maintained by the employer of the anesthesiologist assistant or facility where the anesthesiologist assistant is employed shall be deemed to satisfy the requirements of this subsection if the record is available to the Board for review upon request of the Board. The anesthesiologist assistant, supervising anesthesiologist, employer or facility, as applicable, shall provide a copy of the performance assessment or review, as applicable, to the Board upon request of the Board.

Sec. 20. *An anesthesiologist assistant shall:*

1. Provide competent medical care and assume as his or her primary responsibility the health, safety, welfare and dignity of all patients;

2. Deliver health services to patients without regard to race, religious creed, color, age, sex, disability, sexual orientation, gender identity or expression, national origin or ancestry;

3. Adhere to all state and federal laws governing informed consent concerning the health care of a patient;

4. Seek consultation with his or her supervising anesthesiologist or supervising anesthesiologists, as applicable, other providers of health care or qualified professionals having special skills, knowledge or experience whenever the welfare of a patient will be safeguarded or advanced by such consultation;

5. Become familiar with and adhere to all state and federal laws applicable to his or her practice as an anesthesiologist assistant, including, without limitation, the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and the regulations adopted pursuant thereto, and other federal and state laws and regulations governing the confidentiality of health information;

6. Provide only those services for which the anesthesiologist assistant is licensed and qualified by education, training and experience;

7. Avoid conflicts of professional interest; and

8. Comply with all applicable provisions of chapter 629 of NRS and the regulations adopted pursuant thereto.

Sec. 21. ***1. An anesthesiologist assistant shall not administer general anesthesia, conscious sedation, deep sedation, a regional anesthesia block or neuraxial anesthesia to patients unless the general anesthesia, conscious sedation, deep sedation, regional anesthesia block or neuraxial anesthesia is administered:***

(a) In an office of a physician or osteopathic physician which holds a permit pursuant to NRS 449.435 to 449.448, inclusive;

(b) In a facility which holds a permit pursuant to NRS 449.435 to 449.448, inclusive;

(c) In a medical facility, as that term is defined in NRS 449.0151; or

(d) Outside of this State, if the anesthesiologist assistant is otherwise legally permitted to do so.

2. As used in this section:

(a) "Conscious sedation" has the meaning ascribed to it in NRS 449.436.

(b) "Deep sedation" has the meaning ascribed to it in NRS 449.437.

(c) "General anesthesia" has the meaning ascribed to it in NRS 449.438.

Sec. 22. ***1. An anesthesiologist assistant shall make a note in the records of every patient for whom the anesthesiologist assistant assists in the practice of medicine concerning the services provided to the patient.***

2. A note described in subsection 1 must include, without limitation:

(a) A clear indication of the times that the anesthesiologist assistant provided care to the patient;

(b) The name of the supervising anesthesiologist; and

(c) The date of the anesthesia service.

Sec. 23. *1. An anesthesiologist assistant shall not:*

(a) Falsify or alter records of health care;

(b) Falsify or alter the medical records of a hospital so as to indicate his or her presence at a time when he or she was not in attendance or falsify those records to indicate that procedures were performed by him or her which were in fact not performed by him or her;

(c) Render professional services to a patient while the anesthesiologist assistant is under the influence of alcohol or any controlled substance or is in any impaired mental or physical condition;

(d) Acquire any controlled substances from any pharmacy or other source by misrepresentation, fraud, deception or subterfuge;

(e) Fail to honor the advance directive of a patient without informing the patient or the surrogate or guardian of the patient and without documenting in the patient's records the reasons for failing to honor the advance directive of the patient contained therein;

(f) Engage in any sexual activity with a patient who is currently being treated by the anesthesiologist assistant;

(g) Engage in disruptive behavior with any physician, hospital personnel, patient, member of the family of a patient or other person if the behavior interferes with patient care or has an adverse impact on the quality of care rendered to a patient;

(h) Engage in conduct that violates the trust of a patient and exploits the relationship between the anesthesiologist assistant and the patient for financial or other personal gain;

(i) Engage in or conceal conduct which brings the profession of assisting anesthesiologists into disrepute;

(j) Engage in sexual contact with a surrogate of a patient or other key person related to a patient, including, without limitation, a spouse, parent or legal guardian, that exploits the relationship between the anesthesiologist assistant and the patient in a sexual manner;

(k) Make or file a report that the anesthesiologist assistant knows to be false, fail to file a record or report as required by law or willfully obstruct or induce another person to obstruct such a filing;

(l) Fail to report any person that the anesthesiologist assistant knows, or has reason to know, is in violation of the provisions of this chapter or chapter 630 of NRS relating to the practice of medicine or practice as an anesthesiologist assistant;

(m) Misrepresent in any manner, either directly or indirectly, his or her skills, training, professional credentials, identity or services; or

(n) Administer or use a single-use medical device:

(1) For more than one procedure;

(2) For more than one patient; or

(3) In a manner inconsistent with the manufacturer's instructions or directions included on or with the single-use medical device.

2. As used in this section:

(a) "Single-dose vial" means a vial, including, without limitation, a sealed sterile vial, which may be accessed by insertion of a needle and which, according to the manufacturer's instructions:

(1) Contains only one dose of a medication; and

(2) May be used for only one patient.

(b) "Single-use medical device" means a medical device that is intended for one use or on a single patient during a single procedure and includes, without limitation, a blade, clip, catheter, implant, insufflator, lancet, needle, sleeve, syringe and single-dose vial.

Sec. 24. *1. An anesthesiologist assistant is subject to disciplinary action by the Board if, after notice and hearing in accordance with this chapter, the Board finds that the anesthesiologist assistant:*

(a) Has willfully and intentionally made a false or fraudulent statement or submitted a forged or false document in applying for a license;

(b) Has held himself or herself out as or authorized another person to represent the anesthesiologist assistant to be a licensed physician;

(c) Has performed medical services otherwise than:

(1) Pursuant to section 12 of Assembly Bill No. 270, chapter 247, Statutes of Nevada 2023, at page 1548, or subsection 6 of section 17 of this regulation; or

(2) At the direction and under the immediate supervision of the supervising anesthesiologist of the anesthesiologist assistant;

(d) Is guilty of malpractice in the assisting of the practice of medicine;

(e) Is guilty of disobedience of any order of the Board or an investigative committee of the Board, any provision in the regulations of the State Board of Health or the State Board of Pharmacy or any provision of this chapter or chapter 630 of NRS;

(f) Is guilty of administering, dispensing or possessing any controlled substance otherwise than in the course of legitimate medical services or as authorized by law and the supervising anesthesiologist of the anesthesiologist assistant;

(g) Has been convicted of a violation of any federal or state law regulating the prescribing, possession, distribution or use of a controlled substance;

(h) Is not competent to assist in the practice of medicine;

(i) Has lost his or her certification issued by the National Commission for Certification of Anesthesiologist Assistants or its successor organization;

(j) Has failed to notify the Board of an involuntary loss of certification issued by the National Commission for Certification of Anesthesiologist Assistants, or its successor organization, within 30 days after the involuntary loss of certification;

(k) Has assisted in the practice of medicine after his or her license as an anesthesiologist assistant expired or was revoked or suspended;

(l) Has been convicted of a felony, any offense involving moral turpitude or any offense relating to assisting in the practice of medicine or the ability to assist in the practice of medicine;

(m) Has had a license as an anesthesiologist assistant revoked, suspended, modified or limited by any other jurisdiction or has surrendered such a license or discontinued assisting in the practice of medicine while under investigation by any licensing authority, a medical

facility, a branch of the Armed Forces of the United States, an insurance company, an agency of the Federal Government or any employer; or

(n) Has violated any provision that would subject a practitioner of medicine to discipline pursuant to NRS 630.301 to 630.3065, inclusive, or NAC 630.230.

2. To initiate disciplinary action against an anesthesiologist assistant, an investigative committee of the Board must file with the Board a written complaint, specifying the charges.

Sec. 25. *Before the Board takes disciplinary action against an anesthesiologist assistant, the Board will provide to the anesthesiologist assistant and to each supervising anesthesiologist of the anesthesiologist assistant a written notice specifying the charges made against the anesthesiologist assistant and that the charges will be heard at the time and place indicated in the notice. The notice will be served on the anesthesiologist assistant and each supervising anesthesiologist at least 21 business days before the date fixed for the hearing. Service of the notice will be made and any investigation and subsequent disciplinary proceedings will be conducted in the same manner as provided by law for disciplinary actions against other licensees.*

Sec. 26. *1. If the Board or any investigative committee of the Board has reason to believe that the conduct of any anesthesiologist assistant has raised a reasonable question as to his or her competence to practice as an anesthesiologist assistant with reasonable skill and safety to patients, the Board or committee, as applicable, may order that the anesthesiologist assistant undergo a mental or physical examination or an examination testing his or her competence to practice as an anesthesiologist assistant by physicians or any other examination designated by the Board to assist the Board or committee in determining the fitness of the anesthesiologist assistant to practice as an anesthesiologist assistant.*

2. Every anesthesiologist assistant who applies for or is issued a license and who accepts the privilege of assisting in the practice of medicine in this State shall be deemed to have given his or her consent to submit to an examination pursuant to subsection 1 when the anesthesiologist assistant is directed to do so in writing by the Board.

3. For the purposes of this section, the report of testimony or examination by the examining physicians does not constitute a privileged communication.

4. Except in extraordinary circumstances, as determined by the Board, the failure of a licensed anesthesiologist assistant to submit to an examination when he or she is directed to do so pursuant to this section constitutes an admission of the charges against him or her. A default and final order may be entered without the taking of testimony or presentation of evidence.

5. An anesthesiologist assistant who is subject to an examination pursuant to this section shall pay the costs of the examination.

Sec. 27. *If an anesthesiologist assistant loses certification issued by the National Commission for Certification of Anesthesiologist Assistants, or its successor organization, his or her license to assist in the practice of medicine is automatically suspended until further order of the Board.*

Sec. 28. *1. Any person whose practice as an anesthesiologist assistant has been limited or whose license as an anesthesiologist assistant has been suspended until further order of the Board may petition the Board for removal of the limitation or suspension.*

2. In hearing a petition made pursuant to subsection 1, the Board:

(a) May require the person to submit to a mental or physical examination or an examination testing his or her competence to practice as an anesthesiologist assistant, or any

other examination it designates, and submit such other evidence of changed conditions and of fitness as it deems proper;

(b) Will determine whether, under all circumstances, the time of the petition is reasonable; and

(c) May deny the petition or modify or rescind its order as it deems the evidence and the public safety warrants.

3. The licensee has the burden of proving by clear and convincing evidence that the requirements for removal of the limitation or suspension have been met.

4. The Board will not remove a limitation or suspension unless it is satisfied that the licensee has complied with all of the terms and conditions set forth in the final order of the Board and that the licensee is capable of practicing as an anesthesiologist assistant in a safe manner.

Sec. 29. *If the Board issues a letter of warning, a letter of concern or a nonpunitive admonishment to an anesthesiologist assistant pursuant to NRS 630.299, the Board will deliver a copy of the letter or admonishment to the supervising anesthesiologist supervising the care of the relevant patient as shown in the medical records of the patient.*

Sec. 30. *1. The Board will appoint three licensed anesthesiologist assistants to an advisory committee. If appointed on or after January 1, 2027, the anesthesiologist assistants appointed pursuant to this subsection must have lived in and actively and continuously practiced in this State as licensed anesthesiologist assistants for at least 3 years before their appointment.*

2. The Board may appoint to the advisory committee described in subsection 1 a supervising anesthesiologist. A supervising anesthesiologist appointed pursuant to this

subsection must have lived in and actively and continuously practiced in this State as a licensed physician for at least 3 years before his or her appointment.

3. The Board will give appointees to the advisory committee written notice of their appointment and terms of office. The term of each appointee to the advisory committee must not exceed 4 years, except that a member of the advisory committee must continue to serve until the Board appoints a replacement as his or her successor.

4. At the request of the Board, the advisory committee shall review and make recommendations to the Board concerning any matters relating to licensed anesthesiologist assistants.

5. The members of the advisory committee serve without compensation.

Sec. 31. *If any of the following transfers occur during the provision of anesthesia or any related service, the anesthesiologist who is primarily responsible for the care of the patient after the transfer shall ensure that the transfer is clearly indicated in the medical records of the patient:*

1. A transfer of authority from one anesthesiologist to another anesthesiologist.

2. A transfer of duties from one anesthesiologist assistant or certified registered nurse anesthetist to another anesthesiologist assistant or certified registered nurse anesthetist.

Sec. 32. *1. Any person whose practice as a physician assistant has been limited or whose license as a physician assistant has been suspended until further order of the Board may petition the Board for removal of the limitation or suspension.*

2. In hearing a petition made pursuant to subsection 1, the Board:

(a) May require the person to submit to a mental or physical examination or an examination testing his or her competence to practice as a physician assistant, or any other

examination it designates, and submit such other evidence of changed conditions and of fitness as it deems proper;

(b) Will determine whether, under all circumstances, the time of the petition is reasonable; and

(c) May deny the petition or modify or rescind its order as it deems the evidence and the public safety warrants.

3. The licensee has the burden of proving by clear and convincing evidence that the requirements for removal of the limitation or suspension have been met.

4. The Board will not remove a limitation or suspension unless it is satisfied that the licensee has complied with all of the terms and conditions set forth in the final order of the Board and that the licensee is capable of practicing as a physician assistant in a safe manner.

Sec. 33. NAC 630.010 is hereby amended to read as follows:

630.010 As used in this chapter, unless the context otherwise requires, the words and terms defined in ~~[NRS 630.005 to 630.026, inclusive, and]~~ NAC 630.025 ***and section 2 of this regulation*** have the meanings ascribed to them in those sections.

Sec. 34. NAC 630.040 is hereby amended to read as follows:

630.040 For the purposes of this chapter and chapter 630 of NRS, "malpractice" means the failure of a physician, physician assistant, ***anesthesiologist assistant,*** practitioner of respiratory care or perfusionist, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.

Sec. 35. NAC 630.045 is hereby amended to read as follows:

630.045 1. Any document submitted to the Board by a licensee or an applicant for a license to practice medicine, to practice as a physician assistant, ***to practice as an***

anesthesiologist assistant, to practice as a practitioner of respiratory care or to practice as a perfusionist must bear the original signature or an authenticated electronic signature of the licensee or applicant.

2. The Board may refuse to accept any document submitted by a licensee or an applicant for a license that does not comply with the requirements of subsection 1.

3. As used in this section, "document" means any written submission, notification or communication, including, without limitation:

(a) An application for a license;

(b) A request for renewal of a license;

(c) A request for a change of status; or

(d) A notification of a change of address.

Sec. 36. NAC 630.230 is hereby amended to read as follows:

630.230 1. A person who is licensed as a physician or physician assistant shall not:

(a) Falsify records of health care;

(b) Falsify the medical records of a hospital so as to indicate his or her presence at a time when he or she was not in attendance or falsify those records to indicate that procedures were performed by him or her which were in fact not performed by him or her;

(c) Render professional services to a patient while the physician or physician assistant is under the influence of alcohol or any controlled substance or is in any impaired mental or physical condition;

(d) Acquire any controlled substances from any pharmacy or other source by misrepresentation, fraud, deception or subterfuge;

(e) Prescribe anabolic steroids for any person to increase muscle mass for competitive or athletic purposes;

(f) Make an unreasonable additional charge for tests in a laboratory, radiological services or other services for testing which are ordered by the physician or physician assistant and performed outside his or her own office;

(g) Allow any person to act as a medical assistant in the treatment of a patient of the physician or physician assistant, unless the medical assistant has sufficient training to provide the assistance;

(h) Fail to provide adequate supervision of a medical assistant who is employed or supervised by the physician or physician assistant, including, without limitation, supervision provided in the manner described in NAC 630.810 or 630.820;

(i) If the person is a physician, fail to provide adequate supervision of a physician assistant ***or an anesthesiologist assistant*** or adequate collaboration with an advanced practice registered nurse with whom the physician is collaborating;

(j) Fail to honor the advance directive of a patient without informing the patient or the surrogate or guardian of the patient, and without documenting in the patient's records the reasons for failing to honor the advance directive of the patient contained therein;

(k) Engage in the practice of writing prescriptions for controlled substances to treat acute pain or chronic pain in a manner that deviates from the policies set forth in the *Guidelines for the Chronic Use of Opioid Analgesics* adopted by reference in NAC 630.187; or

(l) Administer or use, or allow any person under his or her supervision, direction or control to administer or use, a single-use medical device:

(1) For more than one procedure;

(2) For more than one patient; or

(3) In a manner inconsistent with the manufacturer's instructions or directions included on or with the single-use medical device.

2. A physician or physician assistant shall comply with all applicable provisions of chapters 440 and 629 of NRS and any regulation adopted pursuant thereto.

3. As used in this section:

(a) "Chronic pain" has the meaning ascribed to it in section 3 of the *Guidelines for the Chronic Use of Opioid Analgesics* adopted by reference in NAC 630.187.

(b) "Single-dose vial" means a vial, including, without limitation, a sealed sterile vial, which may be accessed by insertion of a needle and which, according to the manufacturer's instructions:

(1) Contains only one dose of a medication; and

(2) May be used for only one patient.

(c) "Single-use medical device" means a medical device that is intended for one use or on a single patient during a single procedure and includes, without limitation, a blade, clip, catheter, implant, insufflator, lancet, needle, sleeve, syringe and single-dose vial.

Sec. 37. NAC 630.240 is hereby amended to read as follows:

630.240 1. If a licensee desires to surrender his or her license to practice medicine, ***practice as an anesthesiologist assistant, practice*** perfusion or ***practice*** respiratory care while an investigation concerning the license or disciplinary proceedings concerning the licensee are pending, the licensee shall submit to the Board a sworn written statement of surrender of the license accompanied by delivery to the Board of the actual license issued to him or her.

2. The voluntary surrender of a license is not effective until it is accepted by the Board in a public meeting. An order accepting such a surrender must prescribe a period of at least 1 year but not more than 10 years during which the holder of the surrendered license is prohibited from applying for reinstatement of the license.

3. The Board will:

(a) Make the voluntary surrender of a license public; and

(b) Deem the voluntary surrender of a license to be disciplinary action and report the surrender to applicable national databases.

4. The voluntary surrender of a license, the failure to renew a license or the placement of a license on retired status pursuant to section 1 of LCB File No. R118-21 does not preclude the Board from hearing a complaint for disciplinary action made against the licensee.

Sec. 38. NAC 630.243 is hereby amended to read as follows:

630.243 If a committee conducting an investigation pursuant to NRS 630.311 becomes aware that the physician, physician assistant, ***anesthesiologist assistant,*** practitioner of respiratory care or perfusionist who is subject to the investigation has tested positive for exposure to the human immunodeficiency virus, the committee shall appoint a group of specialists in the fields of public health and infectious diseases who shall:

1. Review all the circumstances of the practice of the physician, physician assistant, ***anesthesiologist assistant,*** practitioner of respiratory care or perfusionist; and

2. Advise the committee, in accordance with the ***most recent*** guidelines on [~~"Health Care Workers Infected with HIV"~~] ***the exposure of health care workers to the human immunodeficiency virus*** established by the Centers for Disease Control and Prevention, on the

action, if any, the committee should take concerning the physician, physician assistant, ***anesthesiologist assistant,*** practitioner of respiratory care or perfusionist.

Sec. 39. NAC 630.275 is hereby amended to read as follows:

630.275 1. The Board will, pursuant to subsection 3 of NRS 630.336, keep confidential all records relating to a program established by the Board to enable a physician, physician assistant, ***anesthesiologist assistant,*** practitioner of respiratory care or perfusionist to correct:

(a) A dependence upon alcohol or a controlled substance; or

(b) Any other impairment which could result in the revocation of his or her license.

2. The Board will, pursuant to subsection 4 of NRS 622.330, keep confidential a consent or settlement agreement between the Board and a licensee that provides for the licensee to enter a diversionary program for the treatment of an alcohol or other substance use disorder.

Sec. 40. NAC 630.465 is hereby amended to read as follows:

630.465 1. At least 30 days before a hearing but not earlier than 30 days after the date of service upon the physician, physician assistant, ***anesthesiologist assistant,*** practitioner of respiratory care or perfusionist of a formal complaint that has been filed with the Board pursuant to NRS 630.311, unless a different time is agreed to by the parties, the presiding member of the Board or panel of members of the Board or the hearing officer shall conduct a prehearing conference with the parties and their attorneys. All documents presented at the prehearing conference are not evidence, are not part of the record and may not be filed with the Board.

2. Each party shall provide to every other party a copy of the list of proposed witnesses and their qualifications and a summary of the testimony of each proposed witness. A witness whose name does not appear on the list of proposed witnesses may not testify at the hearing unless good cause is shown.

3. In addition to the requirements of NRS 622A.330, each party shall provide to every other party any evidence that the party proposes to introduce at a hearing. All evidence, except rebuttal evidence, which is not provided to each party at the prehearing conference may not be introduced or admitted at the hearing unless good cause is shown.

4. Each party shall submit to the presiding member of the Board or panel or to the hearing officer conducting the conference each issue which has been resolved by negotiation or stipulation and an estimate, to the nearest hour, of the time required for presentation of its oral argument.

Sec. 41. Section 1 of LCB File No. R118-21 is hereby amended to read as follows:

Section 1. A licensee may apply to the Board to change the status of his or her license to practice medicine, ***practice as an anesthesiologist assistant, practice*** perfusion or ***practice*** respiratory care to retired by filing with the Board a notice in writing that states the intention of the licensee to retire from active practice. Upon the provision of such notice, the Board will change the status of the license to retired if:

1. The licensee is otherwise in good standing;

2. There are no complaints or investigations pending against the licensee; and

3. No disciplinary action is pending against the licensee.

NEVADA STATE BOARD OF MEDICAL EXAMINERS

9600 Gateway Drive
Reno, NV 89521

Nick M. Spirtos, M.D., F.A.C.O.G.
Board President

Edward O. Cousineau, J.D.
Executive Director

MEMORANDUM

TO: All Licensees and Interested Parties

FROM: Sarah A. Bradley, J.D., MBA

SUBJECT: Changes to LCB Draft of LCB File No. R069-23

DATE: January 26, 2024

The Nevada State Board of Medical Examiners (Board) has scheduled a public hearing on LCB File No. R069-23. The Proposed Regulation Draft prepared by the Legislative Counsel Bureau is available at: https://medboard.nv.gov/uploadedFiles/medboardnvgov/content/About/R069-23_Text.PDF. Upon review of this regulation draft, two non-substantive changes appear to be necessary.

First, section 4, subsection (1)(j) should be amended to replace "The various places of his or her residence for the 5 years immediately preceding the date of his or her application" with "A public address and the mailing address at which the applicant prefers to receive correspondence from the Board" as shown below.

> ***(j)*** ~~***The various places of his or her residence for the 5 years immediately preceding the date of his or her application.***~~ ***A public address and the mailing address at which the applicant prefers to receive correspondence from the Board.***

Second, section 16, subsection 5 should be amended by moving the phrase "determined by a supervising anesthesiologist to have received adequate clinical training in anesthesiology" to subsection 2 as shown below.

> ***2. An anesthesiologist may delegate the supervision of a student in a training program for anesthesiologist assistants only to a provider of anesthesia determined by the anesthesiologist to have received adequate clinical training in anesthesiology.***

. . .

Telephone 775-688-2559 Fax 775-688-2321 https://medboard.nv.gov/ nsbme@medboard.nv.gov

5. As used in this section, "provider of anesthesia" means:

(a) An anesthesiologist;

(b) An anesthesiology fellow;

(c) An anesthesiology resident;

(d) An anesthesiologist assistant; or

(e) A certified registered nurse anesthetist ~~determined by the supervising anesthesiologist to have received adequate clinical training in anesthesiology~~.

Please call me at 775-324-9365 or contact me by email at bradleys@medboard.nv.gov if you have any questions or concerns about these changes or this regulation.

NEVADA STATE BOARD OF MEDICAL EXAMINERS
9600 Gateway Drive
Reno, NV 89521

Nick M. Spirtos, M.D., F.A.C.O.G.
Board President

Edward O. Cousineau, J.D.
Executive Director

MEMORANDUM

TO: **Board Members**

FROM: **Sarah A. Bradley, J.D., MBA**

SUBJECT: **Changes to LCB Draft of LCB File No. R069-23 Requested by JISC on HHS**

DATE: **February 27, 2024**

LCB File No. R069-23 was discussed by the Joint Interim Standing Committee (JISC) on Health and Human Services (HHS) at a meeting held on Friday, February 16, 2024. At that meeting, the Chair of the JISC on HHS suggested that the Board consider removing the following provisions from the regulation:

From section 3(1)(a), containing requirements for applicants for licensure as an anesthesiologist assistant: ~~***Be able to communicate adequately orally and in writing in the English language.***~~

Staff has been able to verify that the examination required by the National Commission for Certification of Anesthesiologist Assistants (NCCAA) is provided only in English, and, therefore, it may not be necessary for the Board to include this as a requirement for licensure in regulation.

Section 4(1)(h), containing information to be included in an application for licensure as an anesthesiologist assistant: ***Whether the applicant has an untreated medical condition that may affect his or her ability to safely practice as an anesthesiologist assistant.***

This was a drafting error by the Legislative Counsel Bureau. To comply with the Americans with Disabilities Act of 1990 (ADA), this portion of the regulation should read "an untreated medical condition" and staff is requesting that the Board adopt the regulation with this change as shown above with the addition in ***purple***.

Section 4(1)(i), containing information to be included in an application for licensure as an anesthesiologist assistant: ~~***Whether the applicant uses prescription drugs or other substances that may affect his or her ability to safely practice as an anesthesiologist assistant.***~~

This is not a question that the Board currently asks other applicants for licensure and this was not included in the Board's initial regulation draft. Instead, this was discussed at the October 18, 2023 workshop and subsequently added to the proposed regulation language. According to comments received at the public hearing on February 20, 2024, hospitals will ask this prior to providing a licensee with hospital privileges. Therefore, because this is not something that the Board asks other applicants for licensure and it is something that hospitals will ask prior to credentialing a provider, it may not be necessary for the Board to include this in regulations for anesthesiologist assistants.

MINUTES OF
OCTOBER 18, 2023
WORKSHOP

NEVADA STATE BOARD OF MEDICAL EXAMINERS
9600 Gateway Drive
Reno, NV 89521

Nick M. Spirtos, M.D., F.A.C.O.G.
Board President

Edward O. Cousineau, J.D.
Executive Director

* * * M I N U T E S * * *

REGULATION WORKSHOP ON R069-23

Held in the Conference Room at the Offices of the
Nevada State Board of Medical Examiners
325 E. Warm Springs Road, Suite 225, Las Vegas, Nevada 89119

and Phone Conferenced to

The Conference Room at the Offices of the
Nevada State Board of Medical Examiners
9600 Gateway Drive, Reno, Nevada 89521

WEDNESDAY, OCTOBER 18, 2023 – 1:30 p.m.

Staff Present
Sarah A. Bradley, J.D., MBA, Deputy Executive Director
Mercedes Fuentes, Legal Assistant
Valerie Jenkins, Legal Assistant

Public Present
Amanda Brazeau
Susan Fischer
Brittany Green
Hasnain Photowala
Bradford Isaacs, M.D.

Agenda Item 1
CALL TO ORDER AND INTRODUCTIONS

The meeting was called to order by Sarah A. Bradley, J.D., MBA, Deputy Executive Director, at 1:31 p.m. Ms. Bradley stated that this was the time and place for the regulation workshop for R069-23.

Agenda Item 2
PUBLIC COMMENT

Ms. Bradley stated there were a few members of the public present in the Las Vegas Board Office, and two members of the public present in the Reno Office.

There was no public comment at either location.

Agenda Item 3
PRESENTATION AND DISCUSSION OF PROPOSED REGULATION R069-23

Ms. Bradley stated that there was a bill passed this last session that added anesthesiologist assistants (AAs) as a new licensed profession in the State of Nevada. As a result, regulations are needed to be created for licensing this new profession. Ms. Bradley stated that she would go over each provision of the proposed regulation and take any comment on each section:

Provision 1: The first provision is regarding a mental or physical examination of an anesthesiologist assistant (AA) if the investigative committee believes it is necessary after receiving a complaint regarding the AA. There was no discussion on this provision.

Provision 2: This provides that when there are restrictions placed on someone's license (i.e., as a result of discipline, etc.), the person can petition the Board to remove the restriction. There was no discussion on this provision.

Provision 3: This provision was copied from NRS 630.373 that states that a physician cannot administer general anesthesia in places that are not property permitted and/or listed in the statute. Adding this to regulations regarding AAs is to prevent AAs from getting involved in providing anesthesia in such places, as well, such as medi-spas. For Section 2 of this provision, Dr. Isaacs had a question regarding what was included in general anesthesia. Did it include partial/regional "block" anesthesia, conscious sedation, etc.? Ms. Bradley stated the wording came from NRS 630.373, and Dr. Isaacs suggested adding more specific references to the different types of anesthesia that are prohibited.

Provision 4: This regulation was copied from the regulations for physician assistants (PAs) contained in NAC 630. The members of the public agreed that they fit except for the reference to supervision of a medial assistant in subsection (1)(h). Ms. Bradley agreed and confirmed that subsection (1)(h) would be removed from the regulation draft.

Provision 5: This regulation was copied from the Board's regulations for other professions, such as those for PAs, and includes application requirements, qualifications for licensure, and requirements for demonstrating competency if an applicant has been out of practice for 24 months or more. There was discussion on this provision regarding whether the NCCAA offers a re-entry program. Ms. Bradley said that this provision would be updated to utilize the resources available from NCAA for assessing re-entry competency.

Provision 6: This regulation covers items that will be included in applications for licensure, such as applicant demographics, information about an applicant's educational background, and questions regarding the applicant's criminal history. Ms. Green asked about Provision 6(1)(g), which talks about an AA being arrested for drug use and/or drug trafficking and what the process would be. Ms. Bradley

stated that there will be a question on the application that asks if the applicant is currently using any illicit drugs or has an untreated addiction; if an applicant has an addiction, is being treated for that addition, and is safe to practice there will be no issue with that person obtaining licensure. This question is on the license application of all licensing types. Ms. Green also asked about whether the Board would ask about treated medical conditions and prescription medications that applicants may take that may affect their ability to practice safely. Ms. Bradley would update this and add that in.

Provision 7: Ms. Bradley explained that this was again copied from existing regulations governing other professions that the Board licenses regarding rejecting an application due to providing false credentials or other deficiencies in the applicant's application. There were no changes suggested to this provision.

Provision 8: Ms. Bradley that again this provision was copied from existing regulations governing other professions that the Board licenses and ensures that applications may be denied if a person has engaged in conduct that would be grounds for initiating discipline, if the person was a licensee. There were no changes suggested to this provision.

Provision 9: This language was copied from the regulations for PAs receiving a temporary license because the applicant is scheduled to take exam but hasn't yet or has taken the exam and is awaiting results. The AA with a temporary license would be required to wear a badge that says, "Anesthesiologist Assistant Graduate," rather than one that says just "Anesthesiologist Assistant," since the person is not yet certified. As written, temporary licenses will be good for one year. Ms. Bradley said she would check into the number of times a candidate can take the NCCAA certification examination and find out how many times the examination is offered each year and she would make sure this provision is consistent with that.

Provision 10: This provisions states what information will be on each AA license There were no changes suggested to this provision.

Provision 11: Ms. Bradley stated this provisions states the requirements and timing for AA license renewal. The Board renews licenses for all other license types on June 30th of odd years. It will be the same time frame for the anesthesiologist assistants. This provision requires AAs to notify the Board of their practice locations and update changes to that within 30 days.

This provision was discussed and the consensus from the public was that it would be best to just require AAs to provide their public and mailing addresses to the Board, where they will receive correspondence form the Board. When the AA's address changes, he or she will be required to notify the Board of that change within 30 days. Ms. Bradley said that she would update this provision to reflect these changes.

Provision 12: This provision states that there will be a two year renewal cycle, and to renew an AA will be required to show that he or she is currently certified, and that he or she has completed 40 hours of CMEs. The Board will give notice of the license expiration 60 days prior, along with renewal instructions. If the AA fails to renew on time, he or she will be twice the renewal fee for a late renewal. There were no changes suggested to this provision.

Provision 13: This provision adds a CME requirement for AAs to take bio-terrorism courses within the first two years of initial licensure because AB270 adds AAs to NRS 630.253. There were no changes suggested to this provision.

Provision 14: This provision allows for an AA to receive double credit for CMEs on geriatrics, gerontology, and Alzheimer's or other forms of dementia, just as is permitted for physicians and physician assistants. There were no changes suggested to this provision.

Provision 15: This provision states that tasks assigned to AAs must correlate with their education, training, and be within their scope of practice. AAs must wear a nametag and ensure that they are not mistaken by patients or others as being a physician. There was a concern raised from a member of the public about possible ambiguity between AAs and CRNAs and their duties. Both professions should wear nametags in the hospital setting.

Provision 16: This provision states grounds for disciplinary action for AAs and is copied from regulations for PAs and physicians, with the exception of the requirement that AAs must remain certified by the NCCAA. Loss of NCCAA certification is grounds for discipline and AAs must notify the Board if they lose their NCCAA certification. There were no changes suggested to this provision.

Provision 17: This provision addresses documentation in patient medical records by AAs and states that supervising anesthesiologists will also receive notice regarding discipline for AAs if the supervising anesthesiologist was the supervisor of record for that AA at the time of any alleged incident. There were no changes suggested to this provision.

Provision 18: This provisions creates an advisory committee for AAs consisting of three (3) AA members. The Committee cannot change the law or make other changes, but the Committee can make recommendations to the Board. Members of the public present asked whether an anesthesiologist would also be able to serve on this Committee. A discussion ensued about that, and the consensus was that it would potentially be beneficial to give the Board the option to appoint not only the three (3) AA members, but also an optional anesthesiologist member to assist the Board and the Committee, particularly if there is not an anesthesiologist member on the Board.

Provision 19: This provision states that if an AA loses his or her certification from the NCCAA, the AA's license is suspended until the Board is notified that the AA has re-certified. There were no changes suggested to this provision.

Provision 20: This is pursuant to NRS 629 regarding medical records and essentially states that AAs may not wrongfully destroy records. There were no changes suggested to this provision.

Provision 21: This section is regarding letters of concern that are sent to licensees. If an AA receives a letter of concern, a copy of that letter will also be sent to the AA's supervising anesthesiologist of record as shown in the patient's medical records. There were no changes suggested to this provision.

Provision 22: This section covers licensure of AAs by endorsement. These requirements are the same as those for endorsement for those for PAs, practitioners of respiratory care, and perfusionists. This provision also states that the Board will charge half of the fee established pursuant to NRS 630.268 for the initial issuance of the license if the endorsement applicant is active military member, the surviving spouse of an active military member, a veteran of the military, or the surviving spouse of a veteran. There were no changes suggested to this provision.

Provision 23: This provision addresses the supervision of AA students and the supervision of AA students when performing medical care tasks assigned by the anesthesiologist. The provision currently lists anesthesia provider types, and the suggestion was made that the language be clarified to say "any qualified anesthesia provider" and then listing qualified anesthesia providers to include anesthesiologist, anesthesiology fellow, and anesthesiology resident as long as the supervising anesthesiologist believes that the resident has received adequate clinical training in anesthesiology. Additional discussion ensued adding anesthesiologist assistant to the list and potentially also certified registered nurse anesthetists (CRNAs) also. There was a concern that CRNAs may not want to be added to the list of qualified anesthesia providers, but including them makes the most sense given that they will all be working together and this allows them to work with AA students as an option. Ms. Bradley said that she would update this provision to reflect this discussion.

Provision 24: This provision includes requirements for ensuring informed consent when AAs are used to provide patient care and ensuring that supervising anesthesiologists have written practice protocols regarding the supervision of AAs. The draft as written says that notice of the use of AAs in a practice must be posted in a public place. Susan Fisher and Dr. Brad Isaacs both had questions about this. Are notices like this posted when physician assistants are providing care? Ms. Bradley indicated that she saw this language in another state's regulations and it made sense to ensure that the public is informed. After more discussion, it was decided that AAs wearing a name badge is sufficient and the requirement in this section that the use of an AA to provide patient care be included in a written consent form is sufficient. This provision says that part of the protocol for use of AAs is that transfer of patient

care from one AA to another must be documented in the patient's medical record. There was a concern mentioned that sometimes the transfer of care may be from an AA to a CRNA, or vice versa, so this should be addressed. There was also concern identified with the annual performance assessment for the AA as contained in this provision. This was discussed and the consensus was that the performance assessment should be done every two years which is consistent with the timing of performance assessments required by hospitals to maintain their certifications. There was some discussion about who should do the performance assessment, but, after discussion, the members of the public were satisfied with that portion of the regulation as written. Ms. Bradley said that she was taking notes and would update the regulation draft to be consistent with this discussion.

Provision 25: This provision contains provisions from the ethical code that were copied from the State of Missouri. There were no changes suggested to this provision.

Amendment to LCB File No. R118-21, New Provision #3: The proposed amendment here in the regulation draft is to include AAs in this regulation which has been adopted, but not yet codified. There were no changes suggested to this provision.

Amendments to NAC 630.040, NAC 630.045, NAC 630.210, NAC 630.230, NAC 630.240, NAC 630.243, NAC 630.465: The proposed amendments to these provisions in the regulation draft are to add AAs to each regulation. There was no discussion or additional changes suggested to these provisions.

Agenda Item 4

QUESTION AND ANSWER PERIOD FOR PROPOSED REGULATION R069-23

Ms. Bradley stated that this was the period that members of the public were invited to ask questions about the proposed regulation. Dr. Isaacs asked Ms. Bradley if the regulations would be effective by January 1, 2024. Ms. Bradley stated that the regulations might not be complete by that point. However, AB270 would still be in place and that provides the Board with sufficient authority to issue AA licenses. Dr. Isaacs then asked about the regulation process. Ms. Bradley indicated that the next step would be for the Board to schedule and hold a public hearing, which only can occur after a regulation draft is prepared by the Legislative Counsel Bureau (LCB). The Board has to give 30 days' notice for the public hearing. Then, the regulations must be adopted by the Board after considering all public comment received. Ms. Bradley is hoping that the regulations will be on the Board's meeting agenda for adoption in March 2024. After the Board adopts the regulations, Ms. Bradley has to complete some forms and send those forms and the regulation back to LCB so that the regulation may be added to a Legislative Commission agenda for review and possible approval. The regulation must be approved by the Legislative Commission before it will become the law. The regulations are effective after they are approved by the Legislative Commission and the regulations are stamped by the Secretary of State. Then the new regulations are the law. Given the steps that need to be completed and that the Board did not yet have the regulation draft back from LCB, Ms. Bradley is estimating that the regulations will be ready for adoption by the Board at the March 2024 meeting. Her estimate is that the Legislative Commission may then be able to review and approve the regulations in April 2024 (hopefully). Dr. Isaacs then mentioned that there is a shorter of anesthesia providers in Nevada, so the sooner the Board's regulations are in place the better. Ms. Bradley agreed and said that the Board would still begin issuing licenses in January 2024 even if the regulations were not yet in place. Dr. Isaacs thanked Ms. Bradley for her efforts and said whatever they could do to help, they are there to help. Ms. Bradley said that the Board would be accepting paper applications to start, until the Board's licensing software vendor is able to add AAs to the system as a new license type. Susan Fisher asked if applicants would have to bring the applications to the Board office in person or if the applications could be mailed in. Ms. Bradley said that the Board would accept

paper applications by mail. Susan Fischer then asked about the test for licensure. Ms. Bradley responded that the Board would not be providing a test, and the required test would be the national test offered by the NCCAA for certification. The paper application is where the applicant submits information about his or her education, certification, address, etc. Dr. Isaacs then asked when the process would be final and employers could start posting jobs and hiring AAs. Ms. Bradley said that the regulations would not be in effect yet for a bit longer, but that employers could probably start posting jobs now if they wanted. He said, no, the hospitals will not start their processes until the Board has their processes for licensing outlined and the regulations are approved.

Agenda Item 5
<u>PUBLIC COMMENT FOR PROPOSED REGULATION R069-23</u>

Ms. Bradley said that this portion of the agenda was now the time for members of the public to provide public comment on this regulation. There was no public comment in the Reno or Las Vegas offices.

Agenda Item 6
<u>PUBLIC COMMENT</u>

Ms. Bradley asked for any public comment in the Las Vegas and Reno offices. There was no public comment provided.

Agenda Item 7
<u>ADJOURNMENT</u>

Ms. Bradley adjourned the meeting at 3:03 p.m.

* * * * * *

MINUTES OF NOVEMBER 2, 2023 WORKSHOP

NEVADA STATE BOARD OF MEDICAL EXAMINERS
9600 Gateway Drive
Reno, NV 89521

Nick M. Spirtos, M.D., F.A.C.O.G.
Board President

Edward O. Cousineau, J.D.
Executive Director

* * * M I N U T E S * * *

REGULATION WORKSHOP ON R069-23 AA

Held in the Conference Room at the Offices of the
Nevada State Board of Medical Examiners
325 E. Warm Springs Road, Suite 225, Las Vegas, Nevada 89119

and Video conferenced to

The Conference Room at the Offices of the
Nevada State Board of Medical Examiners
9600 Gateway Drive, Reno, Nevada 89521

THURSDAY, NOVEMBER 2, 2023 – 1:30 p.m.

Staff Present
Sarah A. Bradley, J.D., MBA, Deputy Executive Director
Mercedes Fuentes, Legal Assistant

Public Present
Susan Fisher
Amanda Brazeau

Agenda Item 1
<u>CALL TO ORDER AND INTRODUCTIONS</u>

The meeting was called to order by Sarah A. Bradley, J.D., MBA, Deputy Executive Director, at 1:34 p.m. Ms. Bradley stated that this was the time and place for the regulation workshop for R069-23 relating to anesthesiologist assistants.

Agenda Item 2
<u>PUBLIC COMMENT</u>

Ms. Bradley stated there were no members of the public present in the Las Vegas Board Office, and two members of the public present in the Reno Office.

Susan Fisher, with the Nevada State Society of Anesthesiologists, wanted to thank the Board for taking their previous concerns about the regulation into account, and they have reviewed the latest draft and are in complete agreement with all the changes that have been made.

Ms. Brazeau further thanked Ms. Bradley for her work on this regulation and getting it done so quickly.

Agenda Item 3
<u>PRESENTATION AND DISCUSSION OF PROPOSED REGULATION R069-23</u>

Ms. Bradley stated that there were a couple of changes to the initial regulation draft based on the comments received at the previous workshop. She further stated the next steps were to talk to the Legislative Counsel Bureau (LCB) about updating the Board's initial draft with these changes and to ask LCB about the status of the proposed regulation draft.

Agenda Item 4
<u>QUESTION AND ANSWER PERIOD FOR PROPOSED REGULATION R069-23</u>

Ms. Bradley stated that members of the public were invited to ask questions about the proposed regulation.

There were no questions from members of the public asked at either the Reno or Las Vegas locations.

Agenda Item 5
<u>PUBLIC COMMENT FOR PROPOSED REGULATION R069-23 AA</u>

Ms. Bradley stated that this portion of the agenda was now the time for members of the public to provide public comment on this regulation.

Ms. Fisher asked if this would have to go back through the Board for approval. Ms. Bradley responded that the Board would have to adopt the proposed regulation after receiving the LCB draft and having a public hearing. The changes made to the initial draft were not substantive enough to require Board approval before proceeding with the public hearing, and especially since some of the changes were directly from the requirements for the National Commission for Certification of Anesthesiologist Assistant's reentry program. Ms. Bradley also explained that since LCB has been working on the Board's

initial regulation draft since approximately September 20, 2023, she didn't want to hold up that draft, but would let the Board know that there were a couple of minor changes made to the initial regulation draft and answer any questions that Board members may have.

Ms. Brazeau asked for clarification in Item 23 if they need to list out the specific anesthesia provider types. Ms. Bradley said that she added, "a qualified anesthesia provider means anesthesiologist, an anesthesiology Fellow, an anesthesiology resident, an anesthesiologist assistant, or a certified registered nurse anesthetist" to that section.

Agenda Item 6
PUBLIC COMMENT

Ms. Bradley stated that this portion of the agenda was now the time for members of the public to provide public comment.

There was no public comment in the Reno or Las Vegas offices.

Agenda Item 7
ADJOURNMENT

Ms. Bradley adjourned the meeting at 1:39 p.m.

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TRANSCRIPT OF PUBLIC HEARING

1 BEFORE THE BOARD OF MEDICAL EXAMINERS
2
3 OF THE STATE OF NEVADA
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9 TRANSCRIPT OF HEARING PROCEEDINGS
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11 PUBLIC MEETING
12 FOR REGULATION HEARING
13 R069-23
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15 Tuesday, February 20, 2024
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24 Reported by: Brandi Ann Vianney Smith
25 Job Number: 642994

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1 A P P E A R A N C E S:

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FOR THE NEVADA STATE BOARD OF MEDICAL EXAMINERS:

SARAH BRADLEY
Deputy Executive Director
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

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8 I N D E X

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1 RENO, NEVADA -- FEBRUARY 20, 2024 -- 2:03 P.M.
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3
4
5 1. Call to Order and Introductions
6 MS. BRADLEY: All right. Let's go ahead
7 and get started. It is 2:03 by my watch. We'll go
8 ahead and call the meeting to order.
9 This is a public hearing on a regulation
10 draft that we have filed, and it's R069-23. This is
11 Sarah Bradley, I am the Deputy Executive Director
12 for the Board, and I'll be running the meeting. I
13 think everybody here is probably aware of that and
14 has a copies of it. If not, let us know.
15 This regulation is really because of
16 AB270, from the 2023 legislative session, where the
17 Legislature added a new profession for us to
18 license, which is anesthesiologist assistant.
19 That's what these regulations are about.
20 2. Public Comment
21 So we'll go ahead and move on to item 2,
22 which is just a general public comment period. Do
23 we have public in Las Vegas? I see two people on
24 the camera. Do you have general public comment you
25 want to give?

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1 (No public comments from the south.)
2 MS. BRADLEY: Any general public comment
3 in the north?
4 (No public comments from the north.)
5 MS. BRADLEY: Okay. I'm going to call for
6 it on the reg itself when we get there.
7 3. Presentation and Discussion of Proposed
8 Regulation R069-23
9 Okay. So, now we're going to move on to
10 item 3, and this is -- I'll just give an overview of
11 the regulation and the purpose of it.
12 Again, we have a new licensed type
13 effective January 1 for the Board, and that's what
14 these regulations are about. So I'm going to ahead
15 and kind of walk through the regulation draft.
16 The first section -- so 2 has a definition
17 of certified registered nurse anesthetist, and the
18 reason that is there is because later we do refer to
19 them in the regulation with regard to people that an
20 anesthesiologist can leave a student
21 anesthesiologist assistant with while they're being
22 a student in an AA program.
23 Section 3 talks about requirements for
24 licensure, and a lot of this is similar or the same
25 as we have for physician assistants. A lot of the

1 regulation -- just as background for anyone
2 interested -- I borrowed from both our physician
3 assistant regulations and practitioners and
4 respiratory care.
5 Section 4 talks about the form for an
6 application and the things that will be included in
7 that form and things we're going to ask the
8 applicants about.
9 Section 5, again, it's talking about
10 things that need to be included in the application.
11 And this one is actually for endorsement of section
12 5. That would be somebody who is licensed in
13 another state, eligible to come in under
14 endorsement.
15 Section 6 talks about grounds or reasons
16 we might want to reject an application. Basically
17 it's if they're not qualified, false credentials, or
18 the form is not complete.
19 And, again, section 7 says we can deny an
20 application if someone has done things as described
21 in section 24. Again, very similar for other
22 license types. We'll get to those lists when we get
23 there.
24 Section 8 talks about temporary licenses
25 for anesthesiologist assistants and when those may

1 be provided and under what requirements.
2 Section 9 talks about the contents of the
3 license.
4 Section 10 is that we want a physical
5 public address for each applicant, as well as a
6 mailing address, and then we do want an update to
7 the address within 30 days so that we can always
8 keep in touch with our licensees.
9 Section 11 talks about renewal of the
10 anesthesiologist assistant license, and this is
11 putting on the same timeframe as the other license
12 types that the Board has. It is June 30th, or the
13 next business day, of every odd year. That's when
14 it would expire and need to be renewed by July 1 or
15 that business day that follows after June 30th.
16 Part of the requirements for renewal is
17 going to be maintaining that certification from the
18 National Commission for Certification of
19 anesthesiologist assistants and also continuing
20 education.
21 Section 12, this talks about if an
22 anesthesiologist assistant does a medical review for
23 the Board, they can get continuing education for
24 that. That's the same as for physicians and
25 physician assistants.

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1 Section 13, talks about require continuing
2 education. And these are required subject areas
3 that the Legislature has specified for the Board
4 license types, already physicians and physician
5 assistants, and they have added anesthesiologist
6 assistants into that. That's why these specific
7 areas are there in section 13.
8 Section 14 is also a special area for
9 continuing education, this is in screening, grief
10 intervention, and referral to treatment, that a
11 licensee has to do that at least one time within the
12 first two years of licensure.
13 Section 15, this allows an
14 anesthesiologist assistant to get extra continuing
15 education credit if they take courses in certain
16 areas. And again, that's something that the
17 Legislature has directed the Board to do. That's
18 why it's here in this regulation.
19 Section 16 talks about students in a
20 training program for anesthesiologist assistants. I
21 think there are probably some comments on this
22 section. We'll do that once we finish this
23 overview. Section 16 talks about students and how
24 they can basically work and/or observe while they're
25 still in a student program.

1 Section 17 talks about, essentially,
2 requirements for anesthesiologist assistants when
3 they're practicing. So, name badges, the type of
4 tasks that they're doing, and the fact that they
5 have to be very clear on their role that they're not
6 misleading the public as to their qualifications and
7 things like. Again, very similar to the
8 requirements we have for other folks that work with
9 physicians because we want to make sure the public
10 knows that they are not a physician.
11 Section 18 talks about the fact that if an
12 anesthesiologist uses an anesthesiologist assistant,
13 they should give notice of that fact to the patient
14 and there should be some sort of consent there and
15 explaining the difference between what their role is
16 and their training.
17 Section 19 talks about a performance
18 assessment of an anesthesiologist assistant and the
19 fact that this needs to be done every two years and
20 kept in the file, like the personnel file for the
21 anesthesiologist assistant that that facility or
22 that physician has.
23 Section 24 is basically a kind of code of
24 conduct or ethical code for anesthesiologist
25 assistants and how they should treat patients.

1 Section 21, this is actually something
2 that I borrowed from our NRS, and right now it says
3 that physicians can't do this and they can't
4 supervise this being done, but we want to make sure
5 that anesthesiologist assistants are also aware that
6 they can't do any anesthesia unless it's in an
7 appropriate facility. And sometimes we have seen
8 this issue, so we want to make sure we have it
9 addressed for our new license type.
10 Section 22 talks about documentation and
11 notes in the records. We want to make sure that
12 it's very clear which anesthesiologist assistant is
13 providing care of the patient, as well as the
14 supervisor for them at the time. That would be
15 whatever anesthesiologist is actually working with
16 them, and so that note should be clear there.
17 Then, again, section 23 talks more about,
18 I'd say, ethical duties. Anesthesiologist
19 assistants can't falsify records, be impaired while
20 they're working, and do things that would impact the
21 care of the patient negatively, like disruptive
22 conduct and things like that.
23 Section 24 talks about grounds for
24 disciplinary action for anesthesiologist assistants.
25 Again, similar to how we handle this with other

1 license types, and a lot of these requirements are
2 exactly the same as for physician assistants
3 and physicians.
4 Section 25, again, more about disciplinary
5 action and this is the time period. This says that
6 we will give notice at least 21 business days before
7 a hearing if we are going to have a disciplinary
8 hearing regarding an anesthesiologist's assistant.
9 Section 26, this has to do with if a
10 complaint comes in regarding an anesthesiologist
11 assistant, and the Investigative Committee or the
12 Board itself has concern regarding their competence,
13 they can have this person undergo an examination to
14 make sure, mentally and physically, that they're fit
15 to continue practicing.
16 Section 27, this says if an
17 anesthesiologist assistant loses their national
18 certification that their license with the Medical
19 Board would be suspended until further order of the
20 Board, because, of course, having that certification
21 is required for licensure.
22 Section 28 talks about what an
23 anesthesiologist assistant or the process, at least,
24 for them to ask for changes to conditions that the
25 Board may have put on their license.

1 Section 29 says if the Board issues a
2 letter of warning, letter of concern, or
3 non-punitive admonishment to an assistant, the Board
4 is also going to give a copy of that to the
5 anesthesiologist that was supervising the
6 anesthesiologist assistant at the time.
7 Section 30 creates an advisory committee
8 regarding anesthesiologist assistants. We will have
9 three folks that would be appointed to that
10 committee, and there also can be an anesthesiologist
11 who supervises the anesthesiologist assistants. We
12 put that more optional because we know that they may
13 have other duties that make it harder for them to
14 serve on the committee. But we wanted that option.
15 Section 31 talks about transfer of care.
16 So, again, we talked about noting earlier who was
17 doing the care, anytime there's a transfer of case,
18 one anesthesiologist to another one or one
19 anesthesiologist assistant. And then also certified
20 registered nurse anesthetist are here because,
21 again, the record should be clear who is providing
22 care. So anytime it's changed, that should be noted
23 in the records.
24 Section 32, for some reason this one's
25 about physician assistants. I think this is just

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1 copying the same language we had before, and I
2 didn't realize we had anything about physician
3 assistants in here. So section 32 is actually
4 physician assistant related.
5 Section 33 and the sections that follow,
6 these are all adding anesthesiologist assistants to
7 the Board's existing regulations. Section 33 to 41
8 is adding them in where it seemed appropriate with
9 regard to just kind of general statements regarding
10 licensure, disciplinary actions, things like that.
11 I don't think we have any questions about those.
12 So, again, the purpose of the regulation
13 is to fully implement Assembly Bill AB270 from the
14 2023 legislative session, and make sure that
15 everything is spelled out as it should be for
16 anesthesiologist assistants with regard to
17 applications, disciplinary actions, and requirements
18 for practice.
19 4. Question and Answer Period for Proposed
20 Regulation R069-23
21 I'm going to move on to item 4, which is a
22 question and answer period for proposed Regulation
23 R069-23. This would be the time for anyone in the
24 public to ask questions about the regulation, and
25 then hopefully I can answer them or make a note and

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1 follow up with you later.
2 Do we have any questions in the south?
3 DR. ISAACS: (Inaudible) period that I'm
4 assuming that that refers to the start or the finish
5 of their training and not since they got -- not
6 since they've been licensed and not since
7 (inaudible) training. I'm assuming they go
8 immediately out of training into working in the
9 State of Nevada.
10 THE REPORTER: Did you understand him?
11 MS. BRADLEY: His question, as I
12 understood it, is there's a requirement here
13 regarding 24 months regarding, I think, when they
14 start licensure when they graduate, and you're
15 wanting to clarify that, and --
16 DR. ISAACS: Yeah. The way I read it,
17 they had to work two years before they could be
18 licensed in Nevada, and I don't -- and that may be a
19 wrong assumption on my part.
20 MS. BRADLEY: Yeah. That is not what the
21 intention is. Let me find that section, though,
22 because I'm struggling to find it.
23 Section 3, so what 3 C is supposed to say,
24 and it's good a question because it's confusing
25 because it's referring to the bill and it doesn't

1 read smoothly.
2 This is only supposed to be if the person
3 has not practiced for 24 months, then they may have
4 to do a competency exam for the Board.
5 DR. ISAACS: Seems reasonable.
6 MS. BRADLEY: Yes. And we do that for
7 both physician assistants and physicians. What
8 we're trying to do here, and this was a hard thing,
9 I think, for LCB to draft because the National
10 Association for AA's has a reentry process, so if
11 someone has been out for a set time period, they do
12 have an education program. But I think their
13 program only works if the person has also let their
14 certification lapse.
15 So the intent of, at least this section --
16 and I'm hoping it will be codified that same way --
17 is if you have not practiced for 24 months as an AA,
18 and you have not let your certification lapse, you
19 still have it, and you can't do the reentry that the
20 National Association offers, the Board may want you
21 to prove in some way your competency. They may not.
22 It depends.
23 But that was the intent of that section,
24 and that's why number 2, it says they won't require
25 this if they've done the reentry program. We're

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1 trying to kind of address both things.
2 DR. ISAACS: Okay. That's fine. It's
3 just kind of confusing.
4 MS. BRADLEY: Yes.
5 And there's also, I think, a limit on the
6 number of times they can take the exam. I want to
7 say that's also two years. So it kind of all goes
8 together that if they graduate, they have two years
9 to pass the exam and get certified, and so they'd
10 still be competent, we think, it's just if they go
11 past that 24-month mark.
12 Are there any other questions regarding
13 the regulation? I see no questions up here in Reno.
14 Any more questions in Las Vegas?
15 (No more questions in the south.)
16 MS. BRADLEY: Okay.
17 MR. YOUNG: Pall Young. I'm with Nevada
18 Association of Nurse Anesthetists. Thank you,
19 Sarah, for all the work you've done on this.
20 I was going to through -- I'm not going to
21 take a lot of time. We provided kind of NVANA's,
22 their proposal wanting to remove CRNAs from the reg,
23 specifically the section 16, 2 and 5 portions, that
24 some has been amended. We don't believe, kind of
25 across the state, at least National AA, NA has said

1 it's really not a lot of language, if any, across
2 the U.S. where it's having CRNAs in training of AAs,
3 and so just want to put that on the record.
4 As well as a concern -- again, it was kind
5 of alleviated but still concern in section 16 2.
6 The original language we were fine with, but then
7 when we struck 16 5, some language out of 16 5, and
8 then there was moved up where it was then amended,
9 in 16 2: An anesthesiologist may delegate the
10 supervision of a student in a training program for
11 anesthesiologist assistants only to a provider of
12 anesthesia determined by the anesthesiologist to
13 have received adequate clinical training in
14 anesthesiology.
15 That, again, gives us a little pause for
16 concern as one of the main concerns is having the
17 anesthesiologists determining any CRNAs adequate
18 training or anything to that affect.
19 MS. BRADLEY: I would comment that -- so
20 the way this was initially drafted, section 16, was
21 a mistake. So, the intent was that this language,
22 "determined by a supervising anesthesiologist to
23 have received adequate clinical training in
24 anesthesiology," that was intended to apply to
25 everyone in the list. And we did not -- we also

1 didn't list it like this.

2 Initially we were saying: A provider of

3 anesthesia that they think has the right training.

4 Because from the Medical Board

5 perspective, we would expect every licensee to never

6 transfer care, in any setting, to someone they think

7 is incompetent.

8 We have very similar rules for medical

9 assistants, anyone that a physician might be

10 delegating -- or a physician assistant might be

11 delegating to, they always have to make sure that

12 person's competent. So that language is kind of

13 consistent with our general idea if they are ever

14 delegating.

15 The way it was drafted was an error, and

16 that's why we moved it up, as you noted. The real

17 concern I think we had was that sometimes an

18 anesthesiology fellow or an anesthesiology resident

19 may not have completed enough clinical training to

20 be competent to oversee someone. That's really

21 where that language was supposed to go.

22 But when it was drafted, it went in the

23 wrong place. When I talked to LCB, they suggested

24 that I move it up to section 2, which I think, for

25 our purposes, works because, again, the standard of

1 care at least for medicine would be you make sure
2 that whoever you're delegating is competent. Right?
3 They can't say ever, well, I delegated it. Yeah, I
4 thought they weren't competent. No, no, no. You
5 only every delegate if you think they're competent.
6 That's always a determination we think
7 they should make no matter who it is, and that was
8 why I thought, well, this kind of works for us. And
9 it makes sure it's not pointing out one person on
10 the list because that was not the intent at all.
11 And now I know there's some concern over it.
12 The reason CRNAs are there at all was the
13 thought was these people were working together in
14 one room, hospital, whatever the location is,
15 providing care to the patients, and if a student is
16 there -- I don't know that they're going to delegate
17 it for very long, and I do have a couple of
18 anesthesiologists, one in Vegas and one here, that
19 maybe can speak more. I think the thought was just
20 they may leave that person with a CRNA, and we were
21 just wanting to say that was okay, basically.
22 That's was our intent.
23 I don't think we were trying to task CRNAs
24 with anything in particular or even saying they have
25 to teach them specific things. I read that here and

1 it was like, well, we're not really -- I think the
2 thought was they're in the room too.
3 So I don't if that helps. Do you still
4 have questions?
5 MR. YOUNG: I appreciate that. Yeah,
6 that's -- for the record, that's definitely our
7 concern is they don't really want to be part of the
8 teaching or that process of it.
9 MS. BRADLEY: Yeah. I think our thought
10 is they're all working together, taking care of
11 patients, and we wanted there to be some flexibility
12 that if an anesthesiologist needed to leave the
13 patient with a CRNA, that that's totally fine. I
14 guess our thought is they're an anesthesia provider
15 that's competent to do so.
16 I don't know if there's any comment from
17 Dr. Isaacs or Dr. Matsumura on that?
18 DR. MATSUMURA: For the record, Jerry
19 Matsumura.
20 That's correct, it was not -- it was meant
21 to apply to all the categories, just to say that
22 it's the responsibility of the supervising
23 anesthesiologist to make sure a qualified -- it
24 actually started out as qualified anesthesia
25 provider.

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1 MS. BRADLEY: That's what it used to say.
2 DR. MATSUMURA: And then somebody else
3 said, well, maybe it is resident, fellow
4 anesthesiology assistant, or CRNA.
5 And then the LCB's last version just
6 seemed to have tagged it right onto these.
7 MS. BRADLEY: Yeah.
8 So, initially, we weren't going to say
9 "CRNA" at all; we were just going to say "qualified
10 provider," and then I think in our discussions, we
11 decided to list them out.
12 It looks like we have another comment.
13 MS. BRAZEAU: Amanda Brazeau, Nevada
14 Academy of Anesthesiologist Assistants.
15 That was the intention, initially, is we
16 wanted to be sure that in the hospital setting, when
17 we are working with a physician anesthesiologist,
18 that they can appropriately tell which person
19 they're delegating a task to. We wanted to make
20 sure to be inclusive. We were not trying to
21 specifically target one type of provider.
22 MS. BRADLEY: That was our thought, is
23 that they would be working together.
24 And I think my thought too, I could be
25 wrong, let's just talk about a student in general,

1 are you going to let students actually administer
2 anesthesia, for example?
3 DR. MATSUMURA: Under supervision.
4 MS. BRADLEY: Under supervision. Okay.
5 So they could actually administer?
6 DR. MATSUMURA: Yeah. They could drop
7 medicine, administer it. They do the procedures
8 like intubation and nerve blocks. It's under the
9 direct supervision of the teaching anesthesiologist.
10 And then the other reason we added -- we
11 changed from qualified anesthesia provider to all
12 these categories -- I forgot who the recommendation
13 was -- we included nurse anesthetist because, from a
14 scheduling perspective, logically, it's easier to
15 have your choice of qualified anesthesia provider to
16 still leave the student with the actual
17 anesthesiologist supervising that room anyways.
18 MS. BRADLEY: Yeah. So I think the intent
19 was to include them the care team. I guess I'm
20 hearing maybe they don't want that. I'm not sure
21 how to proceed with that, really, just because -- I
22 think, and I'm not a person that's ever worked in a
23 hospital so I'm looking at those who have.
24 DR. MATSUMURA: In some states, like in
25 Colorado, there's an AA school there, and nurse

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1 anesthetists are involved in the student AA's
2 training also.
3 But at any particular practice of an
4 anesthesiologist assistant, anesthesiologist, or a
5 nurse anesthetist doesn't want to participate in
6 teaching, they're not forced to. They're employer
7 may decide you're not much of a team player, but for
8 the most part, there's no obligation for them to.
9 This just gives us the ability to leave
10 them with an anesthesia resident, anesthesiology
11 fellow, anesthesiologist assistant, or nurse
12 anesthetists.
13 MR. YOUNG: And I completely appreciate
14 that.
15 I think that is the concern of while
16 they're part of the -- now they're included, there's
17 potential for an employer, anesthesiologist to
18 potentially say, okay, you're part of the training
19 aspect.
20 It's my understanding from a client, they
21 do not want to be part of this. That's the --
22 DR. MATSUMURA: Well, I'm second in
23 command of a 70-person anesthesiology group here.
24 It's is voluntary which anesthesiologists have to
25 take students. I think 30 out of the 70, one or

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1 two, and that was plenty. We didn't punish the
2 other guys.
3 MS. BRADLEY: Okay.
4 DR. ISAACS: Thank you. I'm going to
5 support what Dr. Matsumura just said in terms of
6 qualified anesthesia provider as being the intent,
7 and not being subject of all this.
8 With that in mind, the wording is whether
9 you -- I understand the other side of that too and I
10 understand the objection to the wording, but the
11 principle of qualified anesthesia provider being one
12 that's there in the room, with the nurse -- or the
13 student, CAA, I think is the intent. And that's
14 what I think the intent of this particular section
15 is.
16 Is that how you read it, Dr. Matsumura?
17 Or the intent of it?
18 DR. MATSUMURA: I'd agree with that
19 assessment.
20 MS. BRADLEY: To make sure everyone is
21 clear too, and I didn't say this earlier and
22 apologize, I did do a memo that is separate from the
23 draft because I did make a change to that section
24 16. Just so everyone has it, and I want to make
25 sure the record's clear. It's on our website also.

1 We did move that language up regarding
2 that determined to have received adequate clinical
3 training. We moved that up to the top because,
4 again, in the original draft, it looked liked we
5 were targeting just CRNAs and that was absolutely
6 not the intent.
7 Really, it's fellows and residents that we
8 wanted to make sure had enough training, because
9 they may not, depending on where they are in the
10 program.
11 And, again, from our perspective as the
12 Board, we always want our practitioners to make sure
13 anyone they delegate anything to, they believe is
14 competent. It sort fits with the standard of care,
15 so we weren't super concerned. We were trying to be
16 inclusive too.
17 I guess my hope is these people are all
18 going to work together in the hospital. I do know
19 in the critical care hospitals right now, CRNAs are
20 doing more things without -- I mean, they're still
21 supervised, I believe, to some degree, but they can
22 actually be more autonomous under that 336 -- SB336,
23 and, potentially, as the scope may be or things
24 change for CRNAs, I think we might see that
25 changing. I don't know. We'll revisit what we have

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1 to, if and when those times come.
2 DR. MATSUMURA: Consistent with what
3 Ms. Bradley was saying, the intent of that language
4 actually was designed for anesthesiology residents.
5 I was telling her that you can be an
6 anesthesiologist resident and not have had a month
7 of clinical anesthesia your first 12 months. And so
8 the supervisor anesthesiologist should probably
9 think in his judgment that's probably not a good
10 person to leave with a student.
11 That's where the language acts originated.
12 MS. BRADLEY: Yeah. I got it from you. I
13 couldn't remember, I thought it was residents and
14 fellows.
15 But, yeah, you're the one that --
16 DR. MATSUMURA: Well, fellow that had
17 three years of residency.
18 MS. BRADLEY: Okay. So they should know.
19 DR. MATSUMURA: Yeah.
20 MS. BRADLEY: Yeah. I got the language
21 from you, and I knew it was really just the one
22 student we were worried about.
23 The other thing I wanted to add to this,
24 we don't have a program yet in Nevada to train AAs.
25 Now, we may, soon, and maybe we will, and we hope we

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1 will because then we will get more licensees.
2 My hope, even and including this at all,
3 initially I borrowed the language from Colorado,
4 because they talked about how to deal with students.
5 Initially I borrowed it from them, and then refined
6 it a bit because I knew Dr. Matsumura was concerned
7 about the wording that they had in Colorado. And
8 then we refined it a bit more.
9 But, really, we're trying to be proactive
10 because we're hoping, when there's a school, this
11 will be ready to go and everyone will be able to get
12 trained.
13 It's also possible, maybe, some
14 out-of-state schools might send people here. I
15 don't know. I know for medical school, you can do
16 that, you can do a rotation somewhere else where
17 your school's not.
18 DR. MATSUMURA: We do that right now for
19 students from Florida, come out here and rotate the
20 clinical rotations.
21 MS. BRADLEY: Yeah. So, maybe, and I
22 don't know if that happens with AAs or not.
23 DR. MATSUMURA: We had that in there
24 because we wanted to be, as you said, "proactive,"
25 so we didn't have to go back to the legislative

1 session when a school opens and create another bill
2 and change regulation.
3 And there's so many other states that
4 already have regulation in place that we're able to
5 draw from, there's no reason not to include student
6 AAs in the regulations.
7 MS. BRADLEY: I don't recall -- and I will
8 agree. I don't recall. I probably reviewed
9 approximately 12 states, maybe more. I think
10 there's 18 licensing. I reviewed a lot of states
11 and their regs, and some were more, some were less.
12 I don't recall specifically others that
13 did mention CRNAs in their regs. I just don't
14 recall. But I guess our thought was they're going
15 to be working together in a hospital setting, we
16 wanted them to be able to, I guess, work together as
17 freely as they need to.
18 If that alleviates anything?
19 MR. YOUNG: I appreciate that.
20 I don't think to your earlier comment,
21 it's -- especially from the National Association,
22 it's really not out there as the CRNAs involved with
23 AA training or in many regs, if any, from my
24 understanding being told.
25 It was their position that they prefer not

1 to be involved --
2 MS. BRADLEY: Okay.
3 MR. YOUNG: -- for those reasons.
4 MS. BRADLEY: Okay. Well, then I guess I
5 would say -- I think I'm going to echo what
6 Dr. Matsumura says, I mean it's a "may," the
7 anesthesiologist may do this.
8 I think also a part of standard of care is
9 if one of our licensees wants to delegate something
10 and someone says, no, I don't want that, they are
11 not to delegate it to them. And so it's an optional
12 thing, it's not required.
13 Certainly, I will let the Board know --
14 just so everyone understands, and I apologize for
15 not saying this at the start, this is a public
16 hearing on a regulation. We have a draft that, we
17 hope, is ready to go and be adopted with the changes
18 in that memo that I had passed out.
19 The Board meeting is March 1st, and this
20 is on the agenda, and we will bring them all of the
21 comments we've received. I will tell them, and you
22 can also attend the meeting. I will let them know
23 there was concerns about this language and what the
24 concerns were. Then the Board decides whether or
25 not to adopt the regulation as it is.

1 And then the next step for it is to go to
2 the Legislative Commission, and the Legislative
3 Commission decides whether or not to approve the
4 regulation as well. Hopefully the Legislative
5 Commission meeting will be in April, but I can't say
6 for sure. I just know we want it in place as
7 quickly as possible because I know we're getting
8 people licensed, they're going to start working, and
9 we want this in place as quickly as we can.
10 This is not the last step. I will let the
11 Board know the position and the concerns.
12 Any other questions?
13 DR. MATSUMURA: I had one more.
14 You commented on section 32, it's a
15 section referring to physician assistant. This is
16 perfectly covered in section 28 for the
17 anesthesiology assistant.
18 MS. BRADLEY: Yeah.
19 DR. MATSUMURA: It could probably actually
20 be scratched.
21 MS. BRADLEY: I think the reason this is
22 here is that this regulation is not already in place
23 for physician assistants. I will double check.
24 I think what happened when we were -- we
25 added it for anesthesiology assistants, and

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1 somehow -- I'll double check, because LCB added it
2 and I don't know why. I don't know if it's because
3 this doesn't already exist.
4 I know for physicians this is true, is
5 that if their license has been limited, they can
6 come to the Board, and they can request that the
7 Board change that.
8 It's possible -- because some things that
9 happened when I was going through these regs, I did
10 find things that one license type had and one
11 didn't, and they should be consistent. So it's one
12 of those. Yeah. It's possible it's just added
13 something for them. I'll double check that and make
14 sure that I know, because I guess I didn't realize
15 we had anything regarding PAs in here.
16 DR. MATSUMURA: And I kind of agree with
17 Mr. Young. Really a language, a regulation on AAs
18 should really try to keep other categories of
19 practitioners out as much possible, except where it
20 actually as part of a quality of care issue, if
21 they're working together.
22 But this one really doesn't apply to AAs
23 at all.
24 MS. BRADLEY: No, it doesn't. It doesn't.
25 And I'm not sure how it ended up there. I'll have

1 to go back to my notes and figure that out.
2 I think from LCB's perspective, this is
3 just an amendment of all of the Board's regs. So
4 even though we kind of subject them ourselves, they
5 see it as any changes to NAC 630, so it's
6 possible -- yeah, I'll have to double check. I'm
7 not sure how that's there, because we do have
8 another -- we have a couple of other drafts that
9 were pending for the other types of the Board's
10 chapter.
11 Usually we just lump them all together
12 when we're changing 630. Here, we're just making a
13 bunch of new ones.
14 Any more questions?
15 Not seeing any. Okay.
16 5. Public Comment for Proposed Regulation R069-23
17 I'm going to go ahead and go forward to
18 item 5, which is public comment on the regulation
19 itself, R069-23.
20 I don't know if we have any public comment
21 in the south?
22 (No public comments in the south.)
23 MS. BRADLEY: Up here, in the north?
24 I'm thinking, Mr. Young, your comment, we
25 will just include it, and the Board will know about

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1 it, and the fact that, I guess if I summarize it, it
2 sounds like the American Association of Nurse
3 Anesthetists -- okay, because it says
4 "anesetistiolgy" or something.
5 DR. MATSUMURA: Well, for a hundred years,
6 anesthetists; three years ago, they changed it to
7 anesthesiology.
8 MS. BRADLEY: Yes.
9 Okay. So, the American Association of
10 Nurse Anesthesiology would like us to completely
11 remove CRNAs from the regulation, it sounds like.
12 MR. YOUNG: Yes.
13 MS. BRADLEY: Okay. That is their
14 request. We'll put that on the record, and we will
15 let the Board make a decision. And then of course
16 the Legislative Commission.
17 One thing I did want to say that I need to
18 bring up to the Board, so I think we should bring it
19 up today, there is a concern from one of the
20 legislators regarding section 3 where we say "be
21 able to communicate adequately, orally, and in
22 writing in the English language."
23 That is a requirement that is also in the
24 Board's regulations for physician assistants and
25 practitioners of respiratory care. I don't believe

1 it is currently in the regulations for
2 perfusionists. And I don't believe it says it
3 anywhere for physicians.
4 I know that this legislator was concerned
5 that English language competency doesn't talk --
6 doesn't really address your competency to practice,
7 and so he has a concern that it's in here. I will
8 tell you it's in here because I was using the other
9 regulations as a guide.
10 I think there's at least one legislator,
11 maybe more, that would like us not to have that in
12 there.
13 He was concerned about the "be of good
14 moral character and reputation." That's something
15 that we require for all license types in general,
16 but I think he was concerned about that.
17 And, Amanda, while you're here, and I
18 apologize, do you know if the examination for
19 certification is given in other languages?
20 MS. BRAZEAU: I can find out for you.
21 Which section did you just say?
22 MS. BRADLEY: Section 3 says, "adequately,
23 orally, and in writing in the English language
24 regarding communication."
25 MS. BRAZEAU: The national exam?

1 MS. BRADLEY: Yeah. I believe -- I looked
2 on the website, I think it's only in English. The
3 handbook doesn't say anything about it, and I
4 download it, it's approximately 50 pages.
5 Of course, I do have two physicians in the
6 room, I've not seen medical records be other than in
7 English in my time at the Board.
8 The example the legislator gave -- I was
9 at a meeting last Friday, the example he gave was
10 you might have a really highly skilled neurosurgeon,
11 for example, that doesn't speak English, you're
12 still going to allow them, perhaps, to practice. Of
13 course there's qualifications of hospitals and
14 things like that, getting privileges. But I guess
15 my thought is there is a difference between, like, a
16 once-a-year event from someone who is very
17 nationally or internationally renowned versus a
18 day-to-day interaction from practitioners every day.
19 I don't know. I don't have a problem with
20 taking it out, but my guess is they'll need it to
21 pass the national exam.
22 The other concern he had was there's a
23 spot that talks about prescription, but I think it
24 has to do with impairment. Page 6, and it's section
25 4, subection 1, subsection I, and it says:

1 "Whether the applicant uses prescription
2 drugs or other substances that may affect his or her
3 ability to safely practice."
4 Again, I believe that's something that we
5 ask other license types about. But his concern was,
6 I think, stigmatizing people that may need
7 medications. I don't think that's the intent at
8 all; however, as we all know, there could be someone
9 who does need a medication and maybe shouldn't work
10 while they're taking it.
11 Like if it's a highly-affecting-them
12 controlled substance or something, they may need to
13 take time off rather than going back to work if they
14 need to take that for a bit.
15 I don't know if there's thoughts on that?
16 DR. ISAACS: Number one, I've seen the
17 reverse be true, not having competency of being --
18 the English language be an impediment to the
19 learning of students in the practice of
20 anesthesiology. So, the converse is actually very
21 true.
22 And as far as on the sites that are
23 granting privileges, I think that's a question that
24 each and every one of us face on the sites that
25 grant privileges, is that they're not on any

1 medications that inhibit our ability to do --
2 competent, take care of patients.
3 MS. BRADLEY: Okay. That's something that
4 the hospitals ask, it sounds like?
5 DR. ISAACS: Very definitely.
6 MS. BRADLEY: Okay. I know, generally, in
7 our license applications, I think we ask about
8 untreated medical conditions that could impact your
9 ability to practice.
10 I worked -- just for the record, I worked
11 for 16 years in license, in general, with different
12 boards, and that's pretty common. Every board says,
13 don't not tell me what your condition is, but just
14 do you have something that is not treated that could
15 impact your ability to practice safely?
16 Lots of us take things that allow us to
17 practice safely, and we would just say no, because
18 my condition is treated. Right?
19 It's really more for people who have an
20 untreated condition, the ADA does protect that.
21 The prescriptions thing was something I
22 wasn't as familiar with, but it makes sense if
23 hospitals are asking that. Okay.
24 Well, I'll bring those up to the Board as
25 well to see if they want to take those out. I

1 suppose my concern is I want to make sure this
2 legislator isn't upset about our regulation, but at
3 the same time, obviously, we need -- I think the
4 Board just needs to know that, I suppose.
5 DR. ISAACS: Patient protection, that has
6 to be the bottom line on which these decisions --
7 MS. BRADLEY: Yes. And I agree with you
8 that, definitely, that statute says the Board is to
9 protect the public, period.
10 It does sound like, though, even if we do
11 not require, for example, English language or the
12 prescription information, the hospital is going to
13 ask about the prescriptions, regardless, when they
14 go to work there. And English language is going to
15 be an issue if you just can't communicate clearly in
16 the hospital.
17 MS. BRAZEAU: As of now, it's currently
18 only English, the national exam.
19 MS. BRADLEY: Okay. So the national exam
20 is only in English. That's what I thought. Okay.
21 Are there any other questions regarding
22 this regulation?
23 I'm seeing none in Reno. Any in Las
24 Vegas? Nope. Okay.
25

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1 6. Public Comment

2 We will go ahead and move forward to item

3 number 6. This is also just a general public

4 comment period. Members of the public are invited

5 to provide public comment, and it will be limited to

6 four minutes at your discretion if need be.

7 Do we have any general public comment?

8 (No public comment in the south.)

9 MS. BRADLEY: And I don't see any here in

10 Reno.

11 7. Adjournment

12 We will go ahead and adjourn. It is 2:51,

13 by my watch.

14 (Meeting adjourned at 2:51 p.m.)

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1 STATE OF NEVADA)
) ss.
2 COUNTY OF WASHOE)
3
4 I, BRANDI ANN VIANNEY SMITH, do hereby
5 certify:
6 That I was present on February 20, 2024,
7 for the Public Meeting, at the Nevada State Board of
8 Medical Examiners, 9600 Gateway Drive, Reno, Nevada,
9 and took stenotype notes of the proceedings entitled
10 herein, and thereafter transcribed the same into
11 typewriting as herein appears.
12 That the foregoing transcript is a full,
13 true, and correct transcription of my stenotype
14 notes of said proceedings consisting of 39 pages,
15 inclusive.
16 DATED: At Reno, Nevada, this 26th day of
17 February, 2024.
18
19
20
21
22
23 BRANDI ANN VIANNEY SMITH
24
25

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Nevada Rules of Civil Procedure

Part V. Depositions and Discovery

Rule 30

(e) Review by Witness; Changes; Signing. If requested by the deponent or a party before completion of the deposition, the deponent shall have 30 days after being notified by the officer that the transcript or recording is available in which to review the transcript or recording and, if there are changes in form or substance, to sign a statement reciting such changes and the reasons given by the deponent for making them. The officer shall indicate in the certificate prescribed by subdivision (f)(1) whether any review was requested and, if so, shall append any changes made by the deponent during the period allowed.

DISCLAIMER: THE FOREGOING CIVIL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY. THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE STATE RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS

COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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WRITTEN COMMENTS RECEIVED

September 14, 2023
Nevada State Board of Medical Examiners
9600 Gateway Dr.
Reno, NV 89521

RE: Item 13(g) Anesthesiologist Assistant Regulations

Dear Mr. Cousineau, President Nagy, M.D, and Board Members,

Certified Anesthesiologist Assistants (CAAs) are highly trained non-physician advanced practice providers and healthcare professionals that provide anesthesia care. All CAAs possess a science/premedical background, a baccalaureate degree, and also complete a comprehensive didactic and clinical training program at the graduate school level. CAAs are trained extensively in the delivery and maintenance of quality anesthesia care, as well as advanced patient monitoring techniques, and emergency scenarios. CAAs practice exclusively in hospital/operating room settings within the Anesthesia Care Team environment under the direction of a physician anesthesiologist (as described by the American Society of Anesthesiologists™) to help implement an anesthetic plan as prescribed by the anesthesiologist.

Licensure of these medical professionals and the addition of another category of physician extenders that local anesthesiologists can utilize allows more flexibility and ability to help alleviate some of the desperate need for anesthesia providers in the area with an additional provider option within the Anesthesia Care Team (ACT) model. Combining these advanced practitioners with physician anesthesiologists will allow for physician led care and stress a patient centric team approach.

These regulations allow for the licensure of CAAs and will facilitate a smooth transition of this medical profession into Nevada's Healthcare system. We look forward to working with the Nevada State Board of Medical Examiners on these regulations through the drafting, workshop and hearing process.

Sincerely,

S Zunini

Stephanie Zunini
President of the Nevada Academy of Anesthesiologist Assistants

October 17, 2023
Nevada State Board of Medical Examiners
9600 Gateway Dr.
Reno, NV 89521

RE: Regulation R069-23 Workshop

Dear Mr. Cousineau, President Nagy, M.D, and Board Members,

The Nevada Academy of Anesthesiologist Assistants is pleased to see these regulations moving forward and are happy to send our support to the Nevada State Board of Medical Examiners as they move through this process.

Licensure of these medical professionals and the addition of another category of physician extenders that anesthesiologists can utilize, allows more flexibility and ability to help alleviate some of the desperate need for anesthesia providers in Nevada, adding an additional provider option within the Anesthesia Care Team (ACT) model. Combining these advanced practice providers with physician anesthesiologists will allow for physician-led care, stress a patient centric team approach and allow for more Nevada patients to receive the care they need.

These regulations allow for the licensure of CAAs and will facilitate a smooth transition of this medical profession into Nevada's Healthcare system. We look forward to working with the Nevada State Board of Medical Examiners on these regulations and would like to provide one suggestion:

- In provision 23: The NVAAA recommends changing the wording to state that student anesthesiologist assistants can be supervised by "any qualified anesthesia provider" to encapsulate that SAAs may learn from physician anesthesiologists, anesthesiology fellows, anesthesiology residents, certified anesthesiologist assistants, or certified registered nurse anesthetists.

Sincerely,

Stephanie Zunini
President of the Nevada Academy of Anesthesiologist Assistants

Laurie L. Munson

From: Ann Silver <asilver@thechambernv.org>
Sent: Wednesday, October 4, 2023 3:27 PM
To: Sarah A. Bradley
Subject: FW: Proposed Regulation R069-23

WARNING - This email originated from outside the State of Nevada. Exercise caution when opening attachments or clicking links, especially from unknown senders.

Please see below; I sent to an incorrect address.

Ann Silver
Chief Executive Officer
The Reno+Sparks Chamber of Commerce
4065 S. Virginia St. #101, Reno, NV 89502
asilver@thechambernv.org 775.636.9550

From: Ann Silver
Sent: Wednesday, October 4, 2023 3:25 PM
To: bradley@medboard.nv.gov
Subject: FW: Proposed Regulation R069-23

Ann Silver
Chief Executive Officer
The Reno+Sparks Chamber of Commerce
4065 S. Virginia St. #101, Reno, NV 89502
asilver@thechambernv.org 775.636.9550

From: Ann Silver
Sent: Wednesday, October 4, 2023 3:21 PM
To: bradley@medboard.nv.gov
Subject: Proposed Regulation R069-23

Dear Sarah:
Thank you for providing the Reno + Sparks Chamber of Commerce the opportunity to review the proposed language. We do not object as the focus seems to be on the applicant rather than the business itself and will offer greater protections to patients.
Regards,
Ann

Ann Silver
Chief Executive Officer
The Reno+Sparks Chamber of Commerce
4065 S. Virginia St. #101, Reno, NV 89502
asilver@thechambernv.org 775.636.9550

Laurie L. Munson

From:	Paul Young <paul@tomclarksolutions.com>
Sent:	Wednesday, February 14, 2024 11:04 AM
To:	Sarah A. Bradley
Subject:	Comment on BME Reg from NvANA
Attachments:	Nevada AA Proposed Rules Areas of Concern for NVANA Comment Letter (2.14.24).docx

WARNING - This email originated from outside the State of Nevada. Exercise caution when opening attachments or clicking links, especially from unknown senders.

Sarah,

Thanks for taking the time for the discussion today. Please find the proposed comment from Nevada Association of Nurse Anesthetists.

Thank you,
Paul

Paul Young
Partner
Tom Clark Solutions
775.233.0264

Nevada Anesthesiologist Assistant Proposed Rule Comments

Proposed Regulation of the State Board of Medical Examiners LCB File No. R069-23P ("BME Proposed Rule") and Proposed Regulation of the State Board of Osteopathic Medicine LCB File No. R001-24I ("BOM Proposed Rule") contain similar language, so the arguments raised below can be used in NVANA comment letters responding to both rules:

1. **Physician anesthesiologists have no authority to determine the competency of CRNAs.**

   The BME Proposed Rule states that an "anesthesiologist may delegate the supervision of a student in a training program for anesthesiologist assistants only to a provider of anesthesia **determined by the anesthesiologist to have received adequate clinical training in anesthesiology.** … As used in this section, 'provider of anesthesia' includes CRNAs." BME Proposed Rule Sec. 16(2), (5)(e). The BOM Proposed Rule similarly states, "An anesthesiologist may delegate the supervision of a student in an anesthesiologist assistant training program to any qualified anesthesia provider. … As used in this section, a qualified anesthesia provider means … **a certified registered nurse anesthetist that the supervising osteopathic anesthesiologist believes has received adequate clinical training in anesthesiology**." BOM Proposed Rule New Provision #13(1)(2) (emphasis added).

   This bolded language exceeds the authority of BME and BOM.

   CRNAs are governed by Board of Nursing ("BON") regulations. To work as a licensed CRNA in Nevada, CRNAs must meet BON requirements including being an active, Nevada-licensed registered nurse (RN), submitting an educational transcript with their degree posted sent directly from their advanced nursing education program, and submitting their National Board of Certified Registered Nurse Anesthetists (NBCRNA) certification with a valid expiration date.[1] To obtain a NBCRNA certification, CRNAs must show that they have graduated from a multi-year educational program at one of over 130 accredited Nurse Anesthesia Educational Programs.[2]

   Nurse Anesthesia Educational Programs are accredited by the Council on Accreditation (COA). Nurse Anesthesia Educational Programs require that all nurse anesthesia residents (RRNAs) entering nurse anesthesia programs with an appropriate major such as a baccalaureate or graduate degree in nurse and at least 1 year full-time work experience as an RN in a critical care setting.[3] During the program, RRNAs must demonstrate competency in areas such as patient safety, perianesthesia, critical

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[1] Nevada State Board of Nursing, "CRNA Application Requirements," https://nevadanursingboard.org/wp-content/uploads/2023/11/CRNA-Instructions.pdf

[2] National Board of Certification & Recertification for Nurse Anesthetists, "Students," https://www.nbcrna.com/initial-certification/students.

[3] Council on Accreditation, :Standards for Accreditration of Nurse Anesthesia Programs – - Practice Doctorate, revised January 2023," https://www.coacrna.org/wp-content/uploads/2023/03/2004-Standards-for-Accreditation-of-Nurse-Anesthesia-Educational-Programs-revised-May-2022.pdf.

thinking, communication, leadership, and professionalism.[4] RRNA coursework includes Advanced Physiology/Pathophysiology (120 contact hours), advanced pharmacology (90 contact hours), basic and advanced principles in nurse anesthesia (120 contact hours), research (75 contact hours), advanced health assessment (45 contact hours), human anatomy, chemistry, biochemistry, physics, genetics, acute and chronic pain management, 12lead ECG interpretation†, radiology, ultrasound, anesthesia equipment, professional role development, wellness and substance use disorder, informatics, ethical and multicultural healthcare, leadership and management, business of anesthesia/practice management, health policy, healthcare finance, integration/clinical correlation."[5] RRNAs graduate their programs after gaining hands-on, clinical anesthesia experiences on at least 650 patient cases.[6]

The BME governs physicians who are licensed as Medical Doctors (MDs). The BOM governs physicians who are licensed as Doctor of Osteopathic Medicine (DOs). To practice in Nevada, MDs and DOs have their own licensure and educational requirements that are separate and unique from CRNAs.

Healthcare facilities have their own process and standards known as "credentialing" to determine the competency of an MD, DO, or CRNA that works at that facility.

There is no overlap in the law allowing for MDs and DOs to assess CRNA competency, nor can they assess CRNAs since the professions are governed by different certified educational programs, credentialing examinations, state licensing laws and regulations, and on an even more granular level, the requirements of each healthcare facility where they practice.

For these reasons, the language in referencing that a "supervising anesthesiologist" or "supervising osteopathic anesthesiologist" having authority to determine whether a CRNA has "received adequate clinical training in anesthesiology" must be stricken under BME Proposed Rule Sec. 16(4), (5)(e); BOM Proposed Rule New Provision #13(1)(2).

2. **No state laws or regulations explicitly address CRNAs training AA students, and instead, outright prohibit CRNAs training AA students in a clinical setting.**

   In the same section as previously referenced, the proposed rules state that an "anesthesiologist may **delegate the supervision**" of an AA student to those including a CRNA. Rule Sec. 16(2), (5)(e); BOM Proposed Rule New Provision #13(1)(2) (emphasis added).

   This bolded language allowing for delegation of AA student training to CRNAs does not exist in any other state and is outright prohibited in some states. For example, the American Association of Nurse Anesthesiology (AANA") details in their "Position on CRNAs Teaching AAs Students in a Clinical Setting" why CRNAs cannot supervise an

[4] *Id.*
[5] *Id.* At 21.
[6] *Id.* At 28.

AA student, and therefore, cannot be delegated by an MD or DO to do so. Nebraska's Board of Nursing have adopted this Position. *See enclosed.*

3. **MD Anesthesiologists should have a limit on the number of AA students they supervise if they are to simultaneously supervise the maximum number of AAs allowed under federal law or regulations governing Medicare of Medicaid.**

In the same section as previously referenced and only in the BME Proposed Rules does it state that "Nothing in this section limits the number of otherwise qualified providers of anesthesia whom an anesthesiologist may supervise." BME Proposed Rule Sec. 16(4). Compare this to how BME Proposed Rule Sect. 18(5) states that a "supervising anesthesiologist may not simultaneously supervise a greater number of anesthesiologist assistants than authorized by federal law or regulations governing Medicare and Medicaid, or any guidance adopted thereto."

Medicare law requires that an AA work under medical direction of an anesthesiologist.[7] AA's ability to work depends on the availability of an onsite anesthesiologist. For an AA to be medically directed, there must not be more than four cases – or **4 AAs** – to one anesthesiologist (emphasis added). The requirements at 42 C.F.R. §414.450(c) state, "[i]f the physician medically directs two, three, or four anesthesia procedures involving anesthetists or medically supervises more than four concurrent anesthesia procedures…" then the anesthesiologist is no longer medically directing and is medically supervising. Supervision and direction are not the same.

The 7 TEFRA requirements that an anesthesiologist must meet to bill for medical direction are:

1. Perform a preanesthetic examination and evaluation of the patient;
2. Prescribe the anesthesia plan;
3. Personally participate in the most demanding aspects of the anesthesia plan, including induction and emergence, when applicable;
4. Ensure that any procedures in the anesthesia plan that are not performed by the physician are performed by a qualified anesthetist;
5. Monitor the course of anesthesia administration at frequent intervals;
6. Remain physically present and available for immediate diagnosis and treatment of emergencies; and
7. Provide indicated postanesthesia care.

Note how the 3rd TEFRA requirement involves the personal participation of an anesthesiologist in critical portions of a case: when a patient is induced under anesthesia, and when a patient is emerging from anesthesia. Moreover, the 6th TEFRA requirement requires the anesthesiologist's physical presence and availability in case of emergency – basically, life or death situations.

According to Medicare's Condition of Participation (CoP) 42 C.F.R. §482.52(a). an AA must be "under the supervision of an anesthesiologist who is immediately available if needed." An anesthesiologist is considered "immediately available" to assist the

[7] 57 Fed. Reg.33878, 33891, July 31, 1992.

anesthesiologist's assistant under the anesthesiologist's supervision only if he/she is physically located within the same area as the anesthesiologist's assistant, e.g., in the same operative/procedural suite, or in the same labor and delivery unit, and not otherwise occupied in a way that prevents him/her from immediately conducting hands-on intervention, if needed."[8]

Therefore, delegation aside, how can an MD anesthesiologist comply with Medicare law and supervise 4 AAs without a limit to the number of AA students supervised? Even if an MD anesthesiologist delegates the supervision of an AA student to an AA under BME Proposed Rule Sec. 16(5)(d), would that effectively make the MD anesthesiologist responsible for supervising 4 AAs *and* 4 AA students? Either situation should be assessed for risks to patient safety. Since Medicare limits supervision of AAs to 4, under BME Proposed Rule Sec. 16(4), a limit should be placed on the number of AA students that can be supervised by an MD anesthesiologist while the MD anesthesiologist supervises other anesthesia providers.

4. **The Proposed Rules do not clarify that AAs cannot administer anesthesia absent the immediate, physical presence of their supervising anesthesiologist as required under Medicare law.**

BME Proposed Rule Sec. 21; BOM Proposed Rule New Provision #1(1)(2) do not make it clear that the supervising anesthesiologist must be physically present and immediately available for when AAs administer anesthesia, which violates U.S. federal regulations.

In addition to the previously mentioned Medicare law and TEFRA requirements requiring anesthesiologist physical presence, the Centers for Medicare & Medicaid Services (CMS) require a medically directing physician be present for induction and emergency for general anesthesia. Pages 58843-58844 of the Medicare Physician Fee Schedule final rule for CY 1999 state that a medically-directed anesthesiologist must be present for induction and emergence in all cases for general anesthesia to meet the third condition of the seven conditions. According to this section:

> We [CMS] published a final rule in the Federal Register on March 2, 1983 (48 FR 8928) in which the current requirements for medical direction were included to implement section 108 of TEFRA of 1982. Since general anesthesia was the usual mode of practice for anesthesia services, the requirement reflected this practice. However, since 1983, other types of anesthesia care, such as regional anesthetics and monitored anesthesia care have become more common. One of our objectives was to revise the current requirement so that it is consistent with current anesthesia practices. As a result, we have decided that **the medically directing physician must be present at induction and emergence for general anesthesia.** That final requirement is as follows: The medically directing physician participates in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence. (emphasis added).

Therefore, BME Proposed Rule Sec. 21; BOM Proposed Rule New Provision #1(1)(2) should be amended to comply with the CMS rules above.

---

[8] Ctrs. for Medicare & Medicaid Servs., State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, Rev. 151, 11-20-15), TAG A-1001.

Laurie L. Munson

From: Paul Young <paul@tomclarksolutions.com>
Sent: Thursday, February 15, 2024 9:10 AM
To: Sarah A. Bradley
Subject: NvANA's-R069-23
Attachments: Nevada AA Proposed Rules Areas of Concern for NVANA Comment Letter to BME (2.15.24).docx; AANA Position on CRNAs Teaching AA Students in the Clinical Setting 3.1.23.pdf

Follow Up Flag: Follow up
Due By: Thursday, February 15, 2024 4:00 PM
Flag Status: Completed

WARNING - This email originated from outside the State of Nevada. Exercise caution when opening attachments or clicking links, especially from unknown senders.

Good morning Sarah,

NvANA and AANA wanted to provide the attached proposed rule change to R069-23. AANA is out of the state and was inquiring on if there is a call in number for comment. If you have a minute, today, let's maybe get on a short call again to walk through.

Thank you,
Paul

Paul Young
Partner
Tom Clark Solutions
775.233.0264

Nevada Anesthesiologist Assistant Comments on the Board of Medical Examiners Proposed Rule

The following should be raised on record in response to the Proposed Regulation of the State Board of Medical Examiners LCB File No. R069-23P ("BME Proposed Rule").

1. **The Board should strike all references to CRNAs because no state laws or regulations explicitly address CRNAs training AA students. Instead, state laws and regulations outright prohibit CRNAs training AA students in a clinical setting.**

   The Amended BME Proposed Rule states that an "anesthesiologist **may delegate the supervision of a student in a training program for anesthesiologist assistants** only **to** a provider of anesthesia determined by the anesthesiologist to have received adequate clinical training in anesthesiology. … As used in this section, 'provider of anesthesia' includes **CRNAs.**" BME Proposed Rule Sec. 16(2), (5)(e) (emphasis added). This is the only section of the Proposed Rules that reference CRNAs.

   This bolded language allowing for delegation of AA student training to CRNAs does not exist in any other state and is outright prohibited in some states. For example, the American Association of Nurse Anesthesiology (AANA") details in their "Position on CRNAs Teaching AAs Students in a Clinical Setting" why CRNAs cannot supervise an AA student, and therefore, cannot be delegated by an MD or DO to do so. Nebraska's Board of Nursing have adopted this Position. *See enclosed.*

   We therefore request that reference to CRNAs as a provider to whom supervision of AAs can be delegated be stricken from Section 5(e).

2. **We reiterate the Board's comments that the legislative intent of these rules does not provide physician anesthesiologists authority to determine the competency of CRNAs. For this reason, we request an amendment to the rules that eliminates any possible interpretation that physician anesthesiologists have such authority to determine the competency of CRNAs.**

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   As the BME has mentioned during this hearing, this bolded language exceeds the authority of BME.

   CRNAs are governed by Board of Nursing ("BON") regulations. To work as a licensed CRNA in Nevada, CRNAs must meet BON requirements including being an active, Nevada-licensed registered nurse (RN), submitting an educational transcript with their degree posted sent directly from their advanced nursing education program, and

submitting their National Board of Certified Registered Nurse Anesthetists (NBCRNA) certification with a valid expiration date.[1] To obtain a NBCRNA certification, CRNAs must show that they have graduated from a multi-year educational program at one of over 130 accredited Nurse Anesthesia Educational Programs.[2]

Nurse Anesthesia Educational Programs are accredited by the Council on Accreditation (COA). Nurse Anesthesia Educational Programs require that all nurse anesthesia residents (RRNAs) entering nurse anesthesia programs with an appropriate major such as a baccalaureate or graduate degree in nurse and at least 1 year full-time work experience as an RN in a critical care setting.[3] During the program, RRNAs must demonstrate competency in areas such as patient safety, perianesthesia, critical thinking, communication, leadership, and professionalism.[4] RRNA coursework includes Advanced Physiology/Pathophysiology (120 contact hours), advanced pharmacology (90 contact hours), basic and advanced principles in nurse anesthesia (120 contact hours), research (75 contact hours), advanced health assessment (45 contact hours), human anatomy, chemistry, biochemistry, physics, genetics, acute and chronic pain management, 12lead ECG interpretation†, radiology, ultrasound, anesthesia equipment, professional role development, wellness and substance use disorder, informatics, ethical and multicultural healthcare, leadership and management, business of anesthesia/practice management, health policy, healthcare finance, integration/clinical correlation."[5] RRNAs graduate their programs after gaining hands-on, clinical anesthesia experiences on at least 650 patient cases.[6]

The BME governs physicians who are licensed as Medical Doctors (MDs). To practice in Nevada, MDs have their own licensure and educational requirements that are separate and unique from CRNAs.

Healthcare facilities have their own process and standards known as "credentialing" to determine the competency of an MD, DO, or CRNA that works at that facility.

There is no overlap in the law allowing for MDs (and DOs) to assess CRNA competency, nor can they assess CRNAs since the professions are governed by different certified educational programs, credentialing examinations, state licensing laws and regulations, and on an even more granular level, the requirements of each healthcare facility where they practice.

For these reasons, the language in referencing that a "supervising anesthesiologist" or having authority to determine whether a CRNA has "received adequate clinical training in

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[1] Nevada State Board of Nursing, "CRNA Application Requirements," https://nevadanursingboard.org/wp-content/uploads/2023/11/CRNA-Instructions.pdf
[2] National Board of Certification & Recertification for Nurse Anesthetists, "Students," https://www.nbcrna.com/initial-certification/students.
[3] Council on Accreditation, :Standards for Accreditration of Nurse Anesthesia Programs – - Practice Doctorate, revised January 2023," https://www.coacrna.org/wp-content/uploads/2023/03/2004-Standards-for-Accreditation-of-Nurse-Anesthesia-Educational-Programs-revised-May-2022.pdf.
[4] *Id.*
[5] *Id.* At 21.
[6] *Id.* At 28.

anesthesiology" should be amended back to the original version of this Proposed Rule, with a revision, to read as follows:

> ***2. An anesthesiologist may delegate the supervision of a student in a training program for anesthesiologist assistants only to a provider of anesthesia.***
>
> ***5. As used in this section, "provider of anesthesia" means: 5. As used in this section, "provider of anesthesia" means: ... (e) A certified registered nurse anesthetist ~~determined by a supervising anesthesiologist to have received adequate clinical training in anesthesiology~~.***

3. MD Anesthesiologists should have a limit on the number of AA students they supervise if they are to simultaneously supervise the maximum number of AAs allowed under federal law or regulations governing Medicare of Medicaid.

In the same section as previously referenced and only in the BME Proposed Rules does it state that "Nothing in this section limits the number of otherwise qualified providers of anesthesia whom an anesthesiologist may supervise." BME Proposed Rule Sec. 16(4). Compare this to how BME Proposed Rule Sect. 18(5) states that a "supervising anesthesiologist may not simultaneously supervise a greater number of anesthesiologist assistants than authorized by federal law or regulations governing Medicare and Medicaid, or any guidance adopted thereto."

Medicare law requires that an AA work under medical direction of an anesthesiologist.[7] AA's ability to work depends on the availability of an onsite anesthesiologist. For an AA to be medically directed, there must not be more than four cases – or **4 AAs** – to one anesthesiologist (emphasis added). The requirements at 42 C.F.R. §414.450(c) state, "[i]f the physician medically directs two, three, or four anesthesia procedures involving anesthetists or medically supervises more than four concurrent anesthesia procedures..." then the anesthesiologist is no longer medically directing and is medically supervising. Supervision and direction are not the same.

The 7 TEFRA requirements that an anesthesiologist must meet to bill for medical direction are:

1. Perform a preanesthetic examination and evaluation of the patient;
2. Prescribe the anesthesia plan;
3. Personally participate in the most demanding aspects of the anesthesia plan, including induction and emergence, when applicable;
4. Ensure that any procedures in the anesthesia plan that are not performed by the physician are performed by a qualified anesthetist;
5. Monitor the course of anesthesia administration at frequent intervals;
6. Remain physically present and available for immediate diagnosis and treatment of emergencies; and

[7] 57 Fed. Reg.33878, 33891, July 31, 1992.

7. Provide indicated postanesthesia care.

Note how the 3rd TEFRA requirement involves the personal participation of an anesthesiologist in critical portions of a case: when a patient is induced under anesthesia, and when a patient is emerging from anesthesia. Moreover, the 6th TEFRA requirement requires the anesthesiologist's physical presence and availability in case of emergency – basically, life or death situations.

According to Medicare's Condition of Participation (CoP) 42 C.F.R. §482.52(a). an AA must be "under the supervision of an anesthesiologist who is immediately available if needed." An anesthesiologist is considered "immediately available" to assist the anesthesiologist's assistant under the anesthesiologist's supervision only if he/she is physically located within the same area as the anesthesiologist's assistant, e.g., in the same operative/procedural suite, or in the same labor and delivery unit, and not otherwise occupied in a way that prevents him/her from immediately conducting hands-on intervention, if needed."[8]

Therefore, delegation aside, how can an MD anesthesiologist comply with Medicare law and supervise 4 AAs without a limit to the number of AA students supervised? Even if an MD anesthesiologist delegates the supervision of an AA student to an AA under BME Proposed Rule Sec. 16(5)(d), would that effectively make the MD anesthesiologist responsible for supervising 4 AAs *and* 4 AA students? Either situation should be assessed for risks to patient safety. Since Medicare limits supervision of AAs to 4, under BME Proposed Rule Sec. 16(4), a limit should be placed on the number of AA students that can be supervised by an MD anesthesiologist while the MD anesthesiologist supervises other anesthesia providers.

4. **The Proposed Rules do not clarify that AAs cannot administer anesthesia absent the immediate, physical presence of their supervising anesthesiologist as required under Medicare law.**

BME Proposed Rule Sec. 21 do not make it clear that the supervising anesthesiologist must be physically present and immediately available for when AAs administer anesthesia, which violates U.S. federal regulations.

In addition to the previously mentioned Medicare law and TEFRA requirements requiring anesthesiologist physical presence, the Centers for Medicare & Medicaid Services (CMS) require a medically directing physician be present for induction and emergency for general anesthesia. Pages 58843-58844 of the Medicare Physician Fee Schedule final rule for CY 1999 state that a medically-directed anesthesiologist must be present for induction and emergence in all cases for general anesthesia to meet the third condition of the seven conditions. According to this section:

> We [CMS] published a final rule in the Federal Register on March 2, 1983 (48 FR 8928) in which the current requirements for medical direction were included to implement section 108 of TEFRA of 1982. Since general anesthesia was the usual mode of practice for anesthesia services, the requirement reflected this practice. However, since 1983, other types of anesthesia care, such as regional anesthetics and monitored anesthesia

[8] Ctrs. for Medicare & Medicaid Servs., State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, Rev. 151, 11-20-15), TAG A-1001.

> care have become more common. One of our objectives was to revise the current requirement so that it is consistent with current anesthesia practices. As a result, we have decided that **the medically directing physician must be present at induction and emergence for general anesthesia.** That final requirement is as follows: The medically directing physician participates in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence. (emphasis added).

Therefore, BME Proposed Rule Sec. 21 should be amended to comply with the CMS rules above.

AANA Position on CRNAs Teaching AA Students in the Clinical Setting

CRNAs are involved in helping to train other professionals in specific clinical skills. While CRNAs may be able to train other professionals in specific clinical skills, CRNAs cannot educate other professionals in the entire practice of anesthesia if they are a dependent healthcare provider or their scope of practice is more limited than that of CRNAs. Therefore, the AANA's position and advice is that CRNAs *not* participate in teaching anesthesiologist assistant (AA) students in any setting for the following reasons:

- CRNAs are educated to be autonomous providers who are not required to work with anesthesiologists. In contrast, AAs are dependent providers who must work under the direct supervision of an anesthesiologist in an anesthesia care team (ACT). Consequently, CRNAs are advised not to teach AA students because of limitations and differences in AAs' scope of practice, including the need for an anesthesiologist to be present to supervise AAs.

- CRNAs are able to formulate and implement anesthesia care plans autonomously based on critical thinking and in-depth knowledge, whereas AAs can only work as part of an anesthesia care team (ACT) with all tasks delegated by an anesthesiologist. Therefore, physician anesthesiologists are best positioned to teach, and are responsible for teaching, AA students to assist physician anesthesiologists as part of the ACT.

- CRNAs are qualified to perform all aspects of anesthesia care autonomously, based on their education, training, licensure, and certification; by comparison, AAs have different education, training, licensing and certification, and they are limited to serving in an assistant capacity to physician anesthesiologists. Additionally, the educational path to becoming a CRNA includes rigorous clinical and critical care prerequisites for entry into a nurse anesthesia program; there are no such requirements for entry into an AA program.

- While it is acceptable for CRNAs to train another provider on specific technical skills in certain circumstances, CRNAs cannot educate and evaluate students, other than students training to be independent/autonomous anesthesia providers such as student registered nurse anesthetists (SRNAs), physician anesthesiologist residents, dental anesthesiologist residents, and oral maxillofacial surgical residents in the entire practice of anesthesia due to substantial differences in clinical background, educational paths and scope of practice.

- Note that this position has been adopted by the Nebraska Board of Nursing.

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