MINUTES OF THE
SENATE COMMITTEE ON COMMERCE AND LABOR

Eighty-second Session
May 5, 2023

The Senate Committee on Commerce and Labor was called to order by Chair Pat Spearman at 8:05 a.m. on Friday, May 5, 2023, in Room 2134 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

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

GUEST LEGISLATORS PRESENT:

Assemblywoman Lesley E. Cohen, Assembly District No. 29
Assemblywoman Sandra Jauregui, Assembly District No. 41
Assemblyman Duy Nguyen, Assembly District No. 8
Assemblywoman Sarah Peters, Assembly District No. 24
Assemblywoman Angie Taylor, Assembly District No. 27

STAFF MEMBERS PRESENT:

Cesar Melgarejo, Policy Analyst
Bryan Fernley, Counsel
Veda Wooley, Counsel
Kelly K. Clark, Committee Secretary

OTHERS PRESENT:

Corinne Sedran, Executive Director, Board of Dispensing Opticians
James Morris, General Counsel and Executive Director, American Board of Opticianry & National Contact Lens Examiners
Joe Neville, National Association of Retail Optical Companies
Patrick Kelly, Chief Executive Officer, Nevada Hospital Association
George Ross, HCA Healthcare
Chris Bosse, Renown Health
Marlene Lockard, Service Employees International Union 1107
Sarah Bradley, Deputy Executive Director, Board of Medical Examiners
Tom Clark, Board of Medical Examiners
Bret Frey, M.D., Nevada Chapter, American College of Emergency Physicians
Nicholas Schneider, Vegas Chamber
Michael Hillerby, State Board of Nursing; State Board of Pharmacy
Serena Evans, Nevada Coalition to END Domestic and Sexual Violence
Christopher Ries, Las Vegas Metropolitan Police Department
John Jones, Jr., Nevada District Attorneys Association
Jason Walker, Washoe County Sheriff's Office
Pamela DelPorto, Nevada Sheriffs' and Chiefs' Association
Andrew Pasternak, Nevada State Medical Association
Hana Fahmi
Dora Martinez, Nevada Disability Peer Action Coalition
John Sande IV, Nevada Academy of Physician Assistants
Brian Lauf, Nevada Academy of Physician Assistants
Carmella Downing, Nevada Academy of Physician Assistants
David Baker, M.D.
Blayne Osborn, Nevada Rural Hospital Partners
Ann Miles, Nevada Academy of Physician Assistants
John Larson
George Ross, Touro University
Austin Brown, University of Nevada, Reno
David Brems, Operations Director, Intermountain Health
Daniel Villalobos
Curt Bramble, Utah State Senator
Leila Berg
Stan
Kim McFarland
Susan Fisher, State Board of Osteopathic Medicine

Erin Simmers, M.D., Northern Nevada Emergency Physicians
Sarah Watkins, Interim Executive Director, Nevada State Medical Association
Nick M. Spirtos
Karen Massey, Medical Group Management Association

CHAIR SPEARMAN:
We will open the hearing on Assembly Bill (A.B.) 415.

ASSEMBLY BILL 415 (1st Reprint): Revises provisions relating to dispensing opticians. (BDR 54-846)

ASSEMBLYWOMAN ANGIE TAYLOR (Assembly District No. 27):
Assembly Bill 415 revises provisions relating to dispensing opticians. The Governor is required to appoint members to the Board of Dispensing Opticians. Last Session, we considered but did not pass A.B. No. 391 of the 81st Session, which would have cleaned up outdated provisions relating to the Board. A last-minute amendment was proposed, and we ran up against *sine die*. If you run up against *sine die*, that means your bill is not going to make it.

This Session, we are introducing A.B. 415 to revise and clarify provisions relating to the licensing requirements for current licensees and unlawful acts and related enforcement provisions. These changes are necessary to ensure the Board achieves its primary function of protecting public health, safety and welfare.

The Board has been working on language that would become A.B. 415 over the past two years. It has been an ongoing effort to ensure it effectively streamlines *Nevada Revised Statutes* (NRS) 637 and brings it up to date with the realities of the profession. We have distributed a table (Exhibit C) listing all the changes to NRS 637 in this bill.

This bill does three things. First, it streamlines and organizes the provisions, removing outdated and extraneous language. Second, it clarifies and simplifies the procedure for obtaining a license, including removing barriers for both in-state and out-of-state applicants. Third, it facilitates the Board's enforcement of its laws so it may be done in the most efficient and cost-effective manner possible for all parties. We believe this bill reflects the Board's efforts on all those points as well as the State's general interest in facilitating licensure and job opportunities.

CORINNE SEDRAN (Executive Director, Board of Dispensing Opticians):
I will walk you through the bill.

Section 1 is the heading of the amendments. In section 2, we added a statement of purpose for the entire bill. Sections 3 through 5 are definitions.

Section 6 is an immunity clause, which is comparable to what other boards have in statute regarding immunity for Board members and staff.

Section 7 cleans up the licensing requirements in terms of licensure for apprentices.

Section 8 is a regulatory section and gives the Board authority to regulate the terms of licensure, when licenses expire and license reinstatement.

Section 9 is a fee schedule, comparable to what other boards have in their statute. This single fee section is where everything is laid out together and consolidated.

Section 10 is a consolidation and clarification of complaint provisions.

Section 11 grants the Board citation authority, which is important for enforcement actions, especially for things that are not egregious, but may be a violation of one of our laws or provisions. It gives the Board the ability to issue a citation in lieu of a full-blown hearing.

Section 12 lists more citation provisions.

Sections 14 and 15 clarify the definitions of dispensing optician and ophthalmic dispensing generally.

Section 16 contains exemptions to the statute for physicians and optometrists.

Section 17 clarifies requirements for Board members.

Sections 18 and 19 update and consolidate provisions related to the administration of the Board and its officers and personnel generally.

Section 20 gives further information about Board officers and employment of Board staff.

Section 21 has to do with gifts, grants and donations to the Board. This was previously in our disciplinary action section. It gave the Board the ability to accept grants, gifts and donations to carry out investigations. We thought this was a conflict of interest. We revised it to the Board being able to accept grants and donations comparable to the statutes of other boards.

Section 22 clarifies the Board's regulatory authority with setting minimum standards of practice and for the way ophthalmic lenses will be dispensed.

Section 23 clarifies which records of the Board will remain confidential. Those related to disciplinary actions have been moved to sections 26 through 29. They have not been removed, just moved to a different section.

Section 24 clarifies that an optical establishment may remain open if a dispensing optician is not on site as long as a sign is posted telling the public the optician is not available.

Section 25 clarifies our licensing requirements and allows for license reciprocity. It expedites licensing for military personnel and their spouses, and allows transfers from states that do not issue licenses to dispensing opticians.

Section 26 updates the types of records the Board will keep for its licensees' public records.

Section 27 consolidates all the provisions related to limited licenses in one section. The Board no longer issues limited licenses and has not done so since 2004. We want to consolidate everything related to those licenses to a single section. If the statute is amended in the future, we can remove those provisions altogether if we no longer have limited licenses.

Section 28 clarifies the requirements for employment of licensed dispensing opticians and the oversight of apprentices.

Section 29 has to do with complaints and disciplinary actions, specifically unprofessional conduct of a licensed optician.

Together, sections 29 and 30 streamline provisions related to complaints, the Board's subpoena power and its investigatory and hearing powers.

Section 30 has to do with actions against unlicensed individuals.

Section 31 has to do with issuing citations pursuant to section 11 of this bill.

Section 32 adds two unlawful acts, which are holding oneself out to the public to be an optician without being licensed and violating the expiration date on a prescription.

Section 32.5 is a mandatory provision having to do with a limited license and puts a fee cap on the amount for reinstating a limited license.

SENATOR DALY:
The way I understand section 5 is that at every physical location where you are doing the dispensing work, there must be a licensed professional. If there is a chain with 20 of these offices, the management office where they are not doing any dispensing does not have to have a licensed person. Is that right?

MS. SEDRAN:
Yes, that is correct. "Optical establishment" clarifies we are speaking about the department where the dispensing takes place.

SENATOR DALY:
I wanted to make sure you will have a licensed professional at each individual location where the practice is taking place.

MS. SEDRAN:
Correct.

SENATOR DALY:
In section 18, you are changing when you have the hearing. How will the hearings be carried out? Are you switching to a fiscal year? Is there a set schedule, or is it just once a year?

MS. SEDRAN:
Are you speaking about disciplinary hearings or some other type of hearing?

SENATOR DALY:
Whichever is in section 18. It says, "The Board shall meet at least once each year," and you are switching to a fiscal year.

MS. SEDRAN:
No, we have already been operating on a fiscal year. We just reorganized and streamlined some of the provisions. We already have in our statute that we would operate based on the fiscal year.

SENATOR DALY:
In section 23, you said you were "clarifying" which Board records remain confidential. I would disagree that it is clarified. Section 23, subsection 5 says, "Any other information or record in possession of the Board that is not a public record subject to the provisions of chapter 239 of NRS." Unless it is declared to be confidential, it is a public record. The language in the bill seems to be backward.

MS. SEDRAN:
The intent here is to clarify we are going to be in compliance with Nevada's Public Records Act (NPRA). If it is not a public record, according to NPRA, we can keep it confidential. In section 23, subsection 2, we deleted paragraph (d), which said, "Any other information or records in the possession of the Board." This was to clarify any information or records in the possession of the Board that are not public records subject to those provisions. We just added the clarifying clause at the end, but it had already said any other information or records in the possession of the Board would be confidential.

SENATOR DALY:
Understood, but just because it said that before does not mean it was right. That is why I am bringing it up. When does that stuff become public? The final complaint and action should be public record. This would indicate it would not be and you can keep it confidential. I want to make sure that cannot happen.

MS. SEDRAN:
We reorganized that. It is now in section 29, subsection 7, which says, "An order of the Board that imposes discipline and the findings of fact and conclusions of law supporting the order are public records." That is the same language that was struck through in the other section. We just reorganized it into this section pertaining to disciplinary actions. Anything that is a disciplinary

action or finding of fact will still be subject to public records laws and requests under NPRA. We have not removed that provision; we just moved it.

SENATOR DALY:
I will take a look at it, and maybe you can come talk to me to make sure we are clear on that. Finally, in section 26, subsection 2, you talk about a copy fee.

MS. SEDRAN:
This fee is congruent with NPRA, which says we can charge a fee for staff time for copying incurred by the Board. We do not think we are being excessive. Incidentally, this section says the name of each holder of a license who has been subject to disciplinary action by the Board will be a public record.

SENATOR DALY:
The language about copy fees is already in NRS 239, which applies to everybody. Repeating it here with different language just creates confusion. Why not refer to NRS 239? It would be easier and more consistent.

MS. SEDRAN:
We relied on the statutes of other boards when drafting this language, where this language is common. However, that is something we can address.

SENATOR PAZINA:
In section 24, subsection 2, I noticed there should be signage available if the licensed dispensing optician is not present. In the past, were offices closed when the licensing optician was not present?

MS. SEDRAN:
In the past it was not clear, and we had a lot of questions asking the Board whether they could stay open or not. We went back and forth on the management, if the manager had to be there to open the store. We wanted to clarify it in our statute that yes, you can remain open. The ophthalmic manager does not need to be on site, but a sign needs to be posted.

SENATOR STONE:
Section 21, subsection 2 says, "The Board may accept gifts, grants, donations and contributions of money from any source to assist in carrying out the provisions of this chapter." Are you referring to monetary gifts, or are you talking about material gifts as well? If so, what kind of gifts are we talking

about, and where are they going to be used? Are we allowing Board members to accept gifts from people they are going to be regulating?

MS. SEDRAN:
We have never received a gift, grant or donation that I am aware of. This provision has been in our statute for many years, but it was pertaining to the ability of the Board to do investigations. We did not think it sounded right to have a gift given to conduct an investigation. Individual Board members may not receive gifts; it would just be gifts to the Board as a whole for operating costs. As far as donations and other contributions that are not a monetary gift, I do not know what that would look like. It would just be a monetary gift for the administration of the Board.

SENATOR STONE:
Is this provision needed?

MS. SEDRAN:
It has not been utilized. We could probably remove the reference to things that are not monetary contributions. Not that it matters, but this was another provision that was congruent with the statutes of other boards.

SENATOR STONE:
I am concerned that it raises a red flag of bias. If a benevolent person wants to make a $2 million donation because he or she believes in opticians, wants to further their education and give it to the Board, I do not have a problem with that. But when you allow "gifts," that raises flags when you have a regulatory Board.

JAMES MORRIS (General Counsel and Executive Director, American Board of Opticianry & National Contact Lens Examiners):
I rise in support of this bill and can answer any questions you have.

JOE NEVILLE (National Association of Retail Optical Companies):
We are opposed to the bill as drafted, primarily because we have several objections and suggested changes we think are important. Nevada is 1 of 20 states that licenses opticians, and it is the most restrictive state in the Union. There is no reciprocity between the licensed states. Unlicensed people are not welcomed by the Board to work in our stores. The National Association of Retail Optical Companies is made up of large and small optical firms

throughout the U.S. Nevada is one of the most difficult states for us to work and operate in.

We submitted a letter on April 28 with some of our concerns and suggesting several amendments to the bill. Our goal is not to deregulate, but to bring Nevada into the mainstream.

CHAIR SPEARMAN:
We have had several bills this Session on the topic of eyecare. You might want to look at those bills and see if any of them answer your concerns.

ASSEMBLYWOMAN TAYLOR:
I have not seen the letter Mr. Neville referred to, but I am happy to meet with him to discuss the changes he seeks.

CHAIR SPEARMAN:
We will close the hearing on A.B. 415 and open the hearing on A.B. 401.

ASSEMBLY BILL 401 (1st Reprint): Revises provisions governing schools of nursing. (BDR 54-1042)

ASSEMBLYWOMAN SANDRA JAUREGUI (Assembly District No. 41):
As our frontline healthcare workers, nurses take an all-encompassing view of the patient's well-being so they can provide care and treatment the moment a patient needs it. Nurses are essential in providing care and producing positive healthcare outcomes. A groundbreaking Penn Nursing study from 2002 found a lack of nurses directly relates to increased patient mortality.

We are facing a historic shortage of nurses. Nevada needs to recruit more than 4,000 registered nurses (RN) just to meet the national average. We have seen this problem play out all too frequently. We are all familiar with the COVID-19 pandemic, when cases surged and capacity collapsed. Doctors and nurses had to triage those under their care to save as many patients as possible. Just this winter, a combination of respiratory syncytial virus, flu and COVID-19 infections created a dire situation that caused our pediatric ICUs to reach capacity and nearly caused the same horror as the deaths of 2020. The problem is getting worse, and we need to act now.

This Session, I brought A.B. 108, A.B. 401 and A.B. 443, all measures to help in creating the nurse pipeline essential to fundamentally addressing the shortage.

ASSEMBLY BILL 108: Enacts the Nurse Licensure Compact. (BDR 54-522)

ASSEMBLY BILL 443: Expands the institutions which certain recipients of the Governor Guinn Millennium Scholarship are authorized to attend. (BDR 34-352)

One solution is not going to solve our nursing shortage. This is an all-of-the-above approach we need to tackle this problem and ensure we stabilize and support Nevada's healthcare system.

Assembly Bill 108 did not make it across the finish line. Assembly Bill 401 and A.B. 443 have made it over to your House, and I look forward to the positive impact they will have in our State.

Assembly Bill 401 was a product of the Joint Interim Standing Committee on Commerce and Labor and came at the recommendation of the Service Employees International Union. Assembly Bill 401 will help increase nurses in Nevada by creating permissive language allowing a school to increase the student-teacher ratio from 8 students per teacher to 12 students per teacher. It is important to note this language is permissive only. It does not mandate schools to automatically go to 12. It simply lifts the statutory requirement now capping them at eight.

One school may want to increase the number of students from 8 to 12 and see how it works for its program. Another school may not want to increase the current ratio and will stay at status quo.

PATRICK KELLY (Chief Executive Officer, Nevada Hospital Association):
Assembly Bill 401 is one step toward increasing the number of nurses in Nevada. This bill is simple. It allows a school of practical nursing or a school of professional nursing to increase the size of its classes. The nursing programs are limited to a ratio of one faculty member to eight nursing students.

Assembly Bill 401 permits nursing schools to increase their faculty-to-student ratio to 1 faculty member to 12 nursing students. Increasing the size of the

class is not mandatory. Each school will get to decide. Our nursing pipeline could expand by 50 percent if nursing schools adopted the 1-to-12 ratio.

Keep in mind, this bill addresses only one piece of the pipeline challenge. Nursing faculty wages need to increase. They are not competitive with the private sector. Clinical training also needs to be evaluated. We need staggered clinical training hours, and we need to explore ways in which healthcare providers can assist in training.

Several bills are before the Legislature to provide additional funding for nursing schools. Senate Bill (S.B.) 375 is one. Support for nursing students is in A.B. 443.

SENATE BILL 375: Makes an appropriation to the Nevada System of Higher Education for a grant program to expand undergraduate and graduate nursing programs at institutions within the System. (BDR S-917)

We believe additional resources are on their way to help nursing programs. We want this piece of the puzzle to be in place when those resources arrive.

Assembly Bill 401 can also help students in Nevada. Each year, hundreds of qualified students are denied entry into our nursing programs because our programs are at capacity. Students who want to be nurses become discouraged and move on to other careers.

The big question is why are we turning away qualified students who want to be nurses when we have a severe nursing shortage? Our State's goal should be to enable every qualified student to become a nurse. The Legislative Counsel Bureau (LCB) prepared a report (Exhibit D) on the faculty requirements in other states. The LCB found that for schools of practical nursing, 19 states have an established faculty-to-student ratio higher than our current ratio of 1-to-8. Nine states and the District of Columbia have no specified ratios and do not regulate ratios. The RN program statistics are similar. Sixteen states have ratios higher than our ratio of 1-to-8, and 11 states and the District of Columbia have no specified ratios and do not regulate ratios.

It is not unusual to have a faculty-to-student ratio above 1-to-8. Nevada's nursing statistics are poor. We need more than 5,000 RNs and licensed practical nurses just to meet the national average. Forty-one percent of Nevada

RN licenses are held by nurses with out-of-state addresses. During the pandemic, healthcare providers brought thousands of traveling nurses into the State, and their licenses remain in effect for two years.

We believe the large number of traveling nurses distorts the number of licensed nurses in Nevada and thereby keeps the number of nurses we need artificially low. Last summer, the Nevada Hospital Association conducted a survey of our member hospitals. We asked how many open RN positions each hospital had on July 1, 2022. The answer was over 2,300 open RN positions. We asked the same question about January 1, 2023, and the answer was over 2,400 RN positions. That survey only applied to hospitals. Nursing homes, home health agencies, schools, public health and numerous other healthcare providers were not included in the survey, and we know they need nurses too.

Vivian Health, a national healthcare hiring marketplace, issued a report estimating the demand for nurses from 2020 through 2030. It ranked Nevada having the third-largest increase in demand for RNs in the U.S. The change in demand for RNs is expected to be a 23 percent increase, which is substantial. Nevada clearly needs more nurses. Assembly Bill 401 is one piece of the puzzle for increasing our nursing pipeline.

ASSEMBLYWOMAN JAUREGUI:
Assembly Bill 401 is just one component of increasing the homegrown nurses we have in Nevada. A recommendation from the Joint Interim Standing Committee on Commerce and Labor to expand the Millennium Scholarship to other nursing institutions will also be before this House. Nine schools accept the Millennium Scholarship for nursing programs. Assembly Bill 443 will help expand it to an additional seven schools.

SENATOR HAMMOND:
The bill addresses a problem we are dealing with: workforce shortage in a lot of areas. You talk about how to increase and educate our workforce. You mentioned this bill is going to address one issue—increasing the ratios. If you have a good instructor, there should not be any ratios. It should be dependent upon whether the instructor can handle a larger load.

When you made that comment about paying instructors, that is a prevalent problem across the board when you talk about anybody trying to develop a workforce, and that is getting qualified people to come in and be instructors.

Have you come up with a solution when it comes to finding qualified people to come into the classroom?

ASSEMBLYWOMAN JAUREGUI:
We have not produced any solutions, but one of your colleagues has a bill that would help address some funding for nursing programs. It is S.B. 375, which would help provide extra funding for nursing programs in our State.

MR. KELLY:
One of the things I found out recently is in higher education, certain departments are allowed to pay faculty members more, and the example given to me was the engineering department. Engineering professors are paid more than other professors. I would like to explore how we can get that exception for nursing programs.

SENATOR HAMMOND:
That is a great suggestion. I want to talk to you off-line because there are other solutions we can explore, such as bringing in nurses from the industry to instruct for a short period.

MR. KELLY:
There are hospitals that provide a master's degree RN to schools as teachers, especially in the rural areas. They work at the hospitals, but they are adjunct professors at the school. Those models are starting to be developed.

SENATOR HAMMOND:
That is the kind of out-of-the-box thinking we need. It is hard for somebody who makes a lot of money to leave and then go into a profession like teaching that does not pay a lot of money. This bill is a great first step in tackling the nurse shortage.

SENATOR STONE:
I appreciate the permissive ratios that allow schools with better educators to increase the size of classes. This will provide for a long-term increase in the number of nurses in Nevada.

Unfortunately, the nursing compact bill failed. I am hoping the State will eventually recognize occupational licensing reciprocity with other states as a tool to bring instructors into the State and help with our staff shortages.

SENATOR PAZINA:
The Assemblywoman and I spoke toward the beginning of Session, and we were probably having similar conversations with our constituents who are nurses regarding the incredible need we are facing. I support this bill.

GEORGE ROSS (HCA Healthcare):
My company owns Sunrise Hospital, Mountain View Hospital and Southern Hills Hospital. We are in strong support. I echo what Mr. Kelly said. We are not ready to talk about the details yet, but we are working on something to help solve this problem.

CHRIS BOSSE (Renown Health):
I say ditto to the remarks of the last speaker. We think this is great legislation.

MARLENE LOCKARD (Service Employees International Union 1107):
We are in support of this measure and feel it is one of several moving through the legislative process that can help alleviate the nursing shortage in the State.

Research has shown a positive correlation between the number of nursing faculty members and the number of nursing graduates. A study conducted by the American Association of Colleges of Nursing found schools with a higher nursing faculty-to-student ratio had higher graduation rates than those with lower ratios. Increasing the number of nursing faculty members would also help to address the issue of faculty shortage, which is a contributing factor to the nursing shortage. Many experienced nurses leave the workforce to pursue teaching positions, but we do not have enough faculty positions available to meet the demand. By increasing the number of nursing graduates, more nurses would be available to meet the growing demand for healthcare services.

CHAIR SPEARMAN:
We will close the hearing on A.B. 401 and open the hearing on A.B. 318.

ASSEMBLY BILL 318 (1st Reprint): Revises provisions governing certain providers of health care. (BDR 54-761)

ASSEMBLYMAN DUY NGUYEN (Assembly District No. 8):
Assembly Bill 318 is a cleanup bill that makes administrative changes to the Board of Medical Examiners (BME) and is consistent with what many agencies bring forward concerning the oversight of health care. Copresenting with me is

Sarah Bradley, who will go through the bill, administrative statutes, and the fees and fines the BME collect. A representative from the Office of the State Treasurer is available to answer any questions on how funding for fees and fines are diverted and what sort of accounts can benefit those in the healthcare field.

SARAH BRADLEY (Deputy Executive Director, Board of Medical Examiners):
I will go through the sections of the bill for you.

Section 1 allows the Office of the State Treasurer to use the fine money received by the BME from disciplinary actions to support the improvement of health care in the State, as well as the improvement of the practice of medicine in Nevada.

Section 1.5 clarifies provisions regarding expiration of licenses and updates the requirements to report the expiration of licenses by the BME to other agencies, such as the U.S. Drug Enforcement Administration and the State Board of Pharmacy. Instead of sending a copy of an expiration notice, we will send a list to them, which we think will be more helpful.

Sections 2, 4 and 5 ensure all BME license types are included in the reporting requirements for licensees regarding malpractice payments and claims.

Section 3 makes the same change but also clarifies that the report from a licensee must include the dollar amount of the payment. We have had a couple of questions about that come up more recently, and we want to clarify the dollar amount does need to be included.

Section 5.5 increases the maximum fine amount from $5,000 to $10,000. That is the maximum the BME could assess in a disciplinary matter. This amount has not been changed since 1985. We think it is time to give the BME more room when assessing fines.

SENATOR STONE:
Most fines collected by various regulatory bodies go into the General Fund. This bill would create an exception. Can you explain why you want to do that?

ASSEMBLYMAN NGUYEN:
A number of bills being considered this Session create funding programs to help with the reimbursement of student loans for healthcare providers who want to work in underserved areas. We wanted to help with this effort by having fees and fines go to a similar program to create additional resources for providers who want to practice in underserved areas.

TOM CLARK (Board of Medical Examiners):
The Office of the State Treasurer has stated there are accounts where these dollars can be moved to benefit members of the healthcare community, whether it be for student loans or other types of programs. If the BME levies a fine against a licensee, those dollars are captured to benefit the medical community.

SENATOR STONE:
Does this program already exist, or will you be setting it up if this bill passes? Is there already a mechanism in place to vet applications and get people into underserved areas in Nevada to practice medicine?

MR. CLARK:
The Office of the State Treasurer has several different accounts that can be used. The programs have been created by nonprofits and other organizations that handle the whole application process. The State is just the manager of those funds.

SENATOR DALY:
Is this bill going to create a new account that can be used for the improvement of health care or the practice of medicine in Nevada? On this account, what will the parameters be? What is the application process? What is the mechanism for the money to be transferred out and spent? Is it done by the State Treasurer? Does it have to go to the Interim Finance Committee for those things to happen?

It is a diversion from the General Fund. If these funds are going to be spent, it has to go through the regular process for the expenditure of funds under State law. If it gets diverted to a separate account, does it still have to go through the same process? What will the application be for this? In short, what are the rest of the details? This bill does not tell us much.

MR. CLARK:
I do not have the specifics on that, but I would be willing to bring a representative from the Office of the State Treasurer to your office. The Treasurer sponsored A.B. 45 that creates a specific account to benefit those programs and details how the program would work.

ASSEMBLY BILL 45 (1st Reprint): Creates a program to repay the student education loans of certain providers of health care. (BDR 18-359)

We did not want to make the bill specific to a program that had not been created yet. There are plenty of other accounts in existence to provide for these types of programs.

SENATOR DALY:
If you want to do this, I need to see some more information.

MR. CLARK:
We will do our best working collectively with the BME, the Office of the State Treasurer and the sponsor to bring that information to light.

CHAIR SPEARMAN:
Section 2, subsection 1 of the bill says the insurer of a physician or perfusionist shall report any action for malpractice against the physician, physician assistant (PA), practitioner of respiratory care or perfusionist. Subsection 2 indicates that if they do not do that, there is a fine of $10,000.

Sometimes physicians are reluctant to either report someone or to testify against them. Is there any mechanism in place to ensure that when malpractice occurs, physicians will report it? Do you have any way to go back and verify that an error was made and should have been reported by whoever was there and observed the malpractice? Is there any disciplinary action for failure to report malpractice?

MS. BRADLEY:
I do not believe that portion of the statute is being amended. The amendment in section 2 adds all the BME license types to the requirement that if a malpractice claim is filed, it must be reported to the BME. Right now, physicians are the only ones required to report. If it was an error, meaning they did not mean to, the BME looks at all of those on a case-by-case basis. The BME does not

routinely go after people for failure to report in a strident way. Our goal is to get the information so we can look at the underlying issue.

The reason for these reports is so the BME knows a malpractice matter is pending that may involve patient care. That way, we can investigate and see if we have a practitioner we need to educate or make more competent. That is the reason for the report, not to punish them but to to try to get them on a good path if there is a problem. In egregious cases, there could be strident action, but we look at the patient care itself, not so much the report or failure to report.

CHAIR SPEARMAN:
I recognize that is what you do, but you cannot go back and unring the bell if malpractice causes death or some type of permanent injury. The basis of my question is making sure people understand it is the duty of every medical profession to police themselves. If someone is creating situations that are unsafe for patients, there needs to be some type of leverage to ensure the reporting takes place.

MS. BRADLEY:
I think you are asking about a duty-to-report on a malpractice claim. You are asking about the duty of a licensee to let us know if another licensee is acting improperly.

CHAIR SPEARMAN:
Exactly.

MS. BRADLEY:
I would say the BME is complaint-driven. We need a complaint to start the investigation process and possibly take action. We do investigate based on self-reports, where other physicians are letting us know of an incident. We treat all of those as complaints and investigate them. We also have some educational outreach that tells physicians they have a duty to let us know about potential problems. Otherwise, I am not aware of a case against someone for failing to report in the three and a half years I have been with the BME. However, it is something the BME would look at, and a person could potentially get disciplined for failing to let the BME know of an incident.

BRET FREY, M.D. (Nevada Chapter, American College of Emergency Physicians):
I am here in support of A.B. 318. I have been a member of the BME for almost four years. I looked at this from an ethics and public service perspective when I came on the BME to find where the funds were going. I felt it was in the best service of rural Nevada, especially for those in need of better mental health care in their communities, that we would have the ability to use those funds rather than having them going to the General Fund. That was the nidus of this bill. These funds present a myriad of opportunities. As Senator Daly noted, some specifics need to be sorted out, but I do not want that to take us away from the big picture, which is opportunity.

NICHOLAS SCHNEIDER (Vegas Chamber):
The Vegas Chamber is in support of A.B. 318. We appreciate the efforts to clean up this process as well as divert funds to support our medical providers. We also appreciate that this bill adds a 60-day notice period for the expiration of licenses to provide our medical providers with more notice to make sure they have those fees paid.

CHAIR SPEARMAN:
We will close the hearing on A.B. 318 and open the hearing on A.B. 442.

ASSEMBLY BILL 442 (1st Reprint): Revises provisions relating to persons licensed by the Board of Medical Examiners. (BDR 54-1055)

ASSEMBLYWOMAN SARAH PETERS (Assembly District No. 24):
I am pleased to present A.B. 442. It has been a lot of work coming up with a solution for a problem presented by a constituent related to a scenario in which a physician abused his position of power to harm a patient.

I want to start with some history on this issue. We all know there is a social license for physicians. We appreciate and trust our doctors and those who provide health care to us. The institution is important. Safety and the feeling of validation and security in a healthcare setting are imperative to our health and to the service provided by healthcare providers. Being a healthcare provider also comes with a perception of power, a feeling that a physician knows more than anyone else in the room. However, these positions of power can often be abused. If there are no regulations or oversight in place, people who are the most vulnerable can end up being harmed.

Assembly Bill 442 is an attempt to give a backstop for some of the most egregious abuses of power in our medical institution: sexual assault and domestic violence against patients. When you have been the victim of domestic violence or sexual assault by a healthcare provider, it is one of the most difficult positions to be in as an accuser. To say a person in this position in our society, someone who has a social license to do this work, has harmed me against professional ethics, puts me in a place where I am no longer safe. That accusation puts people in a difficult position in our society, including those who regulate our physicians and other healthcare providers.

I worked with the BME and law enforcement over the last couple of months on what we can do to help create a backstop that says when patients come forward to say they have been harmed by a physician, we should take them seriously. Sexual assault and domestic violence are some of the most serious accusations we take in law enforcement and within our regulatory institutions. We need to ensure we have a way to ensure transparency and due process to review the validity of accusations and ensure that physician or healthcare provider cannot harm another person.

We have cases in Nevada where physicians have harmed up to 45 people and are continuing to practice medicine. There are bad actors who have been stripped of their ability to practice in hospital settings, but they are continuing to practice under their own shingles. They continue to bill Medicaid for services supported by taxpayer dollars because we do not have a process to remove that person's license in certain cases.

This is a specific scenario for which we must develop a process that ensures we are not pushing physicians out of our community without the assurance they are truly bad actors. We want to make sure there is a balance between scorned partners who want to harm another person, against those true accusations that have resulted in true harm.

This bill attempts to find that balance and ensure the backstop is in place for the licensing boards. The language in front of you relates only to the BME, but we have been working toward expanding it to all boards in which a healthcare provider can engage with a person. That would include all the boards under NRS 629. We must develop this process to ensure if a victim comes forward and claims to have been assaulted, the person is truly under investigation with a

substantial amount of credibility, and we can suspend or revoke that license if needed.

I do not want to walk through the bill because there are substantial changes through the amendment (Exhibit E) to address the concerns of law enforcement and ensure we are not overregulating how they conduct investigations. This creates a process where boards and law enforcement are working together to ensure they are doing what needs to be done to protect the public from people who are licensed to practice medicine.

One important piece in the bill is in section 2, subsection 6, where it says if the BME receives a complaint of an action that constitutes domestic violence or sexual assault, the BME will give the information to the appropriate law enforcement agency and direct the person to the appropriate contact in that law enforcement agency. This creates the initial connection between law enforcement and the victim. When we see that your complaint constitutes a violation that is enforceable by law, we say, "Would you like to be connected through us to law enforcement to pursue a case against this person?"

The second important piece is in section 3, subsection 2. This is specific to the BME, but we would like to expand it to all boards under NRS 629. It states that the BME shall adopt regulations setting forth circumstances under which the BME is required to summarily suspend the license of a physician. This might be in response to a single complaint or a number of complaints over time.

It was important to include the establishment of regulations to define this process because transparency is a problem for victims. Victims submit a complaint, and because of the lack of transparency, it appears to be lost in the process. The boards have internal processes designed to protect physicians from wrongful accusations, and that is important. But in the event a person has been harmed and is waiting for justice, it is important there is a process they can define and rely on to see what will happen to the person who has harmed them. It is important the BME adopt these regulations because it needs to be a public process with input from those who are affected by the regulations. It is important to assess the integrity of the institution through a public process and through the input of victims, physicians and those who could be impacted by the potential negative outcomes of an unjust process. We must define what this transparent process should look like and who accountability lies with.

The rest of the bill has changed dramatically. Looking at the proposed conceptual amendment, Exhibit E, the second bullet point is to move those requirements of each licensing board into NRS 629, which includes all the healing arts.

The third bullet adds new provisions for the licensing boards under NRS 629, which are the two sections we just discussed.

The fourth bullet talks about how we get the boards engaging with law enforcement. I am not a lawyer and have no expertise in this area, and it became apparent that establishing a process for communication between law enforcement, that has an obligation to the public, and the BME, that has an obligation to the public and its licensees, in a four-month period was near impossible. So the final bullet creates the obligation during the Interim for all these bodies to get together and work toward a goal of determining our process to ensure we are communicating and capturing these bad actors before more people are harmed.

One of the things I heard from folks who have been victims is they have pursued a solution through law enforcement, through the BME and through medical malpractice. All three have stalled out. The accused physician is continuing to practice, and the recourse has not provided a resolution for the patient or the victim.

In talking to the BME and law enforcement community, the goal is not to leave people hanging. That is never the goal in these situations. It is not to have no resolution in perpetuity. The goal is to make victims whole, or at least support them and ensure there is a resolution at the end. This is very tricky, and we do not know how to do that yet. We do not want to get in the way of law enforcement's obligations to the investigation, and we also do not want to get in the way of the BME's due process.

So how do those entities work together to ensure there is a process that is getting the information between the two organizations to ensure the public is safe? That is what this Joint Interim Standing Committee on Commerce and Labor is designed to do.

SENATOR STONE:
Regarding section 2, subsection 6, I do not have a problem with referring a patient to a public safety agency in a case of alleged misconduct. You are trying to prevent a sexual deviant from exerting power over patients and assaulting them.

I am concerned about making the BME the judge and jury before there is a conviction. You want to suspend the license of a physician based on a complaint. You even mentioned in your testimony complaints brought by a scorned spouse, wife or girlfriend. Once you suspend a license, you are ruining the reputation of that physician. Certainly, if the physician is found guilty of these crimes, that individual deserves to never practice again. But if the physician is not found guilty, you may be sending that person back to a practice that does not exist anymore. Physicians in private practice still must pay rent and employees. Patients will be asking, "Is my doctor a sexual predator?" and decide to find another physician.

You have already responded to another issue I had, which is why you were isolating physicians in this bill. We have other professions, marriage and family counselors, registered nurse practitioners (NP), psychologists, social workers and others that interact with patients.

When I renewed my pharmacist license, the application for renewal asks, "Have you been convicted of a felony? If you have, what is the nature of that felony?" I assume that when a district attorney (DA) gets a conviction for sexual assault involving physicians assaulting patients, there is some form of mandatory communication between that office and the appropriate licensing board. If not, we need to make sure that happens.

My primary concern with A.B. 442 is due process. Physicians or anyone accused of a crime are entitled to due process before we strip them of entitlements that could hurt their professional reputation and destroy their business if the claims are false.

ASSEMBLYWOMAN PETERS:
I appreciate that. I remember when the BME went through the process of deciding how to address addiction in physicians. When a physician is arrested for driving under the influence or accused of being under the influence during an operation, there is a process in place to handle that. It was a long conversation

with the BME on how to address those situations while protecting and supporting our doctors so they do not leave the State or lose their credibility in the community. I have spoken with the other physicians' groups about this piece. How do we ensure the process is protective of the victim in both cases?

Our obligation is to the public, and the obligation of physicians is to the health and safety of their patients. When we have someone who goes outside of that, we must have a process to deal with that. That is an imperative part of the regulatory process, and I am open to suggestions on massaging this language into something that gets to the point. The boards must have a process in place to consider these specific situations in which there could be a serial rapist who is using the power of the position to harm vulnerable people, and this process must also protect the institution and the integrity of the institution. That was my goal in having this be a regulatory process. It needs to be developed with the input of the physicians and with consideration to the scenarios that occur within the industry.

I am open to modifying this language.

SENATOR STONE:
You mentioned the case of a physician operating under the influence of drugs or alcohol. In that situation, guilt or innocence can be determined by a blood test. That is definitive, and a physician who performs open-heart surgery with a blood alcohol level of 0.08 percent should be admonished and have his or her license suspended or revoked. But this bill talks about instances where something has not been proven. That is where there is an issue.

I am glad to hear you are willing to work with us to mitigate that because the last thing I want to do is destroy someone's professional reputation that has taken 20 years to develop based on a complaint from a scorned lover. The license of a physician who is found guilty of taking advantage of patients should be revoked. My concern, however, is to make sure physicians have due process.

ASSEMBLYWOMAN PETERS:
You are right. In the case of substance abuse, guilt or innocence can often be definitively established. There is a process in place to review the physician's well-being and health and ensure a potential opportunity for rehabilitation. That is where this issue diverts. A physician who is a sexual predator should never

practice medicine again. We should not be putting those people back in a position of power to harm people.

I have talked to several victims, and it is incredibly difficult to prove what happened on the operating table. If no one who was in the room is willing to come forward and say this happened, it is difficult to prove the person has been harmed, that what happened in the operating room was in fact sexual assault and not necessary medical practice. That is where the BME must make the determination based on the number of complaints coming in about the same person. That is where the BME must engage and talk to law enforcement about complaints about situations outside of the operating room.

I talked to the Washoe County DA about what the process looks like for someone who submits a complaint. There is some discretion on how far we take the complaint depending on whether we can prove the victim's story. Sometimes those complaints end up just sitting there. However, the regulatory authorities and law enforcement should be able to look for trends in complaints of sexual assault and domestic violence to assess whether that person could be a predator. That is the goal of the Interim conversation: how do we get there? How do we ensure we are working together? I do not have a solution for that. It is part of the reason this has not been addressed yet and why this issue continues to perpetuate in the industry.

You suggested we look into self-reporting, and we talked about that. Law enforcement asked the same thing. Is there a way to self-report? Then we started thinking about the cases we are looking at. When you are a sexual predator taking advantage of vulnerable people, it is highly unlikely that you would self-report. Such people abuse power because they think they deserve to and can get away with it. It is not the same thing as driving under the influence or some other addiction issue. We have worked hard to bring down the stigma on those. Sexual assault is a completely different scenario.

SENATOR BUCK:
I agree with Senator Stone. I would like ask counsel about the constitutionality of summarily suspending a license pending a hearing.

BRYAN FERNLEY (Counsel):
A summary suspension of a license is generally authorized under the due process clause when there is a danger to the public. If there is found to be an

immediate danger to the public, licensing boards could generally suspend a license. There would have to be a hearing within a short time to address whether the suspension should continue and whether the violation happened.

ASSEMBLYWOMAN PETERS:
I have had conversations with several representatives of boards in this building, and I believe the time frame to hold that hearing is up to 45 days.

SENATOR SCHEIBLE:
I like this bill, and I think it is important. We recently had a case in Clark County where a physician was assaulting patients in the context of providing medical care, and he was prosecuted for that.

I also like that we are setting forth regulations that are going to be consistent. In representing my clients in criminal cases, I have seen that different boards have different approaches. When the board does not have a clear regulation or clear rules about what is supposed to happen, things get dicey. You have one doctor who might be pending a preliminary hearing on a sexual assault case and another doctor who has agreed to negotiate but has not yet entered those negotiations. They might get treated differently by different people at the board because they interpret the status of the case differently or because they happen to go through a different person who is reviewing the file. For due process, it is important we say these acts will result in suspension of your license; these acts will require a hearing; these acts will not, so the doctors who are accused of these crimes know their rights in terms of protecting their licenses. Providing regulations is the right approach.

I am confused as to whether the bill is supposed to pertain only to their conduct in the scope of their practice of medicine or outside of that.

ASSEMBLYWOMAN PETERS:
That is a good question, and it is one the courts and the boards have struggled with. When you are a licensed physician, you have an obligation to the public. Anything you do outside and inside of the operating room is under the oath you take. Maybe that is not the same case for all boards. When you have the authority and power given to you under a license as a healthcare provider, your actions in or out of a healthcare facility should be reviewed. However, I suggest that determination be made by the boards through the regulatory process.

SENATOR SCHEIBLE:
Given that, I am confused about the inclusion of domestic violence in this bill. Except in a rare case where you have somebody treating a member of their own family in an office setting, domestic violence would occur outside of the doctor's office or hospital setting. When I read domestic violence in this bill, I am envisioning a case where I am in a dating relationship with a physician who physically abuses me. I feel like I cannot come forward because of the physician's position in the community and reputation. It seems like you are trying to provide a pathway for me to report not just to law enforcement but to the licensing authority that somebody is practicing medicine in Nevada who, behind closed doors, is violent and abusive. Is that the purpose, or am I missing the point?

ASSEMBLYWOMAN PETERS:
We went back and forth on domestic violence with legal staff. I wanted to include physical assault because that can occur outside of the sexual assault arena. The suggestion was to include domestic violence because physical assault falls under the category of domestic violence. That is part of the reason we have that included. In this matter, I am leaning on people who know more about this than I do.

The situation you mentioned is something I have heard in the conversations we had with victims and other people who are willing to come forward and talk about physicians who are harming patients. Such people often have a history of domestic violence, and it is often reported to law enforcement but not to the BME. This is where the communication between the BME and law enforcement is important: we can start to create a profile of the physician's actions. Is that physician a violent person? Does a violent person deserve to be allowed to practice medicine?

SENATOR SCHEIBLE:
I completely agree. Providing ways to address domestic violence outside of the criminal legal system is important because not every problem can be solved by criminalizing people and prosecuting them.

Are there other analogous boards or governing agencies where a victim-survivor can report abusive behavior to the person's professional board? I am thinking about other people who have an obligation to the public, such as teachers and first responders. If the hypothetical case I described involved a teacher instead

of a physician, would I be able to report that teacher's abusive behavior at home to the educational licensing board? Would we want to be able to do that? That is part of my consideration in evaluating the strength of the policy, and it may be in the realm of food for thought.

ASSEMBLYWOMAN PETERS:
I do not have a response for you on that. This is my first dive into licensing boards, but there may be people in the room who can respond.

MR. CLARK:
It is important to note that the Legislative Subcommittee of the BME meets next Friday and thus has not been able to take a position on this amendment. I can consult with the Subcommittee and get back to you on this, if you do not mind repeating the question.

SENATOR SCHEIBLE:
I am also willing to follow up on this offline. I want to make sure we are not setting up a system where doctors are subject to some additional penalties for the same behavior other people engage in. Are there other boards where if you have an obligation to the public and there is reason to believe you are unsafe, violent or a danger to the community, people can report to your licensing board or professional board outside of medicine?

MICHAEL HILLERBY (State Board of Nursing; State Board of Pharmacy):
There are specific offenses in each board's chapter of NRS, and those can have little to do with the actual practice of nursing, medicine or pharmacy that licensees are required to report. Also, if we get information from law enforcement or another source, we will look at the situation, and that can potentially be a reason for discipline. For example, if you are a pharmacist and we find out you are trafficking in drugs outside of your job, you will have some explaining to do to the board. It is because in your day job, you are handling controlled substances in a pharmacy.

Going back to the answer Mr. Fernley gave, you are correct. In NRS 233B.127, the Governor's summary suspension is 45 days. If you do a summary suspension, which all boards, commissions and other agencies can do to a licensee, you have 45 days to institute and complete proceedings to decide the case. Assemblywoman Peters has done a good job of pointing out the delicate balance the law creates between protecting the public and the rights of the

accused. Working through that is going to be somewhat complicated. If there is a criminal investigation going on at the same time, it is unlikely to be completed within 45 days.

In talking with Assemblywoman Peters, we suggested a lengthier effective date for the regulatory part so we could spend time with the Attorney General, law enforcement, other attorneys and experts crafting something that could be uniform across those boards. This will help ensure the issue is handled correctly so that both parties have their rights protected and the State does not find itself in the crosshairs of lawsuits, which could get expensive.

SENATOR SCHEIBLE:
That answers my question and assuages my concerns, and I agree that this bill does a great job of finding the balance point of protecting the public and holding people responsible without undue burden on the accused. I think that you have hit the balance, and I appreciate you coming up impromptu to answer my questions.

SENATOR DALY:
I also have concerns that you are putting in regulation that someone could be suspended on an allegation. I had a similar question to Senator Scheible's regarding the inclusion of domestic violence, because usually that is outside the work setting. There is a distinction. I am not saying it cannot be a factor for the BME to consider; Mr. Hillerby said there are provisions that allow the boards to take such actions into account. But I believe those provisions only apply if the person has been convicted. There has been some proof of violation, and there has been adjudication. We are crossing over a line here.

I am not a lawyer either, but there are different levels of proof. When you are considering a criminal charge, proof is beyond a reasonable doubt. If you are in the civil sphere or under these licensing boards, there are lower levels of proof. Clear and convincing would be next, then preponderance of the evidence, and perhaps the lowest level is rebuttable presumption, where we say you are guilty and you have to prove you are not. We want to avoid that.

Part of my concern with the amendment in Exhibit E is the timing on these matters. It is useful to have the interim standing committees look at this, but are the boards going to adopt regulations before the work is done or after? We

do not want to get ahead of the order of operations and have 20 different boards come up with 20 different ways to do this.

You picked a hard thing to define because people are innocent until proven guilty. Allegations can be made, and suspending a license can be damaging based only on allegations. At the same time, we need to protect people who truly are victims. It is a difficult path to make sure you are not stepping on someone's due process rights. We do not want people to sue the BME for suspending their licenses when they are eventually adjudicated innocent or there is not enough evidence to proceed. You mentioned that the DA has to review every case and ask, "Do I have enough evidence to proceed?" If they do not, they cannot prove it. There are lots of jogs in this puzzle.

ASSEMBLYWOMAN PETERS:
These are the thought processes we have been going through in our meetings: how do we strike this balance? How do we ensure the boards have the backstop of authority needed to potentially suspend a license without a criminal adjudication? It can be difficult to get that in these cases. However, you can see trends that show a person is violent and acting outside of the best interest of the public. The responsibility of the BME is a little different than that of law enforcement, in that the BME is also upholding the integrity of the profession.

My goal with the regulatory development is to give the boards the opportunity to have this conversation, to go through the public regulatory development process in which they have the discussion of what makes sense for them. What is our job in this process? Where do we draw the line when we cannot depend on law enforcement to complete this process for us? Maybe they will come up with a scenario in which that is impossible. That is another conversation we should have about the integrity of the healthcare institution. What is its responsibility to the public if it relies on law enforcement to ensure public safety? That conversation should be had as well, which will be part of the interim committee.

I want to respond to your question on the timelines. As I said, this amendment came in so late because we have been working throughout the process to iterate this in a way that works for everybody. In talking to Mr. Hillerby this morning, his suggestion was to push the regulatory time frame out to January 2025, which I am open to. That would give us the opportunity to come back and address the statute if necessary. I am hopeful that the language we

have developed in the regulatory development piece gives enough latitude while giving enough backstop that we will get to a good place with regulations in that time frame.

SENATOR DALY:
I appreciate that suggestion, and I think this is the path. For the interim standing committees, it will be critical to get the input of a variety of different people and groups on that part.

If it goes through that process and you can find a path, which is still in doubt, we are hoping the boards come up with a relatively consistent and uniform process. This process needs to include what steps to take, when to take them, what constitutes enough evidence and what level of action can be taken. Obviously, this process cannot include criminal proceedings. The boards are not judges, and it is the courts who will eventually make the final decision as to whether we have found the right path.

SERENA EVANS (Nevada Coalition to END Domestic and Sexual Violence):
I am here on behalf of numerous victim-survivors who have allegedly experienced reproductive coercion, medical mutilation and sexual assault at the hands of a prominent obstetrics-gynecologist (OB-GYN) in northern Nevada. I say allegedly not because I do not believe them, but because of pending investigations that have taken far too long to conclude any final findings. I want to thank Assemblywoman Peters for listening to the heartbreaking stories of these victim-survivors and for acting and bringing this bill forward.

Our system has seemingly failed victim-survivors, which is why I am here today. The Nevada Coalition to END Domestic and Sexual Violence was approached in the Interim by a large group of women seeking justice against one doctor. This group of women has submitted more than one complaint filed through the BME claiming unnecessary procedures, sexual assault, botched surgeries, Medicaid fraud and medical coercion. The horror stories I heard made me sick to my stomach. These brave individuals shared with me that they tried to pursue action through law enforcement but were told they do not have jurisdiction. Their complaints to the BME have taken an uncomfortable amount of time for review despite multiple complaints for the same issue against one doctor, including sexual assault. All the while, this doctor is still practicing and likely harming low-income and marginalized communities. Just this week, there were

headlines of a similar situation against a Las Vegas OB-GYN accused of sexual assault and harassment with disciplinary hearings pending.

We are taught to trust our doctors, but these situations are a blatant abuse of power and control, and there must be accountability to stop the ongoing harm. Many of these victim-survivors want to share their stories; but because of the vulnerability of their situations and the power of these high-profile doctors in our community, they are fearful of sharing them on public record. On behalf of those too fearful to speak here today, we urge your support and passage of A.B. 442.

CHRISTOPHER RIES (Las Vegas Metropolitan Police Department):
We support A.B. 442 and the proposed conceptual amendment. We appreciate Assemblywoman Peters and her leadership on this important issue. We are looking forward to working with her during the Interim and continuing our relationship with the BME as well.

JOHN JONES, JR. (Nevada District Attorneys Association):
We are in support of A.B. 442 with the amendment and want to thank Assemblywoman Peters for bringing us into this conversation early. It is an important conversation to have, and we are fully behind the intent of the bill.

On Senator Stone's question, as a DA, I do not always know that I am dealing with a physician when I have a defendant standing in court with me. As we go through the process, we get more information about the physician and, ultimately, if that person is convicted, have a pre-sentence investigation (PSI) report. However, a lot of the PSI is self-reported by the defendant. If the defendant conceals the fact that he or she is a physician or other licensed professional, as a DA, I may not know unless the crime is related to that line of work. That is one of the issues we are going to work on in the Interim as we figure out how this process will work.

With respect to teachers, juvenile probation officers and child welfare workers, there is a statutory process in place that deals with suspension as the process is working itself out. Those are statutes we can look at for guidance in this area as well.

JASON WALKER (Washoe County Sheriff's Office):
I am here in support of A.B. 442 as amended, thanking Assemblywoman Peters for including us in these discussions. There have been many meetings and discussions getting us to this point. As a member of law enforcement, I would have no issue participating in a working group to study any issues relating to the sharing of information between law enforcement agencies and licensing boards.

PAMELA DELPORTO (Nevada Sheriffs' and Chiefs' Association):
I will just say ditto. We are in strong support of the bill as amended and thank Assemblywoman Peters for working with us.

ANDREW PASTERNAK (Nevada State Medical Association):
I am a family physician in Reno. I am here representing the Nevada State Medical Association (NSMA) as past president and testifying in support of A.B. 442. The NSMA is Nevada's largest and oldest physician organization. I want to thank Assemblywoman Peters for listening to our suggestions.

As a physician, I took an oath to serve my patients. On a grander scale, the NSMA exists to advocate for our patients. When it comes to situations such as the one Assemblywoman Peters has described, we want Nevadans to be protected. No one wants bad physicians out of practice more than good physicians. Bad physicians undermine the trust the public puts in Nevada's physicians. We will continue to work with the sponsor to make changes to improve this bill on this important issue.

HANA FAHMI:
I am here in support of A.B. 442. I moved to Carson City to be closer to my grandmother. When I got here, jobs were limited. I had an amazing opportunity to enter certified nursing assistant (CNA) training to become a CNA. I learned how to take care of my grandmother and found work in a facility where I could gain skills and get certified. Unfortunately, I eventually found myself in a scenario that I had to report. In fact, there were many scenarios that should have been reported. This led to my departure from a job I was really good at, doing something I really enjoyed.

At the time, I did not know how things could be changed. Senator Spearman, you made a point about accountability today, and when I heard about this bill, I knew it was important. There are programs you are putting in place that are

brilliant. My teacher was brilliant and made me want to do this work, but I got into places where the environment was not brilliant. This bill is something that could help a lot.

DORA MARTINEZ (Nevada Disability Peer Action Coalition):
We want to thank Assemblywoman Peters for bringing to your attention people with disabilities, who are vulnerable and are part of these victims. Please support A.B. 442.

MR. CLARK:
We have had lots of conversations with Assemblywoman Peters over the last 100 days about this important issue. We know there are bad doctors, and we know there are victims. We are aware of the due process issues and the other issues discussed today.

I am in a neutral position today simply because the Legislative Subcommittee of the BME has not had a chance to review the amendment in Exhibit E. It is consistent with a lot of the conversations we have had. We meet next Friday, and we hope not only will this language be fully vetted by then, but any additional changes will come to the table.

CHAIR SPEARMAN:
Much of the testimony we heard today is a trigger for me. It sounds so much like the experiences of women who are suffering from military sexual trauma, women who were assaulted because the person who did this to them is a superior and they had no place to go. I would encourage the Subcommittee to look at all these things. I am not sure what other states do, but this is an issue, and we must solve it. That is what we are supposed to do as Legislators.

I heard the train is going south. I invite those who are guilty of these types of crimes to jump on board.

We will close the hearing on A.B. 442 and open the hearing on A.B. 364.

ASSEMBLY BILL 364 (1st Reprint): Revises provisions governing physician assistants. (BDR 54-148)

ASSEMBLYWOMAN LESLEY E. COHEN (Assembly District No. 29):
Nevada, like states across the Nation, is grappling with a healthcare provider shortage. Healthcare providers in Nevada are retiring, especially in family practice and primary care. Physician assistants (PA) can help fill this void in our healthcare system. Physician assistants are advanced practice allied health professionals who are nationally certified and licensed in Nevada through the BME and the State Board of Osteopathic Medicine. Before they can earn licensure, PAs undergo rigorous education and training as medical professionals.

With us today is Dr. Brian Lauf, who grew up in Reno and attended Hug High School, Truckee Meadows Community College and the University of Nevada, Reno (UNR). He received PA training from Oregon Health & Science University and the University of Nebraska Medical Center. He earned his doctorate in medical science with an emphasis in education from the University of Lynchburg. He has been a PA in Nevada for over 25 years and is a 2-time Nevada Health Service Corps recipient. He is an associate professor and founding PA program director at the UNR School of Medicine and devotes his time to training and educating aspiring PAs to serve in our communities.

Also with us is Carmella Downing. She is a PA at Carson Tahoe Health and has worked in cardiology for 15 years. She manages the Congestive Heart Failure Clinic and is the Advanced Practice Medical Director for Carson Tahoe Medical Group.

JOHN SANDE IV (Nevada Academy of Physician Assistants):
This is a hefty bill as far as pages go, but it can be summarized quickly. I will try to offer exactly what we are trying to accomplish with this bill from a 30,000-foot perspective. I will do that by illustrating some of the amendments we have agreed to, which will clarify the intent of the bill.

The first part of the bill is less controversial, so I will not address that. The second part of the bill is where I would like to spend most of my time. There seems to be a disconnect between what we are trying to accomplish and what those who oppose this bill believe we are trying to accomplish.

The intent of the bill is to bring decisions regarding the optimal team practice to the practice level rather than the board level. This stated intent might be clear when you are a health professional practicing daily. However, when you are like

me, those words are kind of hollow. I want to start by describing what we are trying to accomplish in layman's terms.

When you are a PA graduate, the law says you must enter into a supervisory agreement with a physician. Under the requirements and regulations, you are required to meet with that physician for four hours a month and submit paperwork to the BME. It is almost like performing surgery with a butter knife. It does not take into consideration anything about the PA's practice, including where they practice, how they practice or who they practice with. It just says supervisory agreement, four hours a month. We think there is a better way.

Let me emphasize that we are not seeking to have PAs practice independently. Not requiring a supervision agreement does not mean PAs will be working independently. It means that PAs and physicians will not need to fill out papers each month in order for the PA to continue practicing. It is also not our intent to make it possible for pop-up PA clinics to be created. The big concern we heard in the Assembly was that we were going to have pop-up PA clinics everywhere.

Our proposed conceptual amendment (Exhibit F) says if a PA is not in a facility that has doctors around or that is owned by doctors—essentially, if a PA works in a medical facility owned by a PA or anyone who is not a doctor—that PA needs to continue under the current system. We are fine with that.

We are also trying to prevent hospitals or clinics from implementing their own requirements regarding how PAs practice and how they are supervised. That is what it means by bringing it to the practice level, the optimal team practice. A PA practicing in a complex field of medicine may actually need 16 or 18 hours a month and maybe more than one supervising physician. This should be the decision made at the practice level, not the BME level. Let us look at what field that PA is practicing in and create the situation that will allow the PA to flourish with the doctors and the other healthcare professionals working in that system. If, on the other hand, you are practicing in primary care, you might not need to meet with a physician for the arbitrary four hours and send paperwork to the BME every month. Maybe the PA needs to do this every other month, maybe every six months. That would be a good thing for the individual facility to decide, but not for us to create an arbitrary standard at the BME level.

A stakeholder approached us two days ago and said, "We are concerned this bill is going to limit our ability to create a job." That person owns a clinic and has

PAs working under supervisory agreements. Some have two supervisors, some do not. We do not want to mess with that situation. We are working on language that will clarify this is not our intent. What is our intent? The point of this bill is these decisions are best left at the practice level, not in arbitrary requirements set by the BME.

It is worth pointing out that PAs are currently at a disadvantage when compared to advanced practice registered nurses (APRN). In 2013, APRNs passed a similar bill to this one. This has not resulted in pop-up APRN clinics. They are not practicing in a collaborative environment in a clinic, but they are still under collaborative agreements. What we are proposing is not as scandalous or as provocative as it might be made to seem. What we are talking about is straightforward and commonsense.

BRIAN LAUF (Nevada Academy of Physicians Assistants):
The Nevada Academy of Physicians Assistants (NAPA) is in support of A.B. 364. I am an Associate Professor at the UNR School of Medicine, and I am the founding Program Director of the Physicians Assistant Studies Program. I am not here in that capacity, and UNR does not have a position on this bill. I have been a PA for over 25 years in Nevada, and I have served twice as the president of NAPA.

I want to discuss two points. The first is the education, qualifications and licensure of PAs. The second is the benefits of modernizing PA practice to better reflect the healthcare models and collaborative practice used by PAs and all members of the healthcare team.

As the professional association for PAs in Nevada, NAPA aims to improve the access to quality health care and give a voice to the PA profession through education and advocacy. With over 1,200 PAs working in every facet of the State's healthcare industry, we are committed to delivering high-quality health care to all Nevadans.

Physician assistant education is at the graduate level and prepares graduates to be medical providers who diagnose, treat, prescribe medications and much more. Acceptance to a PA school is highly competitive. In my program last year, we had over 1,400 applications for 24 seats. Our overall program acceptance rate is 1.7 percent. The average applicant to a PA school brings with them over

6,000 hours of working healthcare experience. With an average age of 27, PA students begin their training with broad and diverse life experiences.

For example, I began my career as a medic in the U.S. Air Force, where I received extensive medical training. After separating from the military, I returned home and attended Truckee Meadows Community College, earning an associate degree in science. I attended UNR where I studied molecular biology prior to being accepted to PA school. Following my primary education, I completed postgraduate degrees at the University of Nebraska, Omaha, and my doctoral degree at the University of Lynchburg.

Physician assistant students undergo rigorous training at the graduate level to include 123 credit hours and 2,000-plus clinical hours in multiple medical and surgical disciplines, including emergency medicine, surgery, family medicine, pediatrics, internal medicine, women's health, behavioral medicine, medically underserved populations and elective rotations that may include subspecialties such as cardiology, endocrinology and urology. After graduating from an accredited school, PAs must pass a comprehensive national board certification examination, which is also a requirement for licensure in Nevada and across the Nation.

To maintain our license, we must complete over 40 hours of continuing medical education (CME) every 2 years while staying current on medical innovations and best practices. To maintain our Board certification, we must complete 100 hours of CME every 2 years and pass our national board exams every 10 years. We must complete training to maintain our U.S. Drug Enforcement Administration license to prescribe controlled substances. The standard professional liability insurance in Nevada for PA medical malpractice coverage is the same as for physicians: $1 million per claim and $3 million per annual aggregate.

Next, I would like to address why we are here discussing this bill, modernizing PA practice to reflect models of collaboration. There has been a lot of thought and discussion about the best manner to improve access to care by providing more flexible practice arrangements. I am confident you are aware that Nevada is at the bottom, or close to it, of multiple healthcare measures, namely access to health care. The issue is worsening, and PAs are here to help address this trend and perhaps turn it around for good.

Research indicates the most up-to-date practice laws allow healthcare teams to decide, at the practice level, how they will best collaborate and meet patient needs. The best evidence also demonstrates the most successful clinical teams are those fully utilizing the skills and abilities of each team member to support efficient patient-centered health care. The key word here is team.

Let me dispel the myth about independent practice. Despite what people believe, today's healthcare system is effectively without independent practice. There are numerous types and levels of regulatory and policy-driven oversight and vast data that create transparency into the efficacy, efficiency and safety of a clinician's practice.

The bottom line is the supervision of PAs outlined in NRS 630 and NRS 633 is far less than the required oversight in medical practice settings, but it is a significant administrative burden and barrier for PAs practicing in patient access. Physician assistants, like physicians, are most often employed by hospitals, medical groups or other facilities. These facilities, as outlined in sections 4 and 23 of the bill, address where PAs are authorized to practice and have supervision and oversight requirements for all employees to ensure patient safety and mitigate liability. Oversight may include granting privileges and credentialing requirements that allow PAs or others to work in certain units, perform certain procedures and deliver other types of services.

Assembly Bill 364 removes the supervisory burden from the statutes regarding PA practice, allowing clinics and hospitals greater flexibility in assembling healthcare teams to meet patient care needs. The more collaborative and interdependent practice arrangements enacted or being considered in several other states have provided greater agility in meeting healthcare needs, especially in our rural areas.

You will hear physicians say that this is about patient safety. I have pages of peer-reviewed literature that speak to the safety and efficacy of PA practice I am happy to provide. In response to the COVID-19 pandemic, Governors of 8 states removed supervision requirements for PAs, and another 13 did so through previous legislation specific to PA practice during a public health emergency. What happened was that PAs did what they were trained to do, serving where they were most needed, and the result was greater healthcare access and continued excellent outcomes for all patients. It is not surprising that branches of the federal government, including the military, the U.S. Department

of Veterans Affairs (VA), and the Indian Health Service, have long ago removed physician supervisory requirements for PAs and recognized their ability to practice safely in various settings.

In thousands of different practice settings and assignments, at home and abroad, military PAs serve in combat and at the White House and provide comprehensive high-quality care to thousands of military members and their families. Nevada PAs greatly respect the breadth and depth of physician training and are proud to practice alongside them every day. Our practices and patients benefit from this team approach when it is defined at the practice level.

It continues to be the position of NAPA that there is room for all healthcare team members to practice to the full extent of their education, training and expertise. As practicing PAs, we currently do and will continue to work closely and collaborate with physicians on the healthcare team. We stand by our historical relationship and devotion to team practice with physicians and all members of the healthcare team.

At the UNR School of Medicine, we have spent the past seven years planning, building and executing the State's only PA program in a public institution to meet the healthcare needs of Nevada. With the modernization of PA practice laws in neighboring states and across the Country, we are at risk of becoming an exporter of this valuable resource. Nevada has experienced this with other health professions. Let us avoid repeating this with PAs. Providing favorable and safe practice laws will allow Nevada to keep this resource.

CARMELLA DOWNING (Nevada Academy of Physician Assistants):
I am a PA working in Carson City and a representative of NAPA's Legislative Committee. Assembly Bill 364 is about the transparency of our current practice within healthcare teams, modernization of outdated language regarding the relationship between a physician and a PA, and the representation of PAs by the medical boards which govern them. Nevada is the only western state that does not have PAs on the board licensing them.

I would like to give a couple examples of how PAs are a vital part of the healthcare team. I helped design and now manage the Congestive Heart Failure Clinic at Carson Tahoe Health. Most patients are seen weekly in the month following discharge from the hospital. The readmit rate within 30 days for heart failure patients at Carson Tahoe was the national average of 23 percent. Since

the start of the clinic, we have averaged 11 percent. In the first quarter of 2023, it was 9 percent. Having a PA manage these visits has enabled more patients to be seen quickly and thus minimized unnecessary emergency room visits and costly hospitalizations. My training as a PA, the collaboration with my physicians, fellow PAs and NPs gave me the knowledge and experience to make this happen.

When I first started on the recruitment committee at Carson Tahoe Health, we reviewed candidates for an urgent care position. An experienced PA was passed over due to the lack of available supervising physicians to sign an agreement with the State. We did not have enough physicians to meet the needs of our patients, let alone have a physician to supervise another PA. We do not have enough providers in Nevada, particularly physicians.

To keep up with the demands of our State, we are neglecting our rural and frontier areas due to burdensome administrative constraints. Fortunately, neighboring states have implemented an environment where PAs can practice to the full extent of their medical training, education and experience. Additionally, Nevada is the only western state that does not allow representation on the boards.

The PA advisory board created for the BME does not allow a PA to vote on professional matters. Physician assistants need to provide meaningful input on the regulation of the profession. There needs to be an expert voice on current knowledge of the profession when regulatory boards make decisions affecting PA licenses. Assembly Bill 364 asks for PA representation on the BME.

Nevada has a suboptimal PA practice landscape. Utah and Wyoming have passed legislation with language similar to that found in A.B. 364. Arizona and Montana both passed bills this year to modernize PA practice. While I am excited for these states and how it can improve practice, I am concerned about our State if we do not improve to get the clinicians we need. How do we expect to address Nevada's issues regarding access to health care without modernizing the regulations that stagnate the ability to hire PAs and their ability to care for their patients? Nevada has fallen behind and will continue to fall behind if we do not modernize our legislation.

DAVID BAKER, M.D.
I am strongly in support of A.B. 364 and have provided a letter of support (Exhibit G).

I have been practicing cardiology in Carson City for about 17 years. I am also the vice president and chief medical officer for Carson Tahoe Health. I strongly support this bill on several grounds. The first is clinical. I have practiced cardiology for about 20 years. I have done so with PAs and NPs in a collaborative system, which has been of huge benefit to myself professionally and to the health of our communities. I work with Ms. Downing as her super collaborative physician. We developed the heart failure clinic together. I am also working with Kenny Larsen, who is running our COPD clinic. These are two clinics that take very sick patients, patients with life-threatening diagnoses coming out of the hospital. These patients have recently been decompensated in their health systems, and we concentrated them into these clinics. The clinics have been massively successful, and they are run by PAs. These clinics have decreased the readmission rates and kept patients out of the hospital. The hospitals benefit by not having to reincur those costs or penalties that come along with increased readmission rates.

I also care for probably 4,000 or 5,000 general cardiology patients in my clinic. I do that with the help of a NP and another advanced practice clinician (APC), which extends what I can do. I could do none of this on my own; I could not even begin to run these clinics on my own. I need PAs and NPs to do so. I have been able to do so for 20 years in a successful manner.

My second role is as an administrator. I helped form and manage Carson Tahoe Medical Group for the past 12 years. We started off in 2010 with about 10 or 12 providers, and I think 2 of those were PAs. We are now up to about 115 providers. About half of those providers are APCs, NPs or PAs. There is no way whatsoever that we could begin to cover the healthcare needs of Carson City without our PAs. There are simply not enough physicians. I do not know of any other groups in town, private groups, that do not have PAs and NPs to help extend them and provide the care to the community that we need.

There are simply not enough doctors. It takes too long to make doctors and turn them over to clinical practice. The PAs are essential to enable us to care for our community.

Finally, I know there is some opposition to this bill from physicians. It seems to center on the fact that there is a clear difference in education between PAs, NPs and physicians. Physician assistants are extremely well-trained and schooled, though I did more than they did. That is why I think the collaborative agreements are huge because you can work together. That team model allows us to take care of patients, provide a high level of quality and extend service to many more people than we could do on our own.

SENATOR DALY:
The amendment in Exhibit F says you are going to have a collaborative agreement with physicians if PAs work in a clinic that is not traditionally staffed or owned by a physician. What happens if you are in a facility traditionally staffed or owned by a physician? Is there still collaboration, or are you changing something? What is the distinction we are trying to get to with the amendment?

MR. LAUF:
We are trying to allow facilities to make that determination. They will determine the level and how a physician and a PA work together at a particular site.

SENATOR PAZINA:
Are practices required to have this collaborative agreement, or is it up to the practice?

MR. LAUF:
I do not believe this requires a practice to have a collaborative agreement. It just gives them the ability to define it. My experience suggests that most facilities will define it. When APRNs received independent practice, many of those facilities instituted policies requiring them to be supervised. It is the safe model, and hospitals recognize that. Speaking as a PA, I would not want to enter into a situation where I did not have that collaboration, with the ability to reach out and ensure the patient care I am delivering has the best people involved.

SENATOR STONE:
I want to make sure we are clear on the semantics. Will PAs be able to work independently without a collaborative agreement in any circumstance under this bill?

MR. LAUF:
Section 4 states that a PA would not be able to work independently outside of those parameters within a facility. The term "independent" would be defined within the facility. I do not believe the PA would be independent because the PA is employed at those facilities, and the oversight is built in.

SENATOR STONE:
Do you see any scenario inside or outside of section 4 that would allow a PA, under any circumstances, to work without a collaborative agreement with a physician?

MR. LAUF:
I do not.

SENATOR BUCK:
What is the difference between a PA and a physician? It seems like you have an extensive background, and I do not understand why you are not a physician.

MR. LAUF:
I have distributed a flier titled, "What is a PA?" (Exhibit H), and I can also give you some personal insights. We are not physicians. We do not go to medical school or complete a residency. We are trained in the same medical models, and we compress the medical education to a shorter period. The profession was developed out of fast-tracking physicians during World War II who recognized that PAs could receive compressed information, go to the battlefield and learn the rest of it in the field. The PA profession was developed after that model: to give us a foundational education and then build on it with experience. That is why there is a provision about 6,000 hours experience after graduation to allow PAs to mature in the environment in which they will be working.

SENATOR BUCK:
Do you have separate liability insurance for you as an individual?

MR. LAUF:
Yes. I have my own individual malpractice policy in my name.

SENATOR SCHEIBLE:
Following up on Senator Pazina's question about the collaborative agreement, why not require a collaborative agreement? I understand that the purpose of the

bill is to allow the practice level of that collaboration to be defined by the parties involved. Why not require that once they do define the terms, they must submit a copy of it to the licensing board?

MR. LAUF:
The issue is parity with our colleagues, the APRNs. They are not required to do that. Therefore, facilities with the added administrative burden will choose the path of least resistance and hire someone who does not require additional paperwork through the State board. If your question is about requiring it at the State board versus at the practice level, requiring at the practice level is what we are trying to do. I do not know if that is in statute or if it is the language that could be included.

SENATOR SCHEIBLE:
I thought that APRNs could practice independently.

MR. LAUF:
Yes, they can practice independently. However, facilities reserve the right to be able to say that as an employed APRN, you are going to have a supervising physician assigned to you.

DR. BAKER:
At Carson Tahoe Health, we employ both NPs and PAs. Nurse practitioners, after two hours, can legally practice independently, but we keep them under a collaborative arrangement. I work closely with the NP at my general clinic. She works at the highest level of her licensure, and we work together to take care of a lot of patients. I do not have any real true administrative burden to have her on board. I also have six PAs under agreements, with Ms. Downing being one of them. The issue there is she does not need my supervision. She does not need me to be filling out forms and that kind of stuff, but I must by law. Six people are under my licensure. I cover neuro, pulmonary, cardiology and emergency care. It creates a big burden on the system and myself to supervise those people when I do not really need to. We have systems in place at Carson Tahoe Health where they work collaboratively with the physicians around them to make sure the care is good, to make sure the cases that are difficult are discussed among a variety of people, but there is no administrative burden the rest of us must absorb.

CHAIR SPEARMAN:
My question relates to the military and the VA. I was looking to see how many PAs have been killed in combat, and there were several. They are typically assigned to a Mobile Army Surgical Hospital, commonly known as a MASH unit, and sometimes there is no physician. There are times, even during peacetime, when the shortage of doctors sometimes requires one doctor to be responsible for three clinics, which I saw when I was at Fort Henry. Every time I go to the VA for medical care, I see a PA. When people leave the military, they usually continue their practice in civilian life. What does the transition period look like between PA duties in the military and PA duties as civilian healthcare professionals?

MR. LAUF:
As a veteran myself, I would say that when it comes to patient care, nothing changes. As PAs, we are still held, inside and outside the military, to adhere to the standard of care applied to physicians, PAs and anyone who is providing medical care. The difference is oversight in the collaboration. In the military, PAs function autonomously, independently and within the teams they are assigned to, just as physicians do in the military. When transitioning to the civilian world, if the PA is lucky to be in a state that does not have a supervisory agreement, it is going to be more akin to their previous experience. If they happen to come to Nevada, they are going to be held to a higher level of administrative burden. They are not changing their medical practice, just the administrative piece of it. That might make it less desirable to come to Nevada to practice compared to another state.

CHAIR SPEARMAN:
Has there been any degradation of services or patient care when PAs transition from military to civilian practice? PAs have held a number of ranks and positions, including company commanders, brigade staff and primary officers in combat zones.

DR. BAKER:
People who come to us with a service background are almost guaranteed to be good under stress, which is an important thing when it comes to providing medical care. They have some leadership history behind them, which makes them valuable in the medical care setting. They tend to be diversely trained. In the military, they may have to care for a wider spectrum of people. They are

more versed in trauma or behavioral health issues with post-traumatic stress disorder. They fit well into a private model.

CHAIR SPEARMAN:
Do we see any degradation of services or patient care?

DR. BAKER:
There is zero degradation; I do not see any. If they come from the Armed Forces into our private system, there is a higher level of care from those PAs compared to the ones who have more of a private background.

CHAIR SPEARMAN:
In the military, direct supervision does not mean I am standing right over you. Direct supervision might mean the supervising doctor is at the main hospital and the PAs are scattered around various clinics. Supervision in the military is different. Some states have the same model as the military, with direct supervision that does not require direct presence. When a PA leaves the military setting, has there been any degradation of services because the physician was not at the same facility but was in proximity?

DR. BAKER:
That is similar to the model we have. I am officially on call at the hospital right now. I have two APCs seeing patients and making sure they are cared for. I am their collaborative physician and have gotten a few texts from them, but they are autonomously practicing right now under my supervision. When I leave here, I will go back to the hospital and we will talk through the cases to make sure the patients are cared for.

What you are describing is almost identical to what we do in healthcare settings where the APCs or PAs are functioning autonomously in a setting where they have a collaborative physician either available by text or physically nearby to help them, should there be any big issues. They are still practicing. There is a difference between independence, where you can go out and hang your own shingle and do what you want to do with nobody looking over you, versus autonomous, where PAs can practice at the highest level of their licensure in a setting also somewhat protected by having physicians there for questions or concerns. I do not see a difference between what you are describing in the military and what we do at Carson Tahoe.

MR. SANDE:
The military operates under a system that we are trying to work toward. If I am not mistaken, the big difference between the way it is today and what we hope it will be several months from now is that the doctors will not have to fill out the paperwork and submit it to the Board of Health to meet their minimum requirements. Those requirements will be set by Carson Tahoe's administration, which will tell the doctors, "You are to collaborate with these numbers of PAs. We expect you to meet with them for six hours a month, and you will report to us rather than to the BME." That is the way the VA is set up. We think that helps health care because it frees up doctors so they are not filling out unnecessary paperwork to submit to the BME; they are able to use that time to work with the PAs and see patients. Is that how you see it, Dr. Baker?

DR. BAKER:
Absolutely. Sometimes, the forms tell us that supervision means filling out forms. In practice, supervision comes down to a half-hour conversation in the hallway about a patient who is difficult. It is sharing charts. It is a lot of indirect supervision that we provide to make sure the care is high quality and safe for patients.

As things stand now, the administrative burden of supervising PAs is significant. The one time we passed over a better qualified PA for an NP was because the administrative burden was real. I only assumed the chief medical officer (CMO) job about six months ago. The prior CMO had four PAs under his supervision with the State. When he left, those PAs did not officially have supervision within our institution. Their ability to do their job and practice medicine was essentially gone until somebody else was assigned to fill that spot, which turned out to be me. With an NP, I do not have to do that. In the functioning world of our group, and I think most groups, we do not differentiate between NPs and PAs, but PAs come with an administrative burden.

CHAIR SPEARMAN:
The VA hospital in Reno is about four miles from another prominent hospital. A PA practices at the VA and then leaves the VA to go to the other hospital. What is the difference in the way PAs provide service at the VA versus at this hospital?

DR. BAKER:
I do not think there is a difference. I have six PAs under the State that I supervise in writing. I will have a clinic in Mammoth, California, a three-hour drive from here. Those PAs do not stop taking care of patients when I am gone. I am there as needed for any questions that come up. Within the beauty of the collaborative system, two PAs are running the hospital for me at Carson Tahoe. One of my partners is also there if issues come up. I have seven partners who are right there and can answer questions. As far as your question is concerned, when somebody transitions from the care model at the VA into the private sector, there really is no difference. There is no supervision requirement that mandates I must sit there the whole time with a PA or an NP. If that were so, they would be of no use. I do not think there is a significant difference between the two worlds.

MR. SANDE:
To answer your question specifically, the difference is that the doctor working at the VA does not have to fill out the paperwork and send it to the BME. The doctor at Renown must work and fill out the paperwork and submit it to the BME once a month. If you are doing it once, that might not be a huge administrative burden. If you are overseeing eight PAs, it is going to take you several hours out of your month to fill out the paperwork. The VA doctor will not have that same time crunch. He or she will be able to spend that time working with PAs or collaborating with his or her other partners. It is the burden of administration we are trying to lessen through this bill.

MR. LAUF:
A PA in the VA system is a federal employee. They are not subject to state licensure. That PA could be functioning in the VA providing care and choose to stay there to avoid the burden of Nevada requirements in licensure. If that PA wanted to go from the VA to the community, the PA would have to go through the process. It would hinder a PA in the VA system to go out and do the same care in the community. The medicine would not change, but the ability to do it would be hindered.

BLAYNE OSBORN (Nevada Rural Hospital Partners):
I am happy to be here in support of A.B. 364. Our PAs are critical to the access to care in rural Nevada, particularly in our rural health clinics. We think this bill does a good job in balancing the reduction of administrative burden with patient safety and quality.

ANN MILES (Nevada Academy of Physician Assistants):
I have been a PA for 20 years, and I have been living my dream. I have had the opportunity to work rurally and then finally on the frontier of Nevada, but it has not been easy. Working in the rural areas, especially on the frontier, is not for a new graduate. You must be an experienced PA to be out there. You must be trained in multiple disciplines because you need to be ready for anything that comes through the door. Even if you are there for family practice, you better be ready for an emergency. That is why as a healthcare provider, like all healthcare providers, we develop a team of professionals we can call on—doctors, PAs, NPs, pharmacists, radiologists and emergency medical technicians, who I called on when I needed them.

The difference between rural and frontier is that rural Nevada is small towns. They have pharmacies, grocery stores, paved roads, restaurants and places to stay, whereas on the frontier you do not have that. My supervising physician was 86 years old. He drove 250 miles to supervise me once a month and look at my files. He was one of the few doctors that went through my files, looked at them and signed them off for me, after which we talked for a couple of hours, mostly about politics.

I support A.B. 364.

JOHN LARSON:
I am a PA practicing at Carson Tahoe Health. I work under supervising physician David Baker. I am grateful for the opportunity to be able to work prior to graduating PA school at Eastern Virginia Medical School. I was a respiratory therapist for six years. The great thing about being a PA is it allows me to use all the training I have had in my life to help the patients I see.

I work with chronic lung disease patients, and we try to reduce readmission to the hospital. It is important to know that my training as a PA is all about collaboration. That is how the profession came about. All my training from a respiratory therapist up to PA school was about working as a team in health care. I am happy to work with NPs and physicians. The reality is PAs and NPs are considered equal in health care, but PAs and NPs are not legislated equally. I am in full support of A.B. 364 in the interest of equalizing my experience with the experience of my peers who are considered equal to me.

GEORGE ROSS (Touro University):
We support this bill on behalf of our PA program at Touro University.

AUSTIN BROWN (University of Nevada, Reno):
I am here on behalf of UNR to provide support on A.B. 364. This bill will increase our State's capacity to address the public health and the growing healthcare shortage.

DAVID BREMS (Operations Director, Intermountain Health):
I have a letter of support (Exhibit I) for A.B. 364.

DANIEL VILLALOBOS:
I am a rural PA in primary care for almost six years, about an hour and a half from Reno. I was born and raised in Smith Valley, which is a rural community with limited access to health care. Growing up here, I witnessed firsthand the limited access to health care, which is why I chose to come back home to provide care to the community where I was raised. When I began my career, I worked with Senator Robin Titus, who was an Assemblywoman at the time, which also required her to be in session for six months. Thankfully, she wanted to keep our clinic open. She agreed to sign my charts and be my supervising medical director (SMD) during those six months. If she had not agreed to supervise me, the community would have suffered, as we would have had to close the clinic.

My current SMD and I are very busy, and if for any reason he decided to relocate or retire, we would have to close our clinic and I would have to uproot my family and move. The rural community would not get the care they need. Our surrounding states are already ahead of this concept. With our population growth and our future in mind, we are going to have further healthcare strains. It is hard enough to get rural providers as it is, and this is only going to get worse with our growing population.

I strongly support A.B. 364 so we can make sure rural Nevada residents have access to health care.

CURT BRAMBLE (Utah State Senator):
I had the privilege of passing the PA bill in Utah two years ago, and there are a couple of points I think need to be emphasized. When you talk about collaboration, the reality is that in the medical fields, collaboration happens as a

regular occurrence. If a family doctor has a patient with cancer, the doctor knows the limit of his or her skills, and there are going to be referrals. The same thing happens with PAs.

In Utah, we had a situation in Gunnison, one of our rural communities, where there was a PA and a physician who were the sole healthcare providers in Gunnison. When the physician passed away, they had been practicing together for 13 years. In the ensuing two and a half years, because of COVID-19, there was no way to get a supervising physician in place in Gunnison. It came out in committee that the Utah Medical Association recognized the quality of care and patient outcomes from the PA were just as good after the death of the physician as they had been when they were working as a team. The issue of supervision and collaboration has been well covered.

Utah is a state that is sparsely populated and has a significant number of rural communities. We have found that access to health care is extremely limited, and having PAs who can provide those services is critical. We passed Utah Senate Bills 27 and 28 in the 2021 Legislative Session. One was on general health care, and the other on mental health because we have a significant lack of access to care in both areas. The PAs are going to practice to the top of their training, experience and education, but there are other external forces. For example, insurance companies, privileges, the tort liability system for malpractice, all act as checks and balances on PAs at whatever level they are practicing.

I would encourage you to give this bill careful consideration. In Utah, we have opened our licensing to any licensed professionals, PAs or doctors, if they are licensed in another state and their license is current. All they need to do is come to Utah, and we will grant them a license. We will endorse their license unless there is some compelling reason to believe they are not qualified. That is the direction this Country is going in providing access to health care.

LEILA BERG:
I strongly support A.B. 364.

I have worked as a primary care PA for eight years. For the last year, I have been working in urgent care in Las Vegas, where I identify myself to every patient and where I am legally required to wear a badge that states I am a PA. Before I started in my current position, I was offered a position working in a

rural medicine primary care clinic. They were unable to hire me because they could not find a physician to take on the supervisory role. The exact same thing happened again in an underserved community clinic. I speak Spanish, and I could have helped these communities.

Nevada ranks as the forty-ninth state in the Country for the number of primary care physicians per capita, and this is dangerous to public health. I see this every day in the urgent care facility where I work. Patients tell me the wait time for a primary care physician is four months. A four-month waiting list is unacceptable and dangerous.

The opposition to this bill is not making any recommendations on how to remedy this long wait time. Many of my urgent care patients come for conditions that could have been easily treated and prevented in a primary care setting. Instead, they need to wait until the condition became urgent, which overburdens our urgent care and emergency room facilities and is harmful to patients' lives. The patients I see who were being seen by primary care are undertreated because of the four-month wait. I frequently need to add to and adjust their medications, even though they are only there for acute reasons. Their primary care physician zips in and out and has no time to fully address the patient's conditions because primaries are so flooded in Nevada.

In my urgent care, NPs, who have no regulatory burdens, consult with collaborators in other states who are hired by my company to do nothing but take their calls. Nurse practitioners love having this access. Physician assistants must have supervisors who are working in their facility, which limits the number of PAs hirable at my company. We are losing PAs to other states. Several of my patients were graduating PAs who told me they had better opportunities in other states that have already passed legislation like A.B. 364.

STAN:
I am in support of A.B. 364.

Senator Bramble was good enough to come and give you some feedback from his perspective. He was the sponsor of a bill that A.B. 364 is modeled after, although it is not quite as comprehensive as the Utah bill.

If I were the decision-maker on this, there are three things I would be thinking about. The first is this is modernization of the relationship between a PA and the

rest of the healthcare system. For years, PAs have been under supervision, when in practice they are more collaborators. As they get experience, they go from under supervision to more of a collaborator over a long period of time. The language that talks about collaboration is more of a reflection of what is happening rather than some new construct in the scope of practice.

The second thing I would look at is access to health care. In Utah, we have a problem getting health care to underserved communities, and that can be rural Utah, communities of color, those in poverty or the homeless population. They have real challenges in getting access to health care, and PAs fill the gap. When physicians are unwilling or unable to deal with these underrepresented populations, it is PAs who come in and fill those gaps. This is an opportunity for more access for those communities, as you allow PAs to become collaborators in the healthcare process.

The third thing is cost. For 30 years, I saw the same physician, and for about 15 of those years he had us seeing others who worked in his practice. One day I was talking to the doctor who had been seeing me and my family for about ten years, and I asked, "Hey, Doc, what's going on?" He said, "I'm a PA, and you're not allowed to call me a doctor." I was stunned because the treatment I got from him, the attention, the knowledge, the diagnosis and the prescribing were every bit as effective as I had gotten from the doctor in whose practice he was functioning.

That is what clued me into the fact that the PAs are every bit as capable of running family practices and being the first door into healthcare needs for families.

Those are the three areas. It is modernization to reflect what we are already doing. It is about access, and it is about cost.

KIM MCFARLAND:
I support A.B. 364.

I am a PA. My daughter and her family live in Alamo, Nevada, and receive their health care from PAs from Caliente. I am the immediate past president of the Utah Academy of Physician Assistants and was involved in passing Utah's Physician Assistant Practice Act. I have been practicing as a PA for 25 years, for 12 years as the sole medical provider in frontier community health centers

where we accepted all comers, including ambulances responding to medical and trauma emergencies on Interstate 70 in Utah. I now practice with Intermountain Connect Care, an urgent care and telemedicine program. I have been licensed in Utah and Idaho.

For almost two years, I was able to practice and serve patients in Nevada through telemedicine during the COVID-19 public health emergency waiver. After the emergency, the waiver ended, and our group of about 21 PAs were no longer able to serve patients in Nevada, while our 11 NPs have been able to continue to serve those patients. The law prevents Nevada patients from accessing care by our group of PAs. The passage of A.B. 364 will allow Nevadans to access care provided by a group of PAs, especially during nights and weekends, since our practice is open 24/7 and 365 days a year.

Our group has been able to save nearly $100,000 a year by removing requirements for supervising physicians in Utah and Idaho, where most of us are licensed. This allows our group to hire more providers to serve our patients. Removing the requirements for supervision for experienced PAs will allow us to license PAs in Nevada to serve our constituents, also to respond with Utah as part of the federal disaster response system. Under that system, as a federal employee, I do not have a supervising physician and am deployed as part of the team that works together to serve in disaster response. There is no degradation of care when I am deployed or when I return home. I provide the same level of care.

Like physicians, when PAs see patients who have problems beyond our expertise, we consult and refer to the appropriate person who can best evaluate and address those complex problems. Utah has seen no PAs before the licensing board for probation issues since our legislative change. There is high-quality evidence the PAs provide excellent care, increase access to care and work in rural and underserved areas at a rate higher than our physician colleagues. I ask you to support A.B. 364 and remove the requirement for experienced PAs to have a supervising physician.

SUSAN FISHER (State Board of Osteopathic Medicine):
The State Board of Osteopathic Medicine is opposed to A.B. 364 as presented today.

I have not heard anything today that would help get more PAs practicing in Nevada, in our rural areas or critical access hospitals. Expanding PA programs to have a greater teacher-to-student ratio so they can crank out more PAs is terrific. However, it is wrong to say they will not go to rural areas because there is not a physician there to supervise them. As the Senator from Utah mentioned, they could not find a physician to go into the town where the physician had died, so the PA was unsupervised. We do not have that problem here because NRS 633.469, section 2, allows a PA to be supervised by a physician who is in a different geographical location. The statute says:

> Except as otherwise provided in subsection 3, a supervising osteopathic physician may provide supervision to his or her physician assistant in person, electronically, telephonically or by fiber optics. When providing supervision electronically, telephonically or by fiber optics, a supervising osteopathic physician may be at a different site than the physician assistant, including a site located within or outside this State or the United States.

They do not have to be on site.

It appears what this bill is trying to do is reduce an administrative burden. Dr. Baker mentioned he supervises six PAs. In *Nevada Administrative Code* 633.288, osteopathic doctors are allowed to supervise 3:1. I believe the BME has the same ratio, 3:1. Expanding the ratio would be a good recommendation.

I have worked in a law firm for more than nine years, which equates to over 700,000 hours. Should I be able to practice as an attorney because I work in a law firm? If PAs want to practice as physicians, they should go to medical school. They are highly trained professionals, and we need them just as we need the APRNs. We need all these mid-level providers, but they do need the supervision.

CHAIR SPEARMAN:
You said you have not heard that would constitute expansion. How would you define expansion?

MS. FISHER:
You heard a bill on the nursing school. There is a ratio of instructor to students of 1:8 and we heard a great bill this morning about expanding that ratio so that one instructor can teach more nurses. That way you can get more students into the teaching programs and get more nurses out in the field. It was mentioned that a PA school in Nevada had 24 openings with over 1,000 applicants. We need to expand those PA programs to get more trained professionals in the field.

CHAIR SPEARMAN:
Do you believe this bill would allow PAs to practice as doctors?

MS. FISHER:
If they are practicing autonomously, seeing patients without being supervised and billing, they are practicing the same way a physician would be practicing and are doing a lot of the same things physicians do. That is fine because they are highly trained, but they are not physicians. There is some confusion for the patients as well. If a PA comes in wearing a badge that says "Doctor," patients think the person has an M.D. or a Doctor of Osteopathic Medicine degree.

MR. PASTERNAK:
I am here in opposition to A.B. 364.

We heard in the opening comments that NPs are not opening independent clinics. I can give you examples of where that is happening, including an NP who quit working in my office, where I take Medicare and Medicaid, to open her own concierge practice where she is only helping those who have the financial means to pay for this service. This bill would allow PAs to follow that same pathway.

I will read my written statement (Exhibit J) in opposition to A.B. 364. We are hearing a lot today that there are burdens to supervision, and I think we all agree with that. Let us therefore look for ways to streamline that supervision process instead.

ERIN SIMMERS, M.D. (Northern Nevada Emergency Physicians):
I am opposed to A.B. 364.

I have been the education liaison for Northern Nevada Emergency Physicians. We work extensively with a PA training program. I am not military, but there is a saying we borrow in emergency medicine that is attributed to Navy Seals, which is, "Under pressure, we do not rise to the occasion; we sink to the level of our training."

I have submitted my written statement (Exhibit K) in opposition to A.B. 364.

SARAH WATKINS (Interim Executive Director, Nevada State Medical Association): We are opposed to this bill.

The Nevada State Medical Association is a patient and physician advocacy association, and our members understand the important role the PA plays in the healthcare team. However, expanding this midlevel position would cause a split in the healthcare system. The education and training of a PA and a physician are not equal. Medical school expects a much deeper and extensive understanding of advanced sciences as a prerequisite to entry. This foundation is built upon, extensively equipping physicians with the skills, knowledge and understanding to provide care that can range from simple to complex. The PA, as the name implies, has a different expectation. The curriculum was founded on the principles of assisting a physician, with a curriculum of two to two and a half years. Compare this to a physician's curriculum of four years followed by three to five years of residency training.

The broad-brush expansion found in A.B. 364 is a dangerous precedent to set in Nevada, apart from almost every other state in this Nation. This 200-page bill would be a wide-ranging scope expansion without consideration of patient safety. For example, A.B. 364 includes language that specifically allows PAs to determine whether an infant has critical congenital heart disease after being flagged on a common infant screening test. Only physicians can confirm this diagnosis. If this diagnosis is incorrectly diagnosed and treated, it can lead to severe complications and possible death.

Studies have also found that mid-level providers tend to prescribe opioids more frequently compared to physicians. A 2020 study published in the *Journal of Internal Medicine* found almost 8.5 percent of PAs prescribed opioids to more than 50 percent of their patients. This is compared to 1.3 percent of physicians that do this prescribing. The study found in states allowing independent prescribing, PAs and NPs were 20 times more likely to overprescribe opioids

than those in prescription-restricted states. The American Medical Association submitted a letter of opposition (Exhibit L) that has more details on this topic.

A team structure and access to high-quality care should be the goal for citizens in Nevada. Allowing more independent practice of mid-level providers will cause a divide in this healthcare system, and it is not the solution.

DR. FREY:
I am opposed to A.B. 364.

Words matter, and words in this bill matter with respect to ensuring public safety. Senator Stone asked if there was any circumstance where a PA would practice independently, and the answer was no. But it was further clarified that a facility could allow independent practice, which would effectively remove the current statutory requirement by leaving it to the facilities.

Section 4, subsection 1, paragraph (a) says that a PA may practice at "any facility that has established a system for evaluating the credentials of and granting practice privileges to physician assistants." This language leaves an opening for those practicing outside of a hospital system or a credentialed clinic owned by a system or physicians to essentially open a medi-spa and do cosmetic procedures ad nauseum. We see this a lot. It is a constant problem for the State. People practice outside of their scope, and complications occur. That language is particularly problematic because it does not spell out "facility" as defined by NRS. This bill would allow, as written and amended, a PA-owned facility to spring up outside the scope of a hospital system or a physician-owned practice, and the PA would essentially write his or her own credentials.

The 6,000 hours is sorely inadequate. In order to practice lawfully in Nevada, I needed to do 16,000 hours of supervised training to hang my shingle in an emergency department. I saw the sickest of the sick during my training. I did not see the less complex problems; I saw the most complex. We cannot expect physicians are going to suddenly create a new system of education during those 6,000 work hours to ensure PAs are seeing the most complex patients so they are prepared for independent practice. It will be independent practice if a facility says it is independent because we are essentially giving this from the BME over to facilities with this legislation.

We should not assume PAs will be fully prepared for independent practice because 6,000 hours of time has passed. We can assume physicians will assign more complex patients to the PAs along the way, and we cannot assume this bill will not compromise quality and safety. We should listen to the patients who say they want the most experienced caregiver when their life hangs in the balance.

I have submitted a written statement (Exhibit M) in opposition to A.B. 364.

NICK M. SPIRTOS:
I am the vice president of the BME. I am not speaking on behalf of the BME, but it should be noted that the Legislative Subcommittee of the BME voted unanimously to oppose this bill.

This bill is problematic for the following reason. Sections 12 and 28 eliminate provisions governing the testing or examination of applicants for licensure as physician assistants. The bill allows authorizing certain unlicensed persons to use the title "Inactive PA." Regarding the prescribing of dangerous drugs, section 36 removes the requirement that the BME consider the experience and training of the PA when adopting those regulations. Lastly, the practice limitation is nothing more than smoke and mirrors, as independent practice is only limited by the requirement that the facility, which is undefined, may establish for the credentialing of PAs.

This is a complicated issue, and many specifics of this bill are being glossed over. There are many ways to address the practice of PAs in Nevada beyond what is included in this bill. It is interesting to note that, as much as the word "collaboration" is used, there was a request from the PAs to meet with our BME to discuss how we could have collaborated on this bill. The issue of access to medical care will not be resolved by lowering the qualifications of those providing the care, particularly without required collaboration.

You should also note we have significant problems with physician oversight as it is, as PAs being overseen by physicians in other fields, such as ER physicians overseeing PAs practicing cosmetic surgery. We have incredible problems in Nevada with PAs practicing while being supervised by physicians outside of their specialty. Also, no states have laws that provide physician assistants to practice without at least a collaborative agreement, outside of an emergency setting.

This bill does not do anything that protects patient safety. With all the words of collaboration used, why not require collaboration? The requirement would not in any way limit the practice of the PA.

If you read the bill carefully, the lack of restriction in terms of prescribing dangerous drugs essentially allows a PA to practice oncology and gynecology because this removes the requirement that the BME consider the experience and training of the PA when adopting those regulations. This is abhorrent and unreasonable to even be considered.

KAREN MASSEY (Medical Group Management Association):
I am the legislative liaison for the Medical Group Management Association in Nevada. We are neutral on A.B. 364. I was not prepared to testify, but I heard a few comments that I want to speak to.

There is no doubt that for most of our member medical groups around Nevada, PAs are a huge part of their practice. Physician assistants working at the top of their license add a lot to our medical system and are an important part of it.

My concern about A.B. 364 is that the regulations serve to be the bare minimum. The folks you have heard from today are incredibly trained. The folks in medical practices from Carson Tahoe and Renown are responsible in collaboration and supervision. I would urge caution that what goes into law is the minimum for people who will be outside those systems.

There could be a great deal of flexibility and collaboration that would look like an amendment and would aid in reducing the bureaucracy of the requirements. To my knowledge, there is no paperwork submitted once a month. It is more flexible than that now, and it may be more flexible in the future. There are documentation requirements at the beginning and end of a relationship. There are interaction requirements, but there is not a transmission of paper monthly.

The ratios set by the boards have become cumbersome for some of the larger practices. There might be some opportunity for a medical director to be able to supervise a broader group of individuals. It is interesting to listen to all this testimony and hear everyone being positive about collaboration, but the bill has elements that speak directly to supervision.

MR. SANDE:
I do not want to relitigate all the things that were said. I have already put on the record what the intent of the bill is. The opposition seems to have broadened that to include things we did not intend. If the language needs to be wordsmithed, I am more than happy to collaborate with them. We did reach out to all the parties, and we have had conversations with most of the people in opposition at various points during the Session. We are willing to work on language in places where it is overbroad or goes beyond our intent.

CHAIR SPEARMAN:
I asked the assistant director of the BME about people who practice unsafely and how we know about them. I think PAs were in that bill. There are already consequences for PAs who practice outside the scope of their license, am I right?

MR. SANDE:
Absolutely. If you are a PA, you have a scope of practice. If you practice outside of that, the BME will discipline you.

CHAIR SPEARMAN:
We have used "supervision," "autonomous" and "indirect" interchangeably. I am not sure those three words mean the same thing. What is the bill specifically trying to do in respect to supervision?

MR. SANDE:
We are not seeking to be autonomous. That is the situation where you heard about pop-up clinics. That is an autonomous practice. That is not what we are seeking. We already agreed to language in the Assembly we thought would address that. If there is further clarification to prevent the medi-spa situation from occurring, we are happy to add it because that is not our intent.

As far as supervision versus collaboration, I am struggling to understand the legal relevance to the two terms. In part, this bill is trying to reflect the PA's practice as it stands today, which is not really a matter of being under supervision. A supervision situation is like a football team, where the doctor is the coach and the PAs and other providers are the team. But that is not what is occurring. The actual situation is more like the physician is the quarterback, and all the providers work together to provide the best health care they can. We have been using the word "collaborative" to describe this situation. We used the

term not for any legal significance it has but to reflect what is actually happening in our healthcare system.

DR. BAKER:
The difference between the level of education and training of the two specialties is obviously real. It took me 15 years of education and training to get to where I could practice as a cardiologist. We understand the PAs and NPs do not have that level of education and training. That is why we work with them in a collaborative arrangement, which is key. When they are in a healthcare system and something bad happens to a patient, we must not allow patient care to fall to the lowest level of training for that individual. Instead, it must rise to the highest level of training for the team.

Across the board, the other clinics I have seen who have employed PAs have collaborative arrangements with physicians who are right there. If someone crashes in Ms. Downing's clinic, one of us, myself or one of my partners, is literally right there to raise the care of that patient to the highest level of training in the team. There is no degradation of patient care because the patient is primarily seen by a PA. We are there to back the PA up when needed in real time. That is the power of the system we have put together. It is not just our system. If you go to any other significant group around the Country, that is how PAs, NPs and doctors work together.

CHAIR SPEARMAN:
You are a physician, and we have also had some doctors in opposition, but they are 180 degrees apart.

DR. BAKER:
I understand the concerns of the opposition. They are worried about PAs or NPs working independently like a physician. I am fully licensed and credentialed, and I can go start my own practice if I want to and be all by myself. But I do not want to practice like that. I have had several cases this week where I pulled my other physician colleagues in to discuss the cases. I routinely go to Ms. Downing for advice on heart failure. She does a lot of it. We talk about a lot of patients. I routinely talk to my PA colleagues as colleagues. The team concept, the collaborative concept, is powerful. We can take care of more patients than I could by myself so that when things get rough, we are there to make sure the patients are cared for at the highest level.

CHAIR SPEARMAN:
On the allegations of PAs going into practice on their own, if they decided to practice on their own, and it is not in the scope of practice of their license, would they be subject to disciplinary action? Also, how would the BME find out?

MR. SANDE:
If they practice outside the scope of their practice and what they are licensed for, they will be disciplined. As for who would alert the BME of that, any patient with concerns could file a complaint with the BME.

Under section 41 of the bill, we specifically listed the areas where PAs can practice. The first one is a hospital, and if we need to work on the language to tighten that up to say it cannot be a medi-spa, we are open to that. The second is a facility owned by a doctor, so the doctor will or should be there and monitoring their practice. At Federally Qualified Health Centers, doctors are typically at those locations. A lot of health care happens at correctional facilities, and both physicians and PAs are employed there.

The last location was where we made the amendment in section 4, subsection 1, paragraph (f), which said "any other location authorized by regulation of the Board." There was a concern that this would allow pop-up PA clinics because the BME could theoretically license a clinic owned by a PA. The amendment added language that says if you are practicing in one of these facilities, you must have a collaborative agreement. We hoped we covered all the bases by saying PAs are only going to be practicing where there are doctors and other healthcare providers. They are not going to be practicing in their own clinics. That is not our intent. That is not what we have been trying to do.

I know there has been testimony saying that is not what the bill does, and I welcome feedback on how we can tighten that language up. We are talking about team practice and bringing it at the practice level. That is what our bill is trying to accomplish.

CHAIR SPEARMAN:
With respect to the pop-up clinics, if someone knew about a pop-up clinic, would there be a duty to report?

MR. SANDE:
I do not think our bill addresses that, but we are happy to consider it.

CHAIR SPEARMAN:
Is there someone here from the BME? If someone sees someone else practicing outside their scope of practice, is there a duty to report?

MR. CLARK:
Are you asking if a physician who sees another physician practicing outside of their scope is required to report it?

CHAIR SPEARMAN:
Anybody. It appears physicians are at the top of the food chain. Does anyone in the medical field have a duty to report another person in that field practicing outside the scope of the license?

MR. CLARK:
I believe there is, but it is not in a regulation or a statute. You heard testimony earlier that good doctors want to make sure bad doctors are gone. That scenario is true throughout the entire healthcare industry. If a PA saw a physician not practicing well, they may not have a specific statutory duty to report, but I think they probably would report it to the BME.

CHAIR SPEARMAN:
That goes to the question I asked in one of the earlier bills. What is the duty to report, and who reports what? I think right now, the BME errs on the side of trying to make someone who is less than proficient to be more proficient.

I am going to ask our Legislative Counsel Bureau to look that up for me. Is there a duty to report? And if not, then I believe it should be added to the statute. If you know someone who has a medical spa and it is outside the scope of practice, you ought to be reporting them. If you know of someone who is a PA and practicing or putting themselves forward as a doctor, you have a duty to report that.

MR. FERNLEY:
I am not aware of a duty to report. I know the medical boards are authorized to receive those complaints from members of the public and other practitioners, and that there may be incentives for practitioners or other people to provide

those complaints. I do not believe there is a requirement to provide that information to the medical boards.

CHAIR SPEARMAN:
In that case, Mr. Sande, I would say that the duty to report should be in statute. If you walk by somebody's facility and see they are advertising services outside the scope of practice, you should report that. If that is happening, you should report that because it is unsafe to the public. The lack of safety that exists right now is not the same thing as justifying opposition to this bill because there should already be a duty to report. If it is not in statute, there is a moral obligation to report someone who is acting outside the scope of practice because it endangers the population.

I would be glad to work with Assemblywoman Cohen to add this to the bill. I am really disturbed by the testimony I have heard of people acting outside the scope of practice, but I did not hear anything about reporting it. That concerns me.

SENATOR STONE:
You bring up some good points. I think the people who are going to report to the BME the quickest are probably competing physicians who see that a PA has opened an office and is trying to provide services.

As I see it, the bill comes down to two things. First, you want to relieve the physician of these reporting requirements to the BME in concurrence with the reporting requirements with an RN, so you do not have this burden of consultation. I am not sure anybody at the BME actually reads all these reports. They are probably submitted just because it is part of the law. Second, you want to add a PA to the BME, which I have not seen any opposition to.

However, we keep hearing that people seem to feel PAs, by virtue of this bill, are going to be able to be practicing autonomously or independently. I have seen your amendment, but the amendment does not make it clear enough. The amendment you have submitted to amend sections 4 and 23 states the physician system must enter into a collaborative agreement if the physician system will work in a clinic that is not staffed or run by a physician. I would prefer to amend sections 4 and 23 to state a PA must, under all practice circumstances, not be permitted to practice without a collaborative agreement. That would spell out they cannot open any kind of independent practice.

A second amendment would be to eliminate the reporting requirements to the BME as previously discussed.

I hope you take those into consideration. That would make me feel more comfortable with the bill. I think it makes it clear that PAs are team members. I do not think we could work and deliver health care in this State without them.

You are looking for some regulatory relief, which is admirable and necessary, but I would rather see that time be put into educating PAs on how to do their jobs better with their physician mentors.

SENATOR PAZINA:
If A.B. 364 were to pass, would that mean direct supervision will not be required for PAs?

MR. SANDE:
We are going to look at Senator Stone's recommendation, and if we adopt that language, the answer is yes. The way the bill is drafted right now, it leaves it to the facility where there are doctors present to decide the scope and whether even a collaborative agreement is necessary. From the information we are getting, requiring some sort of collaborative agreement might put at ease a lot of the concerns. With the proposed amendment, yes it would.

CHAIR SPEARMAN:
Someone said this bill also gives PAs the authority to do some things APRNs are now doing. Mr. Fernley, can you speak to that?

MR. FERNLEY:
Yes, there are various provisions of the bill that provide PAs have similar authority and duties to other providers of health care who provide the services. I am happy to go through the sections and provide the Committee with a list of what those services are.

Section 1 would authorize PAs to complete the form that is submitted to the Nevada Department of Motor Vehicles to indicate a person has epilepsy and is not able to drive. That is currently a form that can be done by a physician or an APRN and is an example of where PAs are being added in to have additional ability to do those kinds of things.

CHAIR SPEARMAN:
I want to emphasize to everyone and anyone listening online, if you know that someone is acting outside the scope of practice, you have a moral obligation to report that. Do not just come to this Committee and tell us it is happening; that means you know there are people putting the public at risk and doing nothing about it. I believe there is a moral duty and an obligation to do that. We will make sure that is in statute for those whose moral compass might be broken so that is clear.

We will close the hearing on A.B. 364. I recommend you get with the sponsor, Senator Stone and myself so we can make sure those changes happen, especially the duty to report.

Is there any public comment? Hearing none, we are adjourned at 12:12 p.m.

RESPECTFULLY SUBMITTED:

_____
Diane Rea,
Committee Secretary

APPROVED BY:

_____
Senator Pat Spearman, Chair

DATE:_____

EXHIBIT SUMMARY				
Bill	**Exhibit Letter**	**Introduced on Minute Report Page No.**	**Witness / Entity**	**Description**
	A	1		Agenda
	B	1		Attendance Roster
A.B. 415	C	3	Assemblywoman Angie Taylor	Table of Revision to NRS 637 by Board of Dispensing Opticians
A.B. 401	D	12	Patrick Kelly / Nevada Hospital Association	Legislative Counsel Bureau Report
A.B. 442	E	22	Assemblywoman Sarah Peters	Proposed Amendment
A.B. 364	F	37	John Sande IV / Nevada Academy of Physician Assistants	Proposed Amendment
A.B. 364	G	43	David M. Baker, M.D.	Support letter
A.B. 364	H	45	Nevada Academy of Physician Assistants	What is a PA? flier
A.B. 364	I	52	David Brems / Intermountain Health	Support letter
A.B. 364	J	58	Andrew Pasternak / Nevada State Medical Association	Opposition letter
A.B. 364	K	59	Erin Simmers, M.D. / Northern Nevada Emergency Physicians	Opposition letter
A.B. 364	L	60	Sarah Watkins / Nevada State Medical Association	Opposition letter from American Medical Association

A.B. 364	M	61	Brent W. Frey, M.D. / Nevada Chapter of the American College of Emergency Physicians	Opposition letter