Testimony re: SB 112, CRNA Modernization
Senate Public Health and Welfare Committee
Presented by Dr. Scott Kaul, CRNA, NSPM-C
February 16th, 2023

My name is Scott Kaul, I live in Lawrence, KS and I grew up in northeast Kansas. I work as a pain management CRNA running a pain clinic in north central Kansas. I stepped into the medical field as a Paramedic initially. During my airway training, I was exposed to anesthesia practice and it became my passion. I completed anesthesia school at Texas Wesleyan University and completed my nurse anesthesia residency here at Stormont Vail in Topeka and earned my doctoral degree in nurse anesthesiology practice. I subsequently completed subspecialty training in non-surgical pain management. I currently hold dual board certification in nurse anesthesia (CRNA) and non-surgical pain management (NSPM-C).

I am supporting SB 112 because of the significant impact it would have on my practice in both cost, access, and general workflow. I also have many colleagues who are CRNA's across rural Kansas whom I have worked with over the past several years that would also see access and cost improvements in their delivery systems. Allow me to share a couple of my personal examples where this bill will directly and immediately impact care in the rural communities where I focus my practice.

The first is in the area of direct patient referral. This outdated CRNA practice act requires orders from either a physician or dentist. Once an order is received, we act completely independently already based on our training and education. On a weekly basis, I receive referrals for pain from chiropractors and nurse practitioners. These APRNs range from primary care to working with neurosurgery. Neither of these types of providers can currently send me patients. This causes delays in access while the team at my clinic searches out a physician involved in the patient's care who can actually write an order to see me or otherwise require a physician somewhere to give me an order. This also results in undue expense to the patient who wants to directly come see me who must go see "a physician" or at least get an order from one first. The other APRNs can now see these patients directly.

The second area causing many issues on a weekly basis is the issue of prescriptive authority. When I have an established patient who needs oral medication or certain therapies, testing, imaging, etc ordered, I have to refer back to the ordering physician. Most commonly, when I determine a patient needs an oral steroid, neuromodulators, or pain medications, I have to call and get ahold of the patient's other provider who can write them a prescription. If I had prescriptive authority, I would be able to just prescribe these medications myself in order to get the treatment they need now. Many times, this simply means getting a different APRN to write the prescription. I am confused every time I see this in practice. My APRN colleagues can write a prescription, but I cannot.

Finally, when working in the hospital setting, even more commonly in rural Kansas, there is not always a physician around. If there is a podiatrist who needs to work, the patient has to have a history and physical done and again, because they are not a physician, this requires a physician. This is another cost and access issue that really has nothing to do with quality or patient risk. The CRNA is trained as an independent provider and our training is extensive in part because of this responsibility.

In conclusion, SB 112 removes practice barriers that currently result in delay of access to care and increased cost while assuring the CRNA has the capability in Kansas to function to the full extent of their training and education.