Have YOU Contacted Your Legislator to OPPOSE SB 521/HB 861?? YOU ou may think the proposed legislation does not affect your CRNA practice, but you're wrong! It affects every CRNA in Tennessee.

Do you practice in a dental office?

Do you practice in an office-based setting?

Are you grandfathered as a CRNA under current law?

Do you administer, dispense or prescribe pharmaceuticals?

The Tennessee Association of Nurse Anesthetists (TANA) OPPOSES SB 521/HB 861. SB 521 by Sen. Joey Hensley/HB 861 by Rep. Cameron Sexton would enact the "Tennessee Healthcare Improvement Act" to establish physician-led patient care teams to oversee the practice of all APNs in Tennessee, including CRNAs. The TMA proposal is **NOT** about improving access to safe, quality care for patients in Tennessee. It **IS** an attempt to restrict the practice of APRNs in Tennessee. TANA opposes TMA's efforts to restrict CRNA practice and any attempt to negatively impact the Board of Nursing's ability to regulate its licensees.

Here's How SB 521/HB 861 Will Impact YOUR CRNA Practice?

1. **As drafted, this bill intentionally does away with the APN grandfathering provision in the Nurse Practice Act under TCA 63-7-126(d).** (SB 521/HB 861 Section 18) ***As such, any CRNA licensed in Tennessee and holding a national specialty certification prior to July 1, 2005 shall no longer be exempt from the requirement of a master's degree or higher in the applicable advanced practice nursing specialty.***
2. A **CRNA's ability to administer, dispense, or prescribe pharmaceuticals** would be limited to those acts **expressly delegated by a patient care team physician to an advanced practice registered nurse.** (SB 521/HB 861 Section 15) ***Under current law, the authority for an APRN to prescribe is provided in TCA 63-7-123 which states that "The board (Board of Nursing) shall issue a certificate of fitness to nurse practitioners who meet the qualifications, competencies, training, education and experience, pursuant to § 63-7-207(14), sufficient to prepare such persons to write and sign prescriptions and/or issue drugs within the limitations and provisions of § 63-1-132." This authority is not a result of a delegation of authority from a physician. CRNAs do not need prescriptive authority to provide anesthesia and related services. (TCA 63-7-103(a)(2)(D) and TCA 63-10-204(42)(c)). CRNAs order, administer and select appropriate anesthesia based on their training, education and experience not as the result of a physician delegation.***
3. Every APRN **shall** be required to practice as part of a patient care team and would only be allowed to provide to render treatment, including the administration, prescribing, and dispensing of pharmaceuticals, as part of the patient care team. (SB 521/HB 861 Section 17(b)(1)) ***Currently, CRNAs practice in many different practice settings, collaborating with physicians and other healthcare professionals to deliver safe, quality anesthesia care. Why do we need to mandate a "one size fits all" model when there is no evidence of poor outcomes or systemic problems with current CRNA practice?***

4. Every APRN **shall** engage in collaboration with at least one (1) patient care team physician, as evidenced in a **written practice agreement**. (SB 521/HB 861 Section 17(b)(3) ***Routinely, a CRNA practicing in a hospital or ASTC may work with several physicians/surgeons to deliver anesthesia. Would CRNAs be required to have a written practice agreement with each physician for each practice setting? Currently, CRNAs practice in many different practice settings, collaborating with physicians and other healthcare professionals to deliver safe, quality anesthesia care. Why do we need to mandate a "one size fits all" model when there is no evidence of poor outcomes or systemic problems with current CRNA practice?***
5. Practice agreements **shall** include a provision for "appropriate physician review" or referral of a complex medical condition. Every practice agreement shall include a formulary that lists the categories of legend drugs and controlled substances that each APRN may prescribe or issue. (SB 521/HB 861 Section 17(b)(6) and (7)) ***Who or what determines "appropriate physician review"? CRNAs do not practice under protocols and formularies Again, this is a "one size fits all" model that does not take into account the that Nurse Practitioners (NP), Certified Registered Nurse Anesthetists (CRNAs), nurse midwives, and clinical nurse specialists (CNS) are distinct health professionals, each with their own specialized education/training, licensure requirements and scope of practice.***
6. The bill defines what would be considered a "complex medical condition", specifying that a condition that is "emergent, substantially disabling, or life-threatening; **requires the use of anesthesia**…" The minimum requirements for complex medical conditions **shall** be included in **every practice agreement, including physician involvement and referral**. (SB 521/HB 861 Section 17(a)(4) and (c)) ***Anesthesia care is complex, and the Board of Nursing has been regulating CRNAs as anesthesia practitioners without incident. Certified Registered Nurse Anesthetists are advanced practice nurses that receive specialized training in the delivery of anesthesia and related services. When anesthesia care is delivered by a CRNA, it is the practice of nursing; when an anesthesiologist delivers it, it is the practice of medicine. The standard of care is the same for all anesthesia care regardless of who provides the service. The Board of Nursing is vigilant in its responsibility to oversee all advanced practice nurses, including CRNAs. Why would we want their authority to be diminished?***
7. Further "if a decision by the board of medical examiners or the board of osteopathic examination as to who or what constitutes a **complex medical condition** contradicts any decision made by the board of nursing concerning a similar complex medical condition**, the decision and rules of the board of medical examiners or the board of osteopathic examination shall supersede the decision made by the board of nursing. "** (SB 521/HB 861 Section 17(c)) . ***The Board of Nursing is vigilant in its responsibility to oversee all advanced practice nurses, including CRNAs. Why would we want their authority to be diminished when there is no evidence saying that it should be otherwise?***
8. A CRNA, providing anesthesia services at a **licensed facility (ex. hospital, ASTC),** may use the physician providing the medical or surgical service as a surrogate for a patient care team physician; however**, if a CRNA provides anesthesia in an office-based setting or dental office, then the physician providing the medical or surgical service could not serve as the patient care team physician, meaning an anesthesiologist would be required.** (SB 521/HB 861 Section 17(g)) ***Currently, CRNAs practice in a myriad of practice settings. A CRNA is granted clinical privileges by the medical staff of the facility where he/she practices. These clinical privileges outline what services a CRNA may perform in the facility. Each of these facilities/practice settings already has rules in place governing their operations, including anesthesia services.***
   - ***Hospitals – Rule 1200-08-01***
   - ***Office Based Surgery – Rule 0880-02-.21***
   - ***ASTC – Rule 1200-08-10***
   - ***Dental offices – Rule 0460-02***
9. **If a CRNA administers opioids or benzodiazepines,** then the patient care-team physician shall have to **review 100% of patient charts.** (SB 521/HB 861 Section 17(e)(5)). ***This "one size fits all" model approach is not fixing an issue but creating more unneeded bureaucracy for CRNAs who routinely give opioids and benzodiazepines for anesthesia care without evidence of a problem.***

PLEASE OPPOSE SB 521/HB 861!!!