Ohio Board of Nursing *www.nursing.ohio.gov*
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Advisory Committee on Advanced Practice Registered Nursing

DRAFT Meeting Minutes
June 11, 2018

Members Attending: Erin Keels, Board member, Chair; Jody Miniard; James Furstein; Christopher Kalinyak; Peter DiPiazza; Kristine Scordo; Sandra Wright-Esber; Michelle Zamudio

Members Absent: None

Board Members Attending: Lisa Klenke

Staff Attending: Lisa Emrich; Anita DiPasquale; Holly Fischer; Tom Dilling; Chantelle Sunderman

Guests Attending: Keeley Harding; Tracey Vitori; Amanda Rumpke, Mercy Health; Bertha Parsell, Mercy and OAAPN; Sharla Mapes; Jesse McClain, OAAPN; Jeana Singleton, Brennan, Manna & Diamond; Erin Ross, Cleveland Clinic, and OAAPN; Judy Audas, OSANA; Tiffany Bukoffsky, ONA; Joscelyn Greaves, Aultman; Meghan Mills, Aultman & 20 Medicine; Deana Sievert, OSU student; Johnnie Dillinger, Pulmonary Critical Care, MVH; Bethany Hoehn, Pulmonary Critical Care, MVH; Amy Fraulini, Southern Ohio Medical Center; Valerie DeCamp, Southern Ohio Medical Center; Margaret Graham, Ohio State University; Kim Thomas; Mary C. Willison; Jennifer Mickley; Derek Dreyer, student; Tyler Rudman, student; Kate Lemke, student; Ashley McGaughy, student; Jordan Leshnock, student; Noah Gruse, instructor; Shaina Hunt, student; Clare Seveeney, student; Amy Alexander, student; Laura Carter, OAAPN; Lisa Moore, OAAPN; Andy Herf, OSANA; Joe Hollabaugh, OSANA; Alex Botsch; Walsh University; Joyce Karl, OAAPN; Mary Jane Maloney, OAAPN; Kelly Leahy, OSANA; Robin Rosselet, OSUMC; Kristi P. Burkhart, Ohio Health; Latina Brooks, CWRU; Lisa Rankin, OSMA; Jen Johns, Cleveland Clinic; Drew Vian, OAAPN; Eric Snyder, OAAPN; Shanna Price, Sanofi; Sarah Kloepfer, OAAPN; Olivia Sapia; Ellesha LeCluyse, Brennan, Manna & Diamond; Cory Smith; Kassy Robinson; Matthew Huffman; Trevor Schimmoeller; Kate Huffman, OHA; Emma Cardone; Bethani Knipfer

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Call to Order and Welcome

Erin Keels, Chair, called the meeting of the Board's Advisory Committee on Advanced Practice Registered Nursing (Advisory Committee) to order at 10:02 a.m., welcomed members and guests, and read the Advisory Committee's charge. She stated the meeting was being recorded for purposes of the minutes and that the minutes will be the official record of the meeting. She stated she was informed that a third party is broadcasting the meeting. Advisory Committee members introduced themselves. Chair E. Keels reviewed Public Participation Guidelines.

Review and Approval of the May 14, 2018 Advisory Committee Meeting Minutes

Sandra Wright-Esber and Michelle Zamudio asked that the draft minutes be revised as follows: On page four, the statement, "...there would be limits to the practice of APRNs in her hospital," be revised by eliminating "in her hospital;" on page five, the statement "... nothing more than the APRN Decision Making Model is needed," be amended to state, "the APRN Decision Making Model is sufficient and additional rules are not needed." Kristine Scordo moved to approve the minutes as revised, and Sandra Wright-Esber seconded. The minutes were approved

unanimously with Peter DiPiazza and Jody Miniard abstaining. M. Zamudio clarified that her statement in the minutes regarding her work as a legal nurse consultant was not meant to imply she is a certified legal nurse consultant.

Public Comments

Chair E. Keels stated that previously at the meetings, a time for public comments was scheduled at the end of the agenda, but today comments will be heard at the beginning in order for the Advisory Committee to consider the comments prior to discussing CNP acute and primary care practice and the Consensus Model. Chair E. Keels stated that written comments received have been distributed to the Advisory Committee members. The public comments were as follows:

Tracey Vitori stated her understanding that an organization wants to blend the practices of primary and acute care, as it pertains to the Advisory Committee's ongoing discussion. She stated she does not support FNPs managing acute/critical care situations. The didactic and clinical preparation and national certifications of an acute care NP and primary care NP are very different. Bedside RN experience does not equate to the clinical expertise provided by clinical rotations in a graduate or post-graduate APRN education program. She discussed two incidents at her hospital that employs FNPs in its emergency department, where FNPs placed chest tubes, after which one patient died and the second required emergency thoracic surgery. Her hospital does not credential FNPs to insert chest tubes because that is not within their scope of practice. She struggles with the idea of APRNs moving into an area of practice in which they have not been prepared by formal graduate education.

Margaret Graham, The Ohio State University College of Nursing, stated she is a Family Nurse Practitioner with forty-three years experience and is faculty in a Family Nurse Practitioner program. Her FNP program does not include insertion of chest tubes, and she stated that it is unfortunate that some CNPs practice outside their scope as mentioned by the previous speaker; however, this should be addressed on an individual basis and should not be a factor as to how practice is regulated. Many family and adult CNPs, who are primary care practitioners, have been practicing for 30 to 40 years. They work in hospitals and have received education and training beyond their initial certification, in a similar manner as a registered nurse who takes on additional practice responsibility. The additional education and training does not grant them permission to practice beyond their scope. Over-regulation could lead to regulating APRNs out of their practices and she asked that the Board not over-regulate APRN practice. Physician assistants are not differentiated by primary and acute care in their practice, so APRN practice also should not be differentiated. She agreed there is a responsibility to ensure APRNs practice within their scope of practice, but additional regulation is not the answer.

Christopher Kalinyak commented in response to M. Graham that the profession of nursing is not just a skill to be taught, but is based on specific theory and professional practices. He stated since CNP graduate and postgraduate programs are established to distinguish primary care and acute care education, and those programs are accredited by organizations including ANCC with separate distinct accreditation standards for each, it is important to also distinguish primary care and acute care in CNP practice. He emailed his views to the Advisory Committee and other individuals. He stated he believes it is wrong to allow various CNPs and physician assistants to practice in fields for which they are not qualified.

M. Graham added that if CNPs certified in family and adult primary care cannot practice acute care, then acute care CNPs should not be permitted to practice primary care outside of the hospital, and that is happening as well. She stated she agreed FNPs should not be inserting chest tubes, because it has not been a part of their education. She stated that regulations are not setting specific, but questioned how CNP practice is then regulated if not by setting.

K. Scordo responded that although many hospital credentialing processes are appropriate, there are many that do not understand the scopes of APRN practice. M. Graham agreed and stated APRNs must help hospitals understand the APRN scopes of practice. M. Zamudio stated that she reviewed OSU's FNP curriculum and noted there was a final course for student individualization. She asked if this course could be individualized to prepare FNPs to manage patients in the emergency department. M. Graham responded that it prepares the student to manage the appropriate patient, but it does not prepare the FNP student to manage patients in the acute care side of the emergency department.

Jesse McClain, OAAPN, stated the two years of discussion of the Advisory Committee divides the nursing profession rather than advancing the practice of Ohio APRNs. APRNs have proven to be safe and have provided quality care for over fifty years. Hospital credentialing is a lengthy and strict process monitored by the Joint Commission. Hospitals would be at risk for liability if their providers were not vetted to standards much stricter than any state statute or rule. It would be unrealistic for the Board to privilege and credential APRNs. Implementing stricter regulations could negatively affect APRNs both socially and financially by forcing them to return to school to maintain their current employment. The article published in *Momentum* changed APRN practices, limited Ohioans' access to care, and placed additional stress on APRNs and hospital systems. Hospital systems are hiring physician assistants over APRNs. No other state or state board regulates specialty areas of APRN practice. Regulatory boards for physicians, physician assistants, chiropractors, and dentists do not issue licenses by specialties or area of national certification that determine their scopes of practice. It is a disservice to patients to restrict APRNs to practice only what was learned with regard to their national certification, and de-values workshops, other types of training, and other methods of APRN continuing education. The Board's APRN Decision Making Model and other tools are used to incorporate new medicine and procedures that were not current when some APRNs attended school. The majority of patients within a hospital are treated for chronic conditions with an occasional acute episode and do not require the care of Certified Nurse Practitioners that have acute care national certification. Many regulations are already in place including APRN scope of practice, the hospital's credentialing system and ongoing practice assessments required by the Joint Commission, the Board APRN Decision Making Model, and the Board’s disciplinary process. If the Board choses to use the Consensus Model, then the Board must utilize the Consensus Model in its entirety, and not just select parts. This includes the Consensus Model statement that scope of practice for a population focus is not setting specific; there should be no requirement for collaboration with a physician; CRNAs should be authorized to practice at their full scope that includes writing orders for medications; APRNs should have full practice authority; and Ohio should join the APRN Licensure Compact. Only a 66% percent majority of the participating organizations determined consensus. Only 31 of the 48 organizations listed on the Census Model agreed on any one subject. Only 30 states have adopted the Consensus Model, though more states have adopted full practice authority for APRNs.

Attorney Jeana Singleton, Brennan, Manna & Diamond, LLC, stated she serves as General Counsel for OAAPN. She commented that Section 121.22, Ohio Revised Code, is the Ohio's Open Meeting Act, and the Ohio Supreme Court opined in *White v. King* that the statute is applicable to email communications. She reminded the Advisory Committee that any discussion of public interest must be held in a public forum.

Erin Ross, Cleveland Clinic, stated she has practiced in the subspecialty of otolaryngology for over twenty years, and her current practice is in otolaryngology and express care. She stated the credentialing process for privileging APRNs at the Cleveland Clinic is rigorous to ensure the right provider is caring for the correct patient, and is the same process for registered nurses, APRNs and physicians, meaning that all education and certifications are taken into account when considering the practitioner, including post-graduate training. She stated CNPs who are nationally certified in family and adult primary care are prepared to care for the most common International Classification of Diseases codes that are seen in the express care environment,

and believes their work in the express care is appropriate. Increasing regulation of practice is not necessary and will complicate patient access to care.

CNP Acute and Primary Care Practice

Chair E. Keels stated that she is aware that an Advisory Committee member recently sent an email reflecting the member's opinion. She stated that the email reflected the individual's opinion on the topic.

S. Wright-Esber stated that the email violated the "Ohio Sunshine Law" and asked the Board to investigate. M. Zamudio added the Board should make the email publicly available. Holly Fischer stated that the Advisory Committee received Open Meetings Act training from the Auditor of State, and a prearranged meeting, to discuss public business may constitute "meeting" under the Open Meetings Act even if conducted via email. She does not believe one unilateral email sent to members of the public and Advisory Committee members meets that definition, however she reiterated that the Advisory Committee members should not be communicating about Committee business among themselves outside of the arranged meeting time. She stated any document or email addressed to the Committee is already a public record and is fully transparent. The document is available through a public records request. S Wright-Esber stated that one of her emails was treated differently and that this disparity should be investigated as she felt she was personally targeted. H. Fischer asked if anyone had any questions about their responsibilities in complying with the Open Meetings Act. All of the Advisory Committee members indicated they did not have questions.

Chair E. Keels summarized the history and previous discussions. The Consensus Model was published in 2008, and is congruent with the Ohio Nurse Practice Act. Over the years the Board has provided responses to questions regarding scope of practice consistent with the Nurse Practice Act and the Consensus Model. The Board published the *Momentum* article to respond to questions about acute and primary care national certification and practice, and national certification. It is not about the practice setting but is about the patient population. As a result of the article, the Board heard disagreement and concerns. HB 216 established the Advisory Committee to advise the Board regarding APRN practice and regulation.

The Ohio Attorney General provided an Opinion that if the Board enforces the requirement for the CNP to have acute care national certification for the management of patients with critical/complex/unstable conditions, it is recommended that the Board adopt rules in order to provide further clarification to CNPs.

The Board held meetings with OHA/OONE to discuss CNP practice in hospitals. OHA/OONE members have told the Board that hospitals now have a better understanding of CNP scope of practice and national certification related to population foci and that the Consensus Model is consistent with the NPA. OHA/OONE recommended that the Board define certain terms and prepare additional guidance documents to use in conjunction with the Consensus Model.

The Advisory Committee is to make a recommendation to the Board, whether Ohio should continue or discontinue following the Consensus Model. The Advisory Committee members agree there is a continuum of patient care, but there are questions about when a patient's condition become critical and should be taken over by an acute care CNP. The NONPF competencies delineate acute care and primary care practice.

Chair E. Keels distributed page ten of the Consensus Model that includes the "Regulatory Model" for APRNs to verify members' understanding of the model. The four roles are the Certified Nurse Practitioner, Clinical Nurse Specialist, Certified Nurse Midwife and the Certified Registered Nurse Anesthetist. Each role requires national certification that is applicable to the specific role. The national certification population foci for the CNP role are Pediatric, Adult-

Gerontology, Women's Health/Gender Related, Neonatal, and Psychiatric/Mental Health. The Pediatric and Adult-Gerontology populations are further subdivided into acute care and primary care as stated in the box directly below the Consensus Model diagram. On the side of the model it indicates licensure occurs at the level of role and national certification population focus. APRN "specialty" is on top of, or above, the population focus on the Model, showing that the CNP may specialize within the CNP's national certification population focus and that specialty is beyond the level of licensure and national certification. Chair E. Keels stated that if members use the term "certification" during the discussion, it should mean "national certification population focus" and "specialty" means "sub-specialization within the CNP's national certification population focus." She asked if everyone was clear about the Regulatory Model and the use of the terms. All members responded that they understood. Chair E. Keels asked for Committee members to state their positions about whether to continue to follow the Consensus Model or discontinue its use.

K. Scordo thanked the members of the public who provided comments. She agreed there is overlap in the continuum of patient care regarding acuity. Not all hospitals are clear about the parameters of CNP practice, and the same or similar practice parameters pertain to pediatrics and psych/mental health. According to the NONPF competencies, the FNP student is prepared to provide primary care services throughout the lifespan, to provide health care from wellness to illness, to treat and manage chronic conditions, and provide comprehensive continuous care that is characterized by long term relationships with the patient. Acute care CNP students, whether Adult-Gerontology Acute Care or Pediatric Acute Care are prepared to provide care to patients with critical care needs, to stabilize patients who are physiologically unstable, technologically dependent, and are highly vulnerable for complications. She stated she is concerned about communications that infer APRNs are fighting about the issue. The OAAPN document refers to "specialty regulation" which is not regulated by the Board; the Board regulates role and the national certification population focus. In a malpractice case, documentation that proves an individual competent to care for a specific population is reviewed first and additional training is to be consistent with the APRN's national certification and scope of practice competencies. She stated Ohio should continue to follow the Consensus Model and she believes APRNs should be working with and not against the Board in using the Consensus Model. She suggested the Board further clarify the Consensus Model and research how other states have done this.

Lisa Klenke commented on the Consensus Model and the Nurse Practice Act (NPA) with respect to her history as a Board member. The current NPA that specified the scope of APRN practice preceded the Consensus Model. When the Consensus Model was published, the Board determined that the law and Consensus Model were congruent with each APRN role and national certification. There was no need at that time to change law or rules because the NPA and rules were consistent with the Consensus Model and the Board was already regulating APRNs that way. The *Momentum* article was published to provide clarity, and the Board has not proposed additional regulations. The Board had no intent to create new regulations when the *Momentum* article was published. The *Momentum* article created challenges because the term acute care was used, and acute care makes many readers think of the hospital setting. She thinks the Advisory Committee members are closer in agreement if members look at the issues.

K. Scordo agreed no new regulations were presented or proposed in *Momentum*; the article increased awareness of the existing law. Years ago, she helped write the OAAPN Tip of the Month, a publication that addressed this issue in the same way the Board has been addressing primary and acute care national certification.

P. DiPiazza agreed with L. Klenke. He said it is hard to argue against the Consensus Model and agrees with the importance of defining "acute." He said the NONPF competencies for acute care and family CNP practice have some similar features and cross over but noted it states acute care certification pertains to managing patients at risk for urgent and emergent conditions.

He does not understand why everyone is struggling with this because as Family Nurse Practitioner, he does not manage the care of critical patients, but follows them peripherally. He stated the hospital setting is not acute care specific and believes there is a place for FNPs in the hospital. The majority of patients who visit the hospital are not receiving care for an acute or critical care issue. He read the definition of acute provided by the World Health Organization as "sudden unexpected urgent/emergent."

Chair E. Keels stated the Centers for Medicare & Medicaid Services (CMS) definition of critical care is applicable for acute care practice because it is about managing the critical, unstable, complex patient. She read, in part, the CMS definition:

> A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition. Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition. Examples of vital organ system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure. Although critical typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s) critical care may be provided in life threatening situations where these elements are not present.

Jody Miniard stated that some Cincinnati area hospital systems no longer credential anyone to practice in the hospital without acute care national certification and she does not agree with this. She understands the existence of overlap in practice; however, for the Board to regulate practice, the line must be drawn with definitions that are clear and communicated. She believes the idea of a FNP placing chest tubes, managing patients in cardiogenic shock, and critical neurological patients is crossing the line, is a definite breaking point, and the Advisory Committee needs to decide that breaking point. She believes FNPs are fully capable of rounding on a stable patient in the hospital. FNPs are capable of providing care to a stable cardiac, GI or nephrology patient. Acute care CNPs can practice both within and outside of the hospital setting. Although she agreed that not every patient in the ICU is unstable, those patients are in ICU for a reason, and if they are at high risk, for example, of needing a chest tube to be placed, it should not be the FNP who is given hospital privileges to place it. J. Miniard stated that creating definitions and building on the APRN Decision Making Model would help APRNs working with their hospital's credentialing processes to determine their privileges. She recommended looking at decision models from other state boards of nursing and examine other states' regulation regarding CNP practice, such as Kentucky and Arizona.

S. Wright-Esber stated she has the same concern voiced by Jesse McClain, OAAPN, whether the Board will adopt the Consensus Model in its entirety and not pick and choose aspects of the Model. She raised concern with the Advisory Committee process, including the members' receipt of materials only a week or two prior to the meeting. She believes the materials should arrive three to four weeks prior to the meeting at which they are to be considered, and she emailed the Advisory Committee Chair regarding this. She stated the meeting materials, the articles, and the May 14th meeting speaker are skewed in favor of the Board's position to regulate acute and primary care certification and practice. The speaker, Dr. O'Sullivan, was in agreement with the Board's position. Dr. O'Sullivan's statements regarding APRN liability were not pertinent to the discussion of scope of practice. Lawsuits involving APRNs would be expected to increase as the number of APRNs in practice increase. The real issue is discussing how APRNs are privileged within institutions. She suggested the Advisory Committee should hear from presenters who will speak to the other side of the issue. She raised concern with the composition of the Advisory Committee, that it is not representative of Ohio's APRN population and that APRNs with acute care certification are over-represented. She questioned the Advisory Committee's ability to make a recommendation to the Board because she is not sure that the right persons are at the table. She stated the Board's recent Advisory Committee appointments shocked her and she was concerned that the Board did not reappoint members to a second

term. She stated that the Board lacks logical consistency and transparency and asked for a fair Advisory Committee process. She appreciated Dr. Graham's comments because the Advisory Committee needed to hear information about family CNP education and practice. She recommended that the Advisory Committee should also hear a presentation from a known attorney who specializes in APRN licensure.

Chair E. Keels asked S. Wright-Esber if her comments meant she does not support the Consensus Model. S. Wright-Esber responded that she supports full APRN practice authority and she has worked diligently on OAAPN committees regarding APRN practice. She wants the Board to have an active presence with OAAPN and support OAAPN. OAAPN is the largest organization that speaks for APRNs in Ohio and therefore the Board should work with OAAPN. She stated other states are not experiencing this same problem with acute versus primary care CNP practice. She is not in favor of the Advisory Committee moving forward at this time. She believes this should be a statewide initiative and there should be discussions with others throughout the state. She is concerned that Ohio is losing APRNs to other states that have full practice authority. Chair E. Keels asked whether her position is not to follow the Consensus Model. S. Wright-Esber responded that Chair E. Keels is over-simplifying the issue and stated the Advisory Committee needs a lot more information before it proceeds.

J. Miniard stated that her role on the Advisory Committee is to represent faculty in an APRN education program. She supports and teaches all national certification population foci. Her goal as an Advisory Committee member is to be non-divisive and non-regulatory and she does not share that same opinion as S. Wright-Esber that acute care CNPs think they are the only ones that should be in the hospital. Many of her students want to perform various procedures during their clinicals, and she tells them that this is not how one learns to take care of a patient, because it is not the procedure itself that is important, it is about understanding the complexity of the patient. She believes she could teach anyone how to insert a chest tube, but not everyone can understand the complexity of the patient unless they have studied it. She stated it would be “insane” to do away with recognition of a CNP's national certification population foci. If national certification were no longer recognized you would have to look at what education is appropriate for the patient populations to be managed and let the hospital do its job. Each APRN is responsible for knowing what they may do.

L. Klenke stated that she has not heard any discussion that supports the CNP doing things that are not within the scope of their education or national certification. She suggested that the Advisory Committee again review the *Momentum* article to identify and discuss the specific points with which persons disagree. She believes misinterpretations of the article have been disseminated and perpetuated. The nurse executives of OONE reviewed the article, held additional dialogue with the Board, and they better understand it.

S. Wright-Esber agreed that reviewing the article again is a valid point but she believes the Board was vested in the article's content and has been left to defend it. She believes the Board's interpretation of the Consensus Model is different from hers and many differing interpretations of the article and the Consensus Model exist. Besides, when it comes to managing a complex patient, what is more complex than a FNP managing a 90 year-old patient with kidney failure and diabetes in the outpatient setting without inpatient assistance. J. Miniard responded she agrees this patient is complex and appropriate for a primary care certified CNP, however managing that patient's care is significantly different from managing the care of a patient with multisystem failure requiring extracorporeal membrane oxygenation, mechanical ventilation, and support with multiple vasoactive infusions.

James Furstein stated the focus should remain on regulating the national certification population foci and not the location where care is provided. Based on the arguments and discussions presented over the last year, he believes that clarifying definitions would address most

concerns. He also stated that he believes there were misinterpretations of the article.

J. Miniard agreed that the article was misunderstood, which is not the fault of the Board; however, she believes the language in the article was somewhat abrupt and interpreted by some reading it that acute care meant hospital based practice. She agrees that the Board should follow the Consensus Model, CNPs are to practice consistently with their national certification population focus, and concise definitions would help. That is the issue, not whether APRNs should have full practice authority or whether we should be following other forms of education. Agreement with the national certification population foci and defining acute and primary care will address the issues. She stated she needs additional information to better understand how the Board intends to use the Consensus Model. She questioned if her agreement to continue to use the Consensus Model means she is agreeing to regulations and eliminating FNPs from practicing in hospitals.

S. Wright-Esber stated she wants to start fresh with the new Advisory Committee members and additional speakers. She believes everyone is closer to agreeing, but regulation is not needed. M. Zamudio believes an additional Advisory Committee member practicing in primary care is needed.

M. Zamudio moved that the Committee on Advanced Practice Registered Nursing recommend to the Board that it appoint an additional Committee member who practices in family/primary care. S. Wright-Esber seconded the motion.

The motion was discussed. P. DiPiazza questioned if one additional FNP member would be more representative of FNPs in Ohio and whether the Advisory Committee should also consider the need for APRNs in psych/mental health, CRNAs, pediatrics, and CNSs. J. Miniard agreed that one additional member would not be a better representation of FNPs in practice. She stated the comments and information from Advisory Committee members and information from the public speakers and APRNs in practice are sufficient. S. Wright-Esber stated that it is important for the Board to consider the types and numbers of Advisory Committee members when considering future appointments. H. Fischer clarified that the statute limits the recommendation to one additional member. The vote was called. The motion carried with four members voting in favor and three members voting against the motion. K. Scordo abstained.

C. Kalinyak stated that "training-up" APRNs for another practice dilutes the profession and he supports the continued use of the Consensus Model, without additional Board regulations. K. Scordo voiced her support for the Consensus Model. P. DiPiazza stated he supports the Consensus Model, and it would be helpful to hear how the Board interprets it. J. Furstein stated he supports the Consensus Model with clarifying definitions. Chair E. Keels stated her support for the Board's continued use of the Consensus Model.

Chair Erin Keels moved that the Advisory Committee recommend to the Board that the Board continue to follow the Consensus Model. K. Scordo seconded the motion. The motion passed with E. Keels, P. DiPiazza, K. Scordo, C. Kaylinyak, and J. Furstein voting in favor of the motion; S. Wright-Esber, J. Miniard and M. Zamudio opposed the motion.

S. Wright-Esber and J. Miniard stated that the Consensus Model is not a law, rule or regulation, and they questioned how the Board following of the Consensus Model lends to the Board's regulation.

L. Klenke read Section 4723.43(C), ORC, the statutory definition of CNP practice. The Consensus Model is congruent with Ohio law. L. Emrich stated the *Momentum* article provided information about the statute. The article was specific to patient care and not a practice setting. She said the Board issues APRN licenses based on national certification. P. DiPiazza stated his organization did not interpret the *Momentum* article to say that FNPs are not allowed in a

hospital setting, but they drew the line at trauma and critical care practices. J. Miniard stated she is also concerned there may be a picking and choosing of the parts of the Consensus Model and the Board needs to adopt all of the Consensus Model otherwise it is not following the Consensus Model. L. Emrich explained that the Consensus Model has different components and one part is specific to Board regulation, the "Regulatory Model" page of the Consensus Model, which was distributed by Chair E. Keels. The Advisory Committee reiterated the need for clarifying definitions in guidance documents. H. Fisher clarified that to adopt definitions the Board would need to do so by rulemaking.

Administrative Rules/Interested Party Meeting

H. Fischer presented an update about the proposed rule language for Rules 4723-9-10 and 4723-9-12, OAC, related to the treatment of chronic/sub-acute pain with opioid analgesics. The proposed revised rules are based on the Medical Board's draft rule and both were previously discussed at the May 14, 2018 Advisory Committee meeting. The Medical Board updated its definition of "sub-acute pain" and changed language to require consideration of a naloxone prescription at the 50 MED level. These revisions were forwarded to Advisory Committee members. A typographical correction was noted.

H. Fischer responded to questions regarding the use of the word “consultation” in Rule 4723-9-10(M)(5)(c)(ii), OAC. The question was whether a health care provider who is a pain management specialist must refer the patient to another pain management specialist. H. Fischer stated that at an 80 MED level, one of the four listed actions must be completed and seeking a pain management consultation is one of the options. The difference in pain management specialists and addiction specialists was discussed. The Medical Board may address pain management consultation in an FAQ. H. Fischer discussed the timeline for the proposed revisions to Rules 4723-9-10 and 4723-9-12, OAC, and the public hearing.

H. Fischer reviewed the five-year review rules. She also discussed Rule 4723-8-11, OAC, *Youth concussion assessment and clearance*. The rule was not scheduled for review until 2020; however, there was an update to the guidelines referenced in the rule. The most current version is now the Berlin 2016 Consensus Statement. Since the Medical Board decided to update its rule, the Nursing Board is proposing to update the rule for consistency. She noted that the related Ohio Department of Health form continues to reference the previous Zurich Guidelines.

In addition, based on the APRN Advisory Committee recommendation, the rules were revised to replace "nurse" with "advanced practice registered nurse." There were no questions pertaining to the rules. The technical revisions rules and the five-year rules will be discussed at an Interested Party Meeting on June 26, 2018. Advisory Committee members and interested parties are welcome to attend. H. Fischer asked that questions or concerns with any of the rules be forwarded to her as soon as is possible.

Legislative Updates

Tom Dilling provided updates on HB 191 and SB 275, CRNA bills. SB 275 had sponsor and proponent testimony. SB 275 would increase the CRNA scope related to ordering certain drugs and practice within the post anesthesia care unit that would be governed by the hospital through a protocol committee. The bill does not include CRNA independent practice. HB 111, informally known at the "pink slip bill," includes amendments and is expected to pass. The language regarding rapid sequence intubation was removed from SB 259, the physician assistant bill.

T. Dilling referred to the Advisory Committee materials that included an email and a draft amendment to Section 4723.43, ORC, received from Andrew Minton, OAAPN lobbyist. OAAPN proposes to address CNP primary and acute care practice by amending the NPA. Mr. Minton provided the proposed legislative language to legislators; there has been no legislative action.

T. Dilling stated at the May Advisory Committee meeting Candy Rinehart reported OAAPN anticipated a bill to eliminate the APRN standard care arrangement would be introduced in May. S. Wright-Esber stated there is a bill sponsor but they are awaiting information prior to it being introduced.

CE Information/FAQs
Because there continues to be questions about CE for APRNs, L. Emrich discussed the Board FAQs regarding APRN CE. CE is not required for the licensure period that ends in 2019 for APRNs. APRNs are required to obtain 24 hours of CE each renewal period starting with the 2019-2021 renewal period. All APRNs must also meet the CE requirements for RN licensure, which include 24 hours for the renewal period that ends in 2019. P. DiPiazza recommended adding language to the document stating APRNs must complete the RN requirements. The Committee members stated they appreciated the FAQs.

Board Process for Advisory Group/Committee Appointments
The Advisory Committee reviewed a memorandum regarding the Board's policy and process for appointing Advisory Group and Committee members.

Future Meetings and topics: The next meeting is October 1, 2018. Chair E. Keels restated the agenda topics recommended by the Advisory Committee members for future meetings:

1. Information and presentations regarding APRN primary care practice in Ohio
2. Information as to how the Board uses the Consensus Model
3. How other states are using or implementing the Consensus Model
4. Report from the Board regarding the Committee's recommendation for an additional member

Adjournment: The meeting adjourned at 2:00 p.m.