AGENDA
Advisory Committee on Advanced Practice Registered Nursing
June 17, 2019 10:00 a.m. to 3:00 p.m.

Charge: The committee shall advise the Board regarding the practice and regulation of advanced practice registered nurses and may make recommendations to the Committee on Prescriptive Governance.

1. Welcome/Introductions/Announcements 10:00 a.m.-10:05 a.m.
   a. Public Participation Guideline

2. Summary of Work to Date 10:05 a.m.-10:25 a.m.

3. Public Comments 10:25 a.m.-10:55 a.m.

4. Guest: Attorney Carolyn Buppert, (tentative) 10:55 a.m.-12:05 p.m.

5. General Information/Updates 12:05 p.m.-12:35 p.m.
   a. Legislative Report to the Board
   b. Preparations for 2019 RN and APRN Renewal
   c. Sample/Summary of APRN Practice Questions

   Lunch and Interested Party Meeting that begins at 1:00 p.m.

6. Proposed Revised Rules 2:00 p.m.-2:30 p.m.
   a. Detox Rules

7. Draft Interpretive Guideline and update from OHA Meeting 2:30 p.m.-2:40 p.m.

8. Public Comments 2:40 p.m.-2:55 p.m.

   Speakers will have no more than five minutes, and perhaps less, at the discretion of the Chair, based on the number of speakers and time available.

9. Other Business 2:55 p.m.-3:00 p.m.

10. Adjourn 3:00 p.m.
MEMORANDUM

TO: Members of Advisory Committee on Advanced Practice Registered Nursing
FROM: Lisa Emrich, Program Manager
DATE: June 4, 2019
RE: Summarizing Documents, Committee Work to Date

We welcome new members to the Board’s Advisory Committee on Advanced Practice Registered Nursing (APRN Advisory Committee). The attached documents are being provided for informational purposes to provide new members with a summary of the APRN Advisory Committee’s prior work.
Certified Nurse Practitioners (CNPs)

Primary Care and Acute Care Practice

July 2017

This report addresses national certification for certified nurse practitioners (CNPs) practicing primary or acute care in Ohio. Section 4723.43, Ohio Revised Code (ORC), requires a CNP to practice consistent with the nurse’s education and certification. To practice acute care, the CNP’s education and certification must be in acute care. Certain stakeholders agree with this position and other stakeholders maintain that a CNP who is not nationally certified in acute care may engage in acute care practice, based on clinical experience obtained post-graduate through the course of employment/workplace training. Further these stakeholders contend that the Board is not following the national Consensus Model for APRN Regulations (Consensus Model)\(^1\) and differs from other state boards of nursing enforcing the law in this manner.

Background

In response to correspondence to the Board expressing concern that CNPs were practicing acute care without the CNP holding national certification in acute care, in the fall of 2016, the Board published an article in its quarterly newsletter *Momentum* entitled "Certified Nurse Practitioners (CNPs) in Primary and Acute Care." (Attachment 1)

Over the past several years, individuals and health care facilities have periodically asked the Board about the national certification required for CNPs practicing primary or acute care in Ohio. The Board’s responses have been based on the statutory provisions of the Nurse Practice Act (NPA), and consistent through the years with the interpretation of law reiterated in the 2016 *Momentum* article. The NPA provisions were enacted dating back to 1996. Attached are examples of Board responses to individuals and facilities. (Attachment 2) Another attachment is a memorandum from a health care facility entitled “Specialty Specific Credentials” that instructs APRNs about the requirements. (Attachment 3)

In addition, the Ohio Association of Advanced Practice Nurses (OAAPN) requested information in 2009 for their “Tip of the Month” stating that when OAAPN representatives were attending national conferences, they identified this as an emerging issue impacting

\(^1\) The Consensus Model for APRN Regulations: Licensure, Accreditation, Certification & Education, July 7, 2008. (Consensus Model) was completed through the work of the national APRN Consensus Work Group and the National Council of State Boards of Nursing APRN Advisory Committee.
APRNs in many states. See Attachment 4 for the OAAPN correspondence and their Tip of the Month in its entirety.

In summary, with the recent proliferation of acute care pediatric and adult acute care NP programs, if you choose to care for patients with complex acute, critical and chronic health conditions, then choose an educational program that prepares you for certification as an acute care nurse practitioner. If however, you wish to work in a primary care setting, then choose an educational program that prepares you for certification as an adult, pediatric, women’s health, geriatric or family nurse practitioner.

Following publication of the 2016 Momentum article, the Board received correspondence from OAAPN asserting that the statute should now be construed to permit CNPs to engage in acute care practice based on clinical experience obtained post-graduate through the course of employment/workplace training and that the national certification in acute care was not required. (Attachment 5)

Because of heightened concerns expressed by multiple stakeholders, on March 8, 2017, the Board requested a formal Opinion from the Ohio Attorney General Office asking "whether under Section 4723.43, Ohio Revised Code, a Certified Nurse Practitioner (CNP) not nationally certified in acute care may engage in acute care practice, based on clinical experience obtained post-graduate through the course of employment/workplace training. (Attachment 6)

The Opinion request itself resulted in strong concerns expressed by certain stakeholders who questioned the need for the request and asked about the possibility of withdrawing the request. The Board explained that the request is consistent with the Board’s past actions when there have been strong opinions and disagreement about the interpretation of statutory language. The Board believes an Opinion request is necessary in this matter to resolve conflicting opinions regarding statutory language, especially in light of substantial and consistent history reflecting the Board’s reading of Ohio law and national consensus on the topic. The Opinion request provides a means to reach a legal conclusion recognized by law in order to clarify the interpretation of statute whose meaning is in dispute or doubt. The Opinion will serve as a basis for future decisions and actions. The letters from interested parties regarding the AGO are provided in Attachment 7.

Consensus Model for APRN Regulations

The Consensus Model was the result of collaborative work of the APRN Consensus Work Group and the NCSBN APRN Advisory Committee, with extensive input from a larger ARPN stakeholder community, including national certification entities, national accreditation organizations, and national associations representing APRN education and practice. It was adopted based on a nationally recognized educational model to establish a firm foundation and greater standardization for APRN practice across the country, based on the health care environment of the 21st century. A listing of the organizations is on pages 29-39 of the document.
The Consensus Model defines APRN practice, describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation. The information below summarizes pertinent parts of the Consensus Model. The Consensus Model in its entirety is included in Attachment 6, as part of the Opinion request.

- APRN education programs must be accredited and include education in three graduate-level courses in advanced physiology/pathophysiology, health assessment, and pharmacology, as well as appropriate clinical experience, known as the APRN core.

- The Consensus Model recommends four APRN roles: CRNA, CNM, CNS, and CNP. APRNs are educated in one of the four roles. (Page 6)

- In addition to the roles, the APRN must be educated in at least one of six population foci: family/individual across the lifespan, adult-gerontology, pediatrics, neonatal, women’s health/gender-related, or psych/mental health. (Page 6)

- Individuals who have the appropriate education must take a national certification examination to assess national competencies of the APRN core, role, and at least one population focus area of practice for regulatory purposes. (Page 6)

- Individuals are licensed to practice at the level of one of the four roles within at least one of the six population foci. Education, certification, and licensure of an individual must be congruent in terms of role and population foci. (Page 6)

- Beyond role and population focus, APRNs may specialize but they are not licensed by specialty area. Specialties provide depth in one’s practice within the established population foci. Preparation in a specialty area of practice is optional and focuses on specific patient populations or health care needs. APRN specialty education and practice build upon and are in addition to the education and practice of the APRN role and population focus. (Page 12)

- APRN specialty preparation cannot expand one’s scope of practice beyond the role or population focus and addresses a subset of the population-focus. (Page 12)

- State licensing boards do not regulate APRN specialties because the specialty evolves from the APRN role/population focus and indicates that an APRN has additional knowledge and expertise in a more discrete area of a specialty. Specialty practice is acquired either by educational preparation or experience and may be recognized through professional nursing credentialing centers. (Page 12)

- For licensure purposes, one exam must assess the APRN core, role, and population focused competencies. For example, a primary care family nurse practitioner would take one national certification examination, which tests the APRN core, CNP role, and “family” population-focused competencies. Specialty competencies must be assessed separately. In summary, education programs preparing individuals with this additional knowledge in a specialty if used for entry into advanced practice registered nursing and for regulatory purposes, must also prepare individuals in one of the nationally recognized APRN roles and in one of the six population foci. (Page 12)
• The CNP provides care along the wellness-illness continuum by providing direct primary and acute care across settings. Both primary and acute care CNPs provide initial, ongoing, and comprehensive care. "CNPs are prepared to practice as primary care CNPs and acute care CNPs, which have separate national consensus-based competencies and separate certification processes." (Page 9)

• "Scope of practice of the primary care or acute care CNP is not setting specific but is based on patient care needs. Programs may prepare individuals across both the primary care and acute care CNP competencies. If programs prepare graduates across both sets of roles, the graduate must be prepared with the consensus-based competencies for both roles and must successfully obtain [national] certification in both the acute and the primary care CNP roles. CNP certification in the acute care or primary care roles must match the educational preparation for CNPs in these roles." (Page 10)

The “APRN Consensus Model Frequently-Asked Questions,” published by NCSBN/LACE², includes the following question and answer: Attachment 8

6. How does an acute care NP fit into the APRN Consensus Model?

The certified nurse practitioner (CNP) is educationally prepared to meet core competencies for all NPs and competencies for a population focus. The competencies at the population focus may be primary care or acute care. Currently the acute care NP preparation is available with an adult-gerontology or pediatric focus. The graduate of an adult-gerontology acute care NP program is eligible to sit for an acute care adult-gerontology certification exam. Similarly, the graduate of a pediatric acute care NP program is eligible to sit for an acute care pediatric NP certification exam. Graduates of acute care population focused NP programs are not eligible to sit for primary care population focused NP certification exams and vice versa. The certified NP would identify himself/herself as an APRN-CNP with either an adult-gerontology or pediatric acute care population focus. (Page 2)

13. If I want to specialize as an APRN in an area such as oncology, palliative care, or nephrology, how would I do so after the APRN Consensus Model is implemented?

Areas such as oncology, palliative care, and nephrology are among the many specialty areas of APRN practice and are not one of the population foci in the APRN Consensus Model. To be eligible for APRN licensure and certification, the APRN must complete his/her educational program in a role and population focus (or foci) as defined in the Consensus Model but can also specialize in a more specific area of practice. Preparation in a specialty area of practice is optional, but if included in the educational program, it must

² LACE is a communication network to include organizations that represent the Licensure, Accreditation, Certification, and Education components of APRN regulation. LACE is intended to be a transparent process for communicating about APRN regulatory issues, facilitating implementation of the APRN Consensus Model, and involving all stakeholders in advancing APRN regulation.
build on the APRN rule/population focus competencies. Clinical and didactic coursework must be comprehensive and sufficient to prepare the graduate to obtain certification for licensure in and to practice in the APRN role and population focus. Educational programs may concurrently prepare individuals in a specialty providing they meet all of the other requirements for APRN educational programs, including preparation in the APRN core, role and population core competencies. A specialty area of practice is developed by the professional organization and is not regulated by boards of nursing. Professional organizations determine the expected competencies for the specialty and establish certification or assessment requirements. It is not required but recommended that the APRN practicing in a specialty area of practice seek specialty certification if available. 

(Page 3)

National Organizations, Statements, and Publications

Below is information from various national organizations and publications gathered for review and further consideration. It is not intended to be an extensive review of all organizations or publications, but rather is meant to reflect the basis for the Board’s past and current interpretation of Ohio law in this matter.

➢ The National Council of State Boards of Nursing (NCSBN)

At the time the Board published the 2016 Momentum article, NCSBN staff reviewed the article and confirmed it was congruent with the Consensus Model. NCSBN recognized this as a pertinent topic and informed Board staff the issue was being addressed in many states.

Subsequently, NCSBN requested that Lisa Emrich, RN, MSN, FRE, Board Program Manager, present this topic at the NCSBN April 2017 APRN Roundtable. Ms. Emrich’s presentation was well received at the APRN Roundtable.

The Board requested further clarification from NCSBN about the position of the Consensus Model regarding the education and national certification requirements for CNPs providing primary and acute care. On July 6, 2017 NCSBN responded in a letter (Attachment 9), concluding “…it is the position of NCSBN that the Consensus Model specifies CNPs who are engaged in acute care practice are to hold national certification in acute care. NCSBN agrees with your Board's position.”

➢ National Organization of Nurse Practitioner Faculties

The National Organization of Nurse Practitioner Faculties issued a “Statement on Acute Care and Primary Care Nurse Practitioner Practice,” September 2011
(Statement). The article’s “Key Elements” are summarized below. The Statement also provides exemplars that illustrate practice distinctions for the Acute Care Nurse Practitioner (ACNP) and Primary Care Nurse Practitioner (PCNP). The Statement is included in Attachment 6, as part of the AGO Opinion Request, in its entirety.

The PCNP and the ACNP are prepared to deliver different types of care. The main emphasis of PCNP educational preparation is on comprehensive, chronic, continuous care characterized by a long-term relationship between the patient and PCNP. In contrast, the ACNP educational preparation focuses on restorative care that is characterized by rapidly changing clinical conditions. The ACNP provides care for unstable chronic conditions, complex acute illnesses, and critical illnesses.

Key Messages

- **Scope of practice must be tied to formal APRN education and not pre-APRN experience or on-the-job training.**

- NP educational programs are either primary care or acute care focused – it is not the full range. Certification as both an ACNP and PCNP requires completion of both formal educational programs or a dual-track adult-gerontology or pediatric program that meet all of the corresponding ACNP and PCNP competencies. (This would be adult-gerontology or pediatric ACNP competencies, and adult-gerontology, family/lifespan, pediatric, or women’s health/gender PCNP competencies).

- Certification must match educational preparation. Certification eligibility should be linked to the educational preparation, and similarly a NP graduate should sit only for certification that corresponds with the population focus of his/her educational preparation.

- Both the PCNP and the ACNP can serve as the point of entry to health care and they also collaborate with each other when managing patients.

- Both the PCNP and ACNP may engage in specialty practice, but this specialization occurs as supplemental to the formal NP education and national certification.

- Both the PCNP and ACNP might evaluate an acutely ill patient, but the severity of the symptoms would determine which provider is most appropriate and best matched to the patient’s acuity level. The PCNP does not have the educational preparation to care for the complex acute or critical patient but does have preparation to manage the simple acute patient. Likewise, the ACNP does not have the educational preparation to provide comprehensive, continuous care but does have the preparation to provide preventive services within the context of restorative care.

- Patient safety is jeopardized when clinicians practice outside their scope of practice. Regardless of the willingness of some employers to credential the NP to practice beyond his/her educational preparation and certification, the NP is obligated to adhere
to his/her scope of practice, as determined by the state in which they practice.

- NPs should be regulated according to the services they perform and population served and not where they provide services.

➢ *Journal of the American Academy of Nurse Practitioners*

“Defining NP scope of practice and associated regulations: Focus on acute care,” was published in the *Journal of the American Academy of Nurse Practitioners* 24 (2012). The following summarizes the section, “Contemporary NP and ACNP issues.” The article is included in Attachment 6, as part of the AGO Opinion Request, in its entirety.

Any NP can work in a hospital if they meet the job qualifications and pass the credentialing and privileging process. For example, the NP prepared as an adult NP working for a cardiology practice seeing patients both in the clinic and during hospitalization for heart failure; managing diuretic therapy on a medical unit is within the NP SOP [scope of practice] in these patients. However, if a patient does not stabilize or deteriorates to the point where more advance therapy is required, such as inotrop support, the patient’s care needs clearly move into the SOP of the ACNP.

What NPs do clinically and where they function within the hospital tends to pose more issues that could be interpreted as practicing beyond their approved SOP. One example is the NP who is not ACNP educated but seeks to provide care to patients who have acute and critical care conditions based on having prior work experience as an RN in an acute/critical care intensive care unit. This RN experience is often erroneously perceived as providing an NP who does not hold ACNP certification with the qualifications to manage these patients when it does not, as NP SOP is based on NP licensure, accreditation, certification and education.

The majority of primary care programs prepare NP graduates with primary care didactic and clinical practice in clinic settings and to a lesser extent, hospital settings. Although primary care NP education is not focused on the management of high acuity patients in a hospital setting, primary care NPs can manage hospitalized patients within their NP SOP. Family and adult NPs often function in hospitals in roles that do not extend to the ICU and caring for the complexly ill patient. Such roles include services in pre-admission screening and testing, palliative care, pain management fast track emergency care, and disease-specific care.

➢ *Carolyn Buppert, MSN, JD, Healthcare Attorney*


➢ *Credentialing and Privileging*

According to the 2008 *Medscape* article, “Developing an Advanced Practice Nursing Credentialing Model for Acute Care Facilities” (Attachment 11):
In the acute care hospital setting, it becomes especially important that nursing administrators have a clear understanding of the scope of practice of the APRNs seeking credentialing and privileging. APRNs requesting credentialing and privileging for acute care skills require proper educational preparation and training and the requisite skills to be practicing within their scope of practice. APRNs who might have been educationally prepared as an adult nurse practitioner or family nurse practitioner who are hired to work in an acute care setting may need post-master’s acute care nurse practitioner education to ensure they are practicing within their scope of practice. For APRNs practicing in the acute care setting who are not trained for acute care practice, seeking credentials and privileging must be in compliance with their education and training as an APRN. Prior nursing experience in a specialty area, such as critical care or acute care, does not entitle APRNs to seek credentials and privileges for acute care practice if their APRN education and training is not acute care focused. However, obtaining a post-masters’ acute care certification training enables APRNs to see credentialing and privileging for acute practice. (Page 281)

➢ **Scope of Practice and the Nurse Practitioner: Regulation, Competency, Expansion, and Evolution**

According to the 2007 Medscape article, “Scope of Practice and the Nurse Practitioner: Regulation, Competency, Expansion, and Evolution” (Attachment 12), the 2003 Institute of Medicine (IOM) report, “Health Professions Education: A Bridge to Quality” called for competency-based education and interdisciplinary practice models for the future. Physician assistant education has developed under a single accrediting body, core curriculum, and board certification mechanisms in the 1970s. The NP role, however evolved in a more fragmented fashion, and curriculum standardization and accreditation standards followed, rather than directed, education. The development in 2002-2004 of the National Organization of Nurse Practitioner Faculties offered a framework for education core competencies. Experience and environment can and will stretch the NP's knowledge and competency beyond that of the basic education level. The article provides the following question and answer:

Should the NP who is educationally prepared as an acute care NP work in an adult primary care setting? The answer is no. The acute care NP program prepares graduates for a specialty focus in acute, episodic, and critical conditions that are primarily managed in a hospital-based setting. The program of study does not contain adequate clinical and didactic content to support the ACNP for a broader role in outpatient primary care diagnosis, treatment, and follow-up. Diagnosis and outpatient management of stable and unstable chronic illness, as well as directing health maintenance of a wide range of conditions, is a required competency for practice in the primary care role. (Page 6)

➢ **Decision Making Models**
Decision making models published by boards of nursing are intended to assist nurses determine if procedures, activities, or tasks are within their scope of practice and if they have the knowledge, skills, and abilities to perform the procedure or task. Decision making models are not designed to define population focus or specialty for APRNs.

Nurses frequently find themselves in the position of needing to learn new procedures, equipment, technology, or an unfamiliar patient care situation. Decision making models are designed for use in these situations. By going through the steps of a decision making model, the nurse determines if the procedure or task is within their scope of practice and/or if they need to obtain orientation, continuing education, demonstrations, training, etc. in order to be competent to perform the procedure/activity. Boards hold all nurses, including APRNs, accountable for their continuing competence in practice.

The Board “APRN Decision Making Model,” (Attachment 13) states:

The Decision Making Model is a guide for APRNs to use when determining whether a specific procedure, task or activity is within the APRN scope of practice and, if so, whether the specific procedure, task or activity is consistent with standards of practice, appropriate to perform based on the individual APRN’s knowledge and skills, and is appropriate based on the clinical setting.

Other State Boards of Nursing

Below is information from state boards of nursing, but it is not intended to be an extensive review of all the states.

➢ Arizona State Board of Nursing

The Arizona State Board of Nursing adopted a white paper, “Registered Nurse Practitioner (RNP) Practicing in an Acute Care Setting on November 19, 2009. (Attachment 14)

Registered nurse practitioner education has evolved into a system consisting of advanced core and focused specialty courses. This educational model prepares graduates for advanced nursing practice as direct care providers within a focused population of care (also known as specialty area). RNP does not follow the medical model therefore RNPs do not readily fit into the process used by facilities to credential physicians and medical residents….The primary component of the RNP ability to practice is their licensure and recognition through national certification in an established population area of practice.....Population is not only defined by diagnosis, gender, and age, but also by acuity and type of care needed. (Page 1)

There are 2 broad categories of RNP preparation: primary care with didactic and clinical education focused on health promotion, disease prevention and treatment of patients primarily in ambulatory and community settings; and acute care with didactic and clinical
education focused on the manage of patients with complex acute, critical and chronic health conditions primarily in acute care (hospital) settings. (Page 2)

Therefore, it is the position of the Board that an RNP who provides acute care services cannot exceed the limits of the advanced practice specialty area. Sole and independent management of the care of complex unstable patients in an acute care setting, including but not limited to an intensive care unit, is in the exclusive domain of the nurse practitioner who has completed an approved acute care nurse practitioner program. A primary care nurse practitioner may have a role in assisting or directing management of the acute care patients as long as the aspect of care is within the limits of their specialty [focused population] and role of nurse practitioner certification. (Page 3)

The RNP is expected to utilize appropriate judgment to determine if a specific role or procedure within a patient care situation is within the scope of practice that he or she is educationally prepared to provide…Experience as an RN, on-the-job training, having a physician sign off order, and the personal comfort of the RNP is not a sound basis for accepting an assignment or role beyond the RNP’s scope of practice. (Page 3)

➢ Kentucky Board of Nursing

The Kentucky Board of Nursing published an article in the spring 2017 issue of KBN Connection entitled, “Certified Nurse Practitioner: Acute Care or Primary Care is my Practice Setting Specific to my Role?” (Attachment 15)

In summary, regardless of the setting, the CNP may legally only manage the care of those patients and conditions for which the CNP is formally educated and for which the CNP is nationally certified. Many of the nurse practitioner certification test plans are available online for review through the specific national certifying agency website. Additionally, the Kentucky Board of Nursing has published the “APRN Scope of Practice Determination Guidelines” and the “APRN Scope of Practice Decision-Making Model” which contain a decision chart providing guidance to APRNs in determining whether a selected act is within an individual APRN’s scope of practice. (Page 2)

➢ Nebraska Board of Nursing

The Nebraska Board of Nursing published an article in the spring 2017 issue of the Nebraska Board of Nursing News entitled, “The Practice Lane, The Many Lanes of APRN Roles and Populations.” (Attachment 16)

In summary, APRNs commit early in the course of education and training to a particular role and population focus. Practice lanes are affirmed with professional certification and subsequent licensure. Lane changes are best preceded with attention and planning for the acquisition of new competencies and other means for defensible practice. Advance practice nurses must assume responsibility for recognizing practice opportunities that may
be misaligned with education and certification, and ultimately present risks patient safety and outcomes. (Page 13)

➢ Texas Board of Nursing

On their website the Texas Board of Nursing provides FAQs for APRN Practice. (Attachment 17) In response to a question about two APRNs approved in different population foci, the Board states:

It is important to understand that scope of practice for the advanced practice registered nurse is founded first and foremost upon his/her advanced education preparation. The patient population, individual advanced education program content and competencies attained in the advanced practice registered nursing education program always serve as the foundation for advanced practice registered nursing practice. Rule 221.13(b), relating to the core standards for advanced practice, further states that advanced practice registered nurses must practice within the role and population focus appropriate to their educational preparation…..Each advanced practice registered nurse is responsible for practicing within the role and population focus licensed by the board and appropriate to his/her education preparation. Additionally, each advanced practice registered nurse is responsible for recognizing when he/she is in danger of exceeding his/her personal and professional scope of practice. (Pages 7-8)

➢ Wyoming Board of Nursing

The Wyoming Board of Nursing published, “What Wyoming APRNs Need to Know about Scope of Practice” in the Summer 2017 issue of the Wyoming Nurse Reporter. (Attachment 18)

For CNPs, which represent the largest group of the four APRN roles, the APRN Regulatory Model also provides clarification regarding acute care versus primary care practice. Specifically, the footnote on p. 10 directly under the model states: The CNP is prepared with the acute care CNP competencies and/or the primary care CNP competencies. At this point in time the acute care and primary care CNP delineation applies only to the pediatric and adult-gerontology CNP population foci. Scope of practice of the primary care or acute care CNP is not setting specific but is based on patient care needs. Programs may prepare individuals across both the primary care and acute care CNP competencies. If programs prepare graduates across both sets of roles, the graduate must be prepared with the consensus-based competencies for both roles and must successfully obtain certification in both the acute and the primary care CNP roles. CNP certification in the acute care or primary care roles must match the educational preparation for CNPs in these roles.

Thus according to the APRN Regulatory Model, CNPs prepared for the family/ across the lifespan role (e.g., FNP; s) are prepared for primary care. There is not the acute care role for FNP; s, and FNP; s who desire to engage in acute care must be prepared at either the adult-gerontology or pediatric population level as an adult-gerontology acute care nurse practitioner (AGACNP) and/or a pediatric acute care nurse practitioner (PACNP). It is also important to note that model does not distinguish primary care from acute care by practice setting and allows for primary care occurring in traditional acute care settings (e.g., urgent care clinic in a hospital) and acute care occurring in ambulatory settings. (Pages 10-11)
Summary and Framework for Further Discussions

The intent in researching and presenting this document is to provide a range of evidence-based information for informed discussions. For discussion purposes, a comprehensive review of the Consensus Model is encouraged in order to reach agreement on the Consensus Model recommendations and direction. The fundamental question is whether Ohio will follow the Consensus Model, which will determine the future direction of APRN practice in Ohio. The following options are posed for consideration.

Option One: Ohio Continues to Follow the Consensus Model

If Ohio continues to follow the Consensus Model, the CNP must be educated in core competencies for a specified population focus (or foci) and based on that education, be nationally certified to practice acute care or primary care.

The first option is for Ohio to continue to follow the Consensus Model, and assure the statute and administrative rules are clear regarding the requirements.

Option Two: Ohio Decides to No Longer Follow the Consensus Model

If Ohio decides to no longer follow the Consensus Model, the Board may adopt rules specifying that national certification in acute care would not be required in order for CNPs who were educated in primary care to practice acute care if the CNP received sufficient documented post-graduate clinical training by a health care employer.

Under this option Board staff would need to review each individual APRN’s post-graduate clinical experience and training provided by the workplace to determine if it meets the requirements.
MEMORANDUM

TO: Board Members

FROM: Lisa Emrich, Program Manager

DATE: April 6, 2018

SUBJECT: Summary: Advisory Committee on Advanced Practice Registered Nursing (APRN Advisory Committee)

HB 216, effective April 6, 2017, established the APRN Committee and specified its composition, charge, and quorum (Section 4723.493, ORC). The charge is to advise the Board regarding the practice and regulation of advanced practice registered nurses and it may make recommendations to the Committee on Prescriptive Governance. Attachment A is a roster of APRN Committee members.

The Board appointed Board Member Erin Keels in 2017 to serve as the Board member representative on the APRN Advisory Committee and the Committee appointed her as Chair. President Sharpnack and Board Member Lisa Klenke, frequently attend the APRN Advisory Committee meetings for the policy issue discussions.

The APRN Advisory Committee met in June and October of 2017 and on January 29, 2018. In October, representatives from the State of Ohio Auditor’s Office provided a presentation about the Open Meetings Act and the Board’s Chief Legal Counsel provided information on the State Ethics Commission and law. At the meetings, the Committee reviewed draft rules about prescribing for acute pain, chronic pain, and medication-assisted treatment (MAT), discussed pending legislation, and received updates regarding APRN licensing.

In addition, a major topic of discussion has been APRN-CNP (CNP) acute and primary care based on graduate level education and national certification. Board members and staff are also meeting with OHA and OONE to discuss CNP practice. Members were asked to bring recommendations regarding CNP practice to the APRN Advisory Committee meeting on May 14, 2018.

The May meeting is an additional meeting for 2018 that was scheduled for the purpose of further review and discussion of the draft rules for MAT and chronic pain and to discuss recommendations regarding CNP practice. Other scheduled meetings for 2018 are on June 11th and October 1st.
As reported at the April Board Retreat, the Advisory Committee on Advanced Practice Registered Nursing (Advisory Committee) has been discussing CNP acute and primary care practice. Since the Board Retreat, the Advisory Committee met on May 14 and June 11, 2018. The minutes of each meeting are included as agenda items 6.4 and 6.8. This Memorandum provides an update of the Advisory Committee discussions and recommendations.

**Recommendation: CNP Primary and Acute Practice**

At the May Advisory Committee meeting, Chair Erin Keels requested that members be prepared to make a recommendation regarding CNP primary and acute care practice at the June meeting, considering the following options:

- **Option One: Ohio Continues to Follow the Consensus Model**
  If Ohio continues to follow the Consensus Model, the CNP must be educated in core competencies for a specified population focus (or foci) and based on that education, be nationally certified to practice acute care or primary care.

- **Option Two: Ohio Decides to No Longer Follow the Consensus Model**
  If Ohio decides to no longer follow the Consensus Model, the Board may adopt rules specifying that national certification in acute care would not be required in order for CNPs who were educated in primary care to practice acute care if the CNP received sufficient documented post-graduate clinical training by a health care employer.

Following discussion and consideration of public comments at the June Advisory Committee meeting, each Advisory Committee member presented their position and the Advisory Committee voted to recommend that the Board continue to follow the Consensus Model.

Chair Erin Keels moved that the Advisory Committee recommend that the Board continue to follow the Consensus Model. Kristine Scordo seconded the motion. The motion passed with five members voting in favor of the motion, and three opposing the motion.
Additional information was requested by the Advisory Committee and will be provided at the October Advisory Committee meeting: information and presentations regarding APRN primary care practice in Ohio, and how Ohio and other states use the Consensus Model.

**Recommendation: Add an Additional Member to the Advisory Committee**

The Advisory Committee recommended that the Board appoint an additional Committee member who practices in family/primary care. The following is an excerpt from the draft minutes of the June 11, 2018 Advisory Committee meeting about the recommendation:

M. Zamudio stated she 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.

Section 4723.493, ORC, addresses the Board’s authority to appoint an additional member:

(D) “....The Committee may also recommend to the board that an individual with expertise in an advance practice registered nursing specialty be appointed under division (B) as an additional member of the Committee.”

**Advisory Committee Positions**

Section 4723.493, ORC establishes the membership of the Advisory Committee. The statutory positions are listed and the members of the Committee and their national certification are specified below.

- Four APRNs each actively engaged in practice in a clinical setting and must include one APRN providing primary care; one CRNA; and one CNM
  - CNM – Ann Marie Auletta Konkoly, effective July 26, 2018 (national certification for CNMs includes both primary care and acute care for women’s health and labor and delivery respectively)
  - CRNA – James Furstein (also licensed as a CNP in pediatric acute care)
  - CNP in primary care – Peter DiPiazza
  - CNP and CNS – Christopher Kalinyak (nationally certified as a CNP and a CNS in psychiatric/mental health. This national certification authorizes the APRN to provide either primary or acute care for persons with psychiatric/mental health conditions.)

- Two APRNs who are faculty members educating students for APRN licensure
  - Jodi Miniard, CNP (national certification in acute care)
  - Kristine Scordo, CNP (national certification in acute care)

- A member of the Board who is an APRN
  - Erin Keels, CNP (national certification in neonatal which includes primary
care of high risk infants up to the first two years of life and critical care of preterm or full term neonates)

- A representative of an entity employing 10 or more APRNs practicing in Ohio
  - Sandra Wright-Esber, CNP, representing an APRN employer (national certification CNP in pediatric primary care)

**National Certification of APRNs Licensed in Ohio**

Based on Ohio eLicense data reported on July 12, 2018, there are 1,394 CNPs nationally certified in acute care and 10,263 CNPs nationally certified in primary care. This does not include CNPs with national certification in neonatal, women’s health, and psychiatric/mental health.

**Summary**

The Board is asked to consider the recommendations of the Advisory Committee.

1. **CNP Primary and Acute Practice:** The recommendation is that the Board continue to follow the Consensus Model. If the Board continues to follow the Consensus Model, there would be no change in the administrative rules or the Nurse Practice Act. The Board would continue to provide information to the Advisory Committee as requested and develop FAQs as needed.

2. **Additional Member Appointed to the Advisory Committee:** The recommendation is for the Board to appoint an additional Committee member who practices in family/primary care. If the Board appointed a person to fill this newly created Committee position, the term would be one year, and would require an annual Board vote for the additional position. The Committee may, for example, recommend a different area of expertise for the position in the future depending upon the Committee’s topics of discussion, or may not recommend an additional position.
MEMORANDUM

TO: Board Members
FROM: Lisa Emrich, Program Manager
DATE: March 22, 2019
SUBJECT: Summary: Advisory Committee on Advanced Practice Registered Nursing

HB 216, effective April 6, 2017, established the APRN Advisory Committee on Advanced Practice Nursing (APRN Advisory Committee) and specified its composition, charge, and quorum (Section 4723.493, ORC). The charge is to advise the Board regarding the practice and regulation of advanced practice registered nurses, and it may make recommendations to the Committee on Prescriptive Governance.

Summary of Meetings and Discussion of CNP Acute and Primary Care

Board member Erin Keels is Chair of the APRN Advisory Committee. In 2018, the Advisory Committee met three times. One meeting was added to the schedule in order to timely review the proposed rule on Medication Assisted Treatment (MAT). In 2019, the Advisory Committee met on February 25, and will meet on April 29, June 17, and October 28. At each meeting, the APRN Advisory Committee includes time for public comments and generally interested parties and associations provide comments regarding agenda items or other matters of interest.

A major topic of discussion continued to be CNP acute and primary care based on graduate level education and national certification. In 2018, two invited guest speakers addressed acute and primary care practice: Ann O’Sullivan, PhD, FAAN, CPNP, professor, publisher, and Chair of the NCSBN APRN Advisory Committee, and Barbara Safriet, JD, professor, publisher, and lecturer on issues of health care professional licensure and regulation.

Dr. O’Sullivan stated that she reviewed the Advisory Committee materials and minutes. She stated her first recommendation would be to recognize the different populations because it is very important to use the right words when discussing population and certification in Family, Adult-Gerontology, and Pediatrics. She noted that many use “APRN specialty” when they should be saying “APRN population.” She noted that “specialty” used in the Consensus Model does not mean the national certification in a population focus, rather, in the Consensus Model specialty refers to areas of specialized practice such as orthopedics, oncology, etc. This is an important point when APRNs are speaking with hospitals, institutions and employers. When employers look at the national norm, the
Consensus Model, they see that specialty is not the same as national certification with a population focus. Dr. O’Sullivan stated it is her belief that there is non-consensus in recognizing the construct of the Consensus Model because there is a philosophical difference among Advisory Committee members in the use of the term specialty. She stated that recognition and use of the Consensus Model is important in protecting APRNs from liability concerns because national, not local, standards are applied in evaluating malpractice claims. She believes that discussion regarding APRN scope of practice should include consideration of practitioner liability; and while the role of nursing boards is to protect the public, delineation of scope of practice results in protection for APRN providers as well.

Barbara Safriet, JD, spoke about national policy and stated she was not commenting on a particular statute or rule. She noted that the Consensus Model is not a government enacted law, rather it is a recommendation by a private organization of licensure boards which strive to promote consistencies and propose model practices between and among state licensure boards, so the Consensus Model has no direct legal affect. She agreed that many confuse population foci with specialty, and they use those terms interchangeably, which is not appropriate. She stated that standardization in APRN education and regulation was important and valuable. She did not question the initial impetus for the Consensus Model, but she believes its current interpretation and implementation have been influenced by expressed opinions with two forms of qualification metrics: Formal education and population-based certification; and competence-based metric that includes demonstrated additional education and training and clinical experience, mostly related to institutional credentialing. She had difficulty believing that a competent CNP could not practice in a specific place such as a nursing home, urgent care clinic or convenient care clinic based on the CNP’s national certification. A CNP’s clinical experience and competence gained through years of practice should not be put aside to consider only formal education and resulting national certification. She recommended the least restrictive requirements available to achieve the goal public health and safety.

Advisory Committee Recommendations and Board Action

At the July 2018 Board meeting, the Board considered recommendations from the APRN Advisory Committee: (1) CNP acute and primary care and (2) add an additional member to the Advisory Committee. (See attached July 2018 Memorandum.) The Board considered the recommendations and below is an excerpt from the Board July 2018 minutes.

Advisory Committee on Advanced Practice Registered Nursing Recommendations

Advisory Committee Chair Erin Keels provided a report on the May 14 and June 11, 2018 Advisory Committee meetings and presented two Advisory Committee recommendations to the Board. Board members discussed the recommendations.

Consideration of Recommendation – Consensus Model

Action: It was moved by Erin Keels, seconded by Sandra Ranck, that the Board continue to follow the Consensus Model. Motion adopted by unanimous vote of the Board members present.

Consideration of Recommendation – Additional Member

Action: It was moved by Sandra Ranck, seconded by Lauralee Krabill, that that the Board not seek applications for an additional member to the Advisory Committee on Advanced
Practice Registered Nursing at this time. Motion adopted by unanimous vote of the Board members present.

Guidance Document

The APRN Advisory Committee continued discussion regarding national certification in acute care and the management of patient conditions that are specific to acute care national certification. APRN Advisory Committee members commented that additional administrative rules regulating APRN practice are not needed if a guidance document is developed to assist CNPs understand overlap and limitations of patient conditions which may be managed based on their national certification. The Committee members stated they were also interested in a definition of critical care and agreed to use the CMS definition. It was discussed that a guidance document would be in the form of an Interpretive Guideline (IG), however, the IG would need to be reviewed by the Attorney General Office before a final draft document could be considered by the Board. Subsequently, a draft IG was written, and the Committee reviewed it at the February meeting. (See attached.) The APRN Advisory Committee members are to provide comments regarding the draft IG at the next meeting on April 29, 2019.
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<th>Chair</th>
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<tr>
<td>Erin Keels, APRN-CNP</td>
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<td>Peter DiPiazza, APRN-CNP</td>
<td>APRN in Primary Care</td>
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<td>Christopher Kalinyak, APRN-CNP</td>
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<td>Jody Miniard, APRN-CNP</td>
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<td>Sandra Wright-Esber, APRN-CNP</td>
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**Board Staff**

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<tr>
<th>Lisa Emrich, RN</th>
<th>Program Manager: Practice, Education, and Administration</th>
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<td>Anita DiPasquale</td>
<td>Staff Attorney</td>
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<td>Chantelle Sunderman</td>
<td>Administrative Professional</td>
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Ohio Board of Nursing,

I am very concerned that your proposed guideline for acute care and primary care are not realistic and will make it even more difficult to practice in Ohio. At a time when access to health care is limited for many vulnerable Ohioans, this guideline makes it more confusing to try to deliver high quality health care. Furthermore, having moved here from Washington, a full practice state, I am already oppressed by the conservative and outdated laws in Ohio. Further restrictions and demands regarding my practice will likely be the final straw to staying and practicing in Ohio.

I am a very busy primary care nurse practitioner and well aware of my scope of practice. This guideline does not consider the multitude of situations that I encounter in my practice. Ohio already has a national reputation for being an NP unfriendly state. Please don't make it even worse.

I request that you do not move forward with this guideline.

Thank you for your consideration.
Kimberly A. Foley, APRN, Family Medicine
MEMORANDUM

To: Board Members, Ohio Board of Nursing

From: Tom Dilling, Legislative Liaison
       Betsy Houchen, Executive Director

Subject: Legislation, 133rd General Assembly Update

Date: May 10, 2019

HB 166, Operating Budget
Director Houchen testified on behalf of the Board in both the House and Senate in support of the budget authorization for fiscal years 20-21. The current substitute version of HB 166 that was voted out of the House on May 9, 2019, includes technical language deleting references to “certificates of authority” that were not stricken as part of the changes in HB 216 from the 131st General Assembly.

HB 177, Standard Care Arrangements
HB 177 was introduced April 9, 2019, proposing to eliminate the standard care arrangements entered into by advanced practice registered nurses (APRNs) and collaborating physicians or podiatrists; prohibit physician prescribing of schedule II controlled substances in convenience care clinics; and remove physician oversight of an APRN granting clearance for a concussed student to return to play or practice in a sport, consistent with other parts of the bill. The bill has had sponsor and proponent testimony in the House Health Committee. Below is an excerpt from sponsor testimony at the April 30, 2019 House Health Committee as reported by Hannah News Service:

Joscelyn Greaves, president of the Ohio Association of Advanced Practice Nurses (OAAPN), provided proponent testimony.

“The landscape of health care has changed dramatically over the past two decades. As more Ohioans than ever are accessing care, particularly in primary care, the system is overwhelmed. More patients are insured and seeking primary care, baby boomers are aging, and the number of primary care physicians continues to decline. According to new data from the Association of American Medical Colleges, by 2030, we could see a shortage of up to 120,000 physicians,” Greaves said.

Greaves said eliminating the currently required standard of care arrangement (SCA) with physicians will allow nurse practitioners (NPs) to expand into rural areas of the state currently being underserved.
“NP expansion to rural areas will only increase with the retirement of the SCA because the difficulty of finding a collaborator will no longer be an issue. For example, after Arizona removed the SCA, the state saw a more than 50 percent growth in NP workforce with more than a 70 percent increase in NPs working in rural areas. Nevada had an increase of over 30 percent within three years of passing their law and North Dakota reported a doubling of the number of NPs after updating their laws.”

Greaves said legal collaboration “has nothing to do with professional collaboration,” which happens all the time with advanced practice registered nurses (APRNs).

“Mandatory collaboration is not ‘over-the-shoulder’ supervision. In fact, many physician collaborators are often not present when and where the health services by APRNs are provided. While some collaborators are in the same practice, others could be located hours away. HB177 does not dismantle professional collaboration. HB177 merely removes the overly burdensome administrative requirement of a legal contract with a physician,” she said. “As our sponsor said, this bill does not increase an APRN’s scope of practice. … The Ohio Board of Nursing is one of the most vigilant regulators in the country and nothing in this bill will make that any different.”

Rep. Lipps said he met with physicians regarding this issue recently, noting their main issue is that they believe they are more thorough than APRNs. He said they weren’t negative, and that some of them weren’t well educated on exactly how the APRN process works.

Greaves told Rep. Boyd she isn’t sure if there has been an increase in online learning for APRNs. She said all of them are certified by the same body nationally and must meet the same guidelines on core competencies.

Rep. Antani pointed to 131-HB216 (Pelanda) and asked what happened between then and now to make HB177 necessary. Greaves said that was helpful, but the decline in physician providers has continued and more have switched to become part of a large health care system.

Antani asked why they aren’t just seeking another expansion in collaborators. Greaves said the problem will just continue to worsen and HB177 will help fix it.

Rep. Liston, a medical doctor, said she appreciates APRNs but is worried that some inexperienced ones might have issues working in rural areas with few other providers to help. Greaves said that can be challenging, but noted there can still be plenty of collaboration with doctors and other APRNs even without a legal contract.

Greaves told Rep. Russo that the majority of APRNs go into primary care, but there are other specialty areas.
Greaves told Russo that SCAs used to be helpful but aren’t needed anymore. She said many APRNs barely ever have contact with their supervising physician.

Greaves told Rep. Clites that under HB177, an APRN could go into Holmes County and start a practice on their own. Greaves told Clites that she wouldn’t expect insurance liability rates to increase significantly.

Dr. Thomas Zaciewski also provided proponent testimony, saying two NPs currently collaborate with him, and one works in his practice with him.

“We work in tandem to deliver the best care possible for our patients. I complement her practice and she complements mine. We cover critical access hospitals and have an extremely busy outpatient treatment center. She runs the outpatient service and makes hospital rounds while I perform surgeries. I have the utmost confidence in her clinical skill and competence. I do not supervise her, and we hold each other accountable for our practice,” he said. “Yet, if something happened to me and I could not practice, this experienced, proven provider would no longer be able to deliver care to our patients because of mandated collaboration and our patient access will suffer. The mandated collaboration contract, known as the SCA, has become a barrier to patients who need access to health care.”

He said his other NP pays around $2,500 a month for her other physician collaborator, but he doesn’t charge her because he is a small business owner himself and recognizes the challenges.

“Simply, in my opinion, the mandated contract is a restriction on free trade and creates an unnecessary barrier for patient access,” he said.

Marie Grosh, an NP who runs her own business doing private house calls for homebound seniors in the Cleveland area, talked about her difficult experiences finding a physician collaborator who she can afford to pay to basically do nothing.

“I finally found a physician I could afford, and I paid him to sign my SCA. He never saw any of my patients. He never provided any services for me and I called him twice in two years. On both of those occasions that I called him, he said he didn’t know the answer to my clinical question. I say this not to undermine physicians at all -- that is not why I am here, and that is not what this bill is about. I say this to underscore the point that I was paying thousands of dollars for a service that provided no value to my patients,” she said, noting her story is not rare and that she hears it all the time from colleagues.

Rep. Russo asked if prohibiting the non-compete clauses employed by large health systems and capping fees would address the problem. Grosh said that wouldn’t address the fact that SCAs aren’t providing any value and shouldn’t be required at all.
Grosh told Rep. Romanchuk some SCAs cost $2,000 a month. Greaves stood up and added that they can cost as much as $5,000 per month.

Proponent testimony was also provided by Jeff Dillon, legislative liaison for Americans for Prosperity of Ohio; Annie Bowen; Larke Recchie, CEO of the Ohio Association of Area Agencies on Aging; Barbara Sykes, state director of AARP Ohio; and Lorraine Kelly, CEO of PsyCare Inc.

**HB 224, Nurse Anesthetists**

HB 224 was introduced on April 29, 2019 and has been referred to the House Health Committee.

The sponsors of the bill in their letter to colleagues requesting co-sponsors that is dated April 3, 2019, described their legislation as doing the following with respect to a CRNA’s scope of practice:

- Define CRNAs as prescribers to explicitly restore their ability to order diagnostic tests, medications, fluids, and treatments for conditions related to the administration of anesthesia or when performing clinical functions. *(The bill prohibits a CRNA from prescribing medications to be filled at the pharmacy for use at home. Rather, this will clarify their ability to order medications, treatments, etc. they currently select and directly administer to patients only during the time CRNAs provide care).*

- Describe a CRNA’s ability to direct registered nurses, licensed practical nurses and respiratory therapists to assist in patient care management;

- Clarify that pre-anesthetic preparation and evaluation (as described in current statute) includes establishing anesthesia care plans, determining if planned anesthesia is appropriate, obtaining informed consent for anesthesia care, and performing and documenting evaluations and assessments including ordering and evaluating diagnostic tests and consulting with other health professionals;

- Specify that a CRNA may select, order and administer pain relief therapies and fluids, treatments and medications for conditions related to the administration of anesthesia, and;

- Maintain CRNA ability to perform clinical functions (as permitted in current statute) and clarifies that clinical functions relate to the tasks nurse anesthesia education programs are required to teach by CRNA training program accreditation standards, and;

- Specify CRNA ability to order fluids, treatments, medications, and diagnostic tests when performing clinical functions.

**SB 61, Nurse Anesthetists**

SB 61 was introduced on February 26, 2019 and has had sponsor and proponent testimony in the Senate General Government and Agency Review Committee. SB 61 would authorize a CRNA in an entity owned or controlled by a hospital or an ambulatory surgical facility (facility) to select, order, and administer drugs other than anesthesia in
the immediate post-operative period in accordance with a protocol that is adopted by the facility in which the CRNA practices. The immediate post-operative period would not include the period of time when a patient is being moved or has been moved from a post-anesthesia care unit to another part of the facility. Certain conditions would be specified in the protocol process that must be met before the CRNA may select, order, and administer the drug.

**HB 144, Nurse Employment-Mandatory Overtime**

HB 144 was introduced on March 19, 2019 and has had sponsor and proponent testimony in House Commerce and Labor Committee. The bill would prohibit a hospital from requiring a registered nurse or licensed practical nurse to work overtime as a condition of continued employment. The bill is a reintroduction of HB 456 from the last General Assembly and which passed the House. The Ohio Nurses Association (ONA) is the chief proponent of the bill.

The sponsor summarized the bill in its first hearing stating that "The intent of the legislation is to prohibit a hospital from requiring a registered nurse or licensed practical nurse to work in excess of an agreed upon, predetermined, scheduled full-time or part-time workweek as a condition of continued employment. Hospitals will be prohibited from terminating employment, proposing to terminate employment, taking disciplinary or retaliatory action, or proposing to take disciplinary or retaliatory action solely because a nurse chooses not to work overtime." He said nurses can still voluntarily work overtime.

Here is an excerpt from sponsor testimony at the May 8, 2019 House Commerce and Labor Committee as reported by Hannah News Service:

Nurses who are forced to work past their scheduled shifts can often suffer from fatigue and other effects that put themselves and patients at risk, proponents of HB144 (D. Manning) argued to the House Commerce and Labor Committee Wednesday. Those who speak up about their working conditions often face threats of termination or professional sanctions, they added.

Three proponents appeared before the committee Wednesday to explain that the bill, while not outright banning overtime work for nurses, would allow them to decline additional hours for safety purposes in non-urgent situations.

Kelly Trautner, interim CEO of the Ohio Nurses Association, explained that fatigue can lead to the increased likelihood of errors, decline in memory, reduced ability to learn and impaired communication skills -- as well as reduced coordination that can lead to workplace and auto accidents.

"Make no mistake: safe nurse staffing is not simply a goal for addressing unsatisfactory working conditions in hospitals. Research has shown an inextricable link between safe nurse staffing and the safety and quality of care patients receive in a hospital. This is a public safety issue," she said in her testimony.
Trautner also noted that medical errors are the third leading cause of preventable death in the U.S. She said 44,000 to 98,000 deaths per year are directly attributed to medical errors, equivalent to as many deaths as a Boeing 747 airliner crashing every day for a year. Rep. Tom Patton (R-Strongsville), who commented that he had several nurses in his own family, said he found that figure shocking.

Rep. Ron Hood (R-Ashville) asked Trautner about the nursing shortage in Ohio and the country. Citing a national study that examined demand through 2030, she said the U.S. is expected to reach an 8 percent surplus nationwide, as well as 49,000 excess nurses in Ohio, though areas of demand still remain. That said, a WalletHub study recently rated Ohio worst in the nation for work environments for registered nurses. (See The Hannah Report, 5/8/19.)

Shelly Malberti, vice president of the Ohio Nursing Association Board of Directors, said that the practice of mandatory overtime is a result of "intentionally cutting nursing budgets and encouraging nursing managers and supervisors to short staff and use mandatory overtime as a tool to increase profits." She recalled a personal experience that took place over six months when electronic medical records were first introduced. While she and her staff were required to undergo hundreds of hours of training, no additional staff were brought on to address their on-the-floor patient load.

Rep. Michael Sheehy (D-Toledo) asked Malberti to describe how the nursing industry has changed in her long career.

"Not only the expectations that nurses carry more patients have changed, but the complexity of the patients has changed. Honestly in 1986 when I graduated from nursing school, [compared to] the patients in the medical surgery units today, the patients -- they didn't even live. We didn't have that technology then that we have now. The patient that is in the hospital is far sicker and the healthy patients are being treated in an outpatient facility," she said.

Asked by Chairwoman Gayle Manning (R-North Ridgeville) if a similar problem faces physicians, Malberti declined to speak on their behalf, but said that among many professions, such as airline pilots and truck drivers, all have limits placed on their hours in order to maintain public safety.

Emma Jasper provided the final testimony, sharing her personal story of losing her mother in 2013 at the age of 11. Her mother worked extended shifts at Mercy Health's Jewish Hospital in Cincinnati, which took a toll on her mental and emotional health. She died after falling asleep while driving home from one of those shifts.

"There were many days I could read the stress on my mom's face. She would pick my brother and I up from school and we would have dinner
together before she had to rush off again for another long night shift. She was scheduled for three days, but those three days soon turned into four and sometimes five day weeks with 13- and 14-hour shifts. There were many times I’d see my strong mom even break down and cry. She was incredibly dedicated to the patients, and it broke her heart knowing that she couldn’t give them the attention they deserved. My mom was utterly exhausted. But what options did she have? Her fellow nurses and patients needed her,” Jasper said in her testimony, ending by saying that she shared her story so that others might avoid similar stories.

**SB 1, Reduce Regulatory Restrictions**

The Ohio Senate introduced SB 1 on February 12, 2019 and the bill was voted out of the Senate on May 8, 2019 by a vote of 24-8. SB 1 is similar to SB 293 from the 132nd GA and has been promoted as priority legislation for the beginning of this session.

As introduced, SB 1 would require each state agency to reduce the number of regulatory restrictions in the agency’s rules by 30% by amending or rescinding rules that contain regulatory restrictions. After an agency has achieved a reduction in regulatory restrictions, it cannot adopt additional regulatory restrictions that would cancel out the reduction. The bill defines "regulatory restriction" as a restriction that requires or prohibits an action, and commonly contains words and phrases like "shall," "must," "require," "shall not," "may not," and "prohibit." The bill also allows JCARR to recommend that the General Assembly invalidate a proposed amendment or rescission of a rule containing a regulatory restriction if the agency does not justify the amendment or rescission.

The bill’s fiscal note states in part that “The bill may increase state agency staffing costs to prepare inventories of regulatory restrictions and annual progress reports in meeting the bill’s target of a 30% reduction in regulatory restrictions over three years. Any additional payroll costs may vary widely by agency depending on the scale of work and the staff resources state agencies use to accomplish the bill’s required tasks.”

Below is a summary of the changes in the substitute version of SB 1 that was accepted and voted out of the Senate Government Oversight and Reform Committee at the fourth hearing on May 7, 2019, as reported by Hannah News Service:

- Clarifies the formula for calculating the net reduction of regulatory restrictions.

- Gives the Joint Committee on Agency Rule Review (JCARR) the ability to modify an agency’s regulatory restriction percentage if the agency is able to demonstrate why the agency is unable to meet the 10-10-10 percent regulatory restriction reduction specified in the bill.

If the agency does demonstrate cause, JCARR may establish an alternative, reduced percentage of regulatory restrictions for the agency, in lieu of the 10-10-10 percent option.
Permits JCARR to report to the Senate President and Speaker of the House in lieu of the entire Legislature "for purposes of administrative efficiency."

- Provides additional legislative guidance to state agencies regarding how to review and assess existing regulatory restrictions.

- Authorizes the Common Sense Initiative to review existing state agency rules for purposes of reducing regulatory restrictions.

- Makes other LSC technical amendments.

**HB 115, Regulator Restriction Reduction**
The Ohio House introduced HB 115 on March 4, 2019 and the bill has had sponsor and proponent testimony in the House State and Local Government Committee. It is a companion bill to SB 1. The bill was last heard in committee on April 10, 2019.

**SB 7, Temporary Licensing-Military**
SB 7 requires state occupational licensing agencies, under certain circumstances, to issue six-year “temporary” licenses or certificates to members of the military and spouses who are licensed in another jurisdiction and have moved to Ohio for active duty. The bill was amended in the Senate Transportation, Commerce and Workforce Committee on March 27, 2019. The amendments included an increase in the duration of the “temporary” licenses from three to six years, an allowance for the Ohio State Medical Board to provide expedited licenses instead of temporary licenses for certain health professions, and an amendment to change temporary license denial and revocation language from “shall” to “may” to allow agencies additional discretion in choosing whether or not to award a license. The bill passed out of committee and was voted out of the Senate unanimously on March 27th.

Current law provides for expedited processing of applications of members of the military and their spouses (see Rule 4723-2-02, OAC). The Board has promoted expedited licensing of the military through rules, processes and approval of certain military nursing programs which were added to statute. The duration of the temporary license, questions related to grounds for voiding the temporary, and the need to require completion of the licensure process such as criminal background checks are issues for further consideration. In addition, cost of implementation, consistency with other licensing and public safety checks, and requirements in the Ohio eLicense platform should also be explored.

**HB 133, Military-Temporary Licensure**
HB 133 as introduced would require state occupational licensing agencies, under certain circumstances, to issue temporary licenses or certificates that are valid for six years to members of the military and spouses who are licensed in another jurisdiction and have moved to Ohio for active duty.

Here is an excerpt from sponsor testimony at the April 3, 2019 House State and Local Government Committee as reported by Hannah News Service:
Rep. Perales offered sponsor testimony, saying that unemployment is among the largest hardships military spouses face, and the issue is so widespread that the U.S. Department of Defense’s (DoD) Office of Military Community and Family Policy has named professional license reciprocity as one of their top priorities.

Of an estimated 3,600 military spouses, 35 percent work in a profession requiring a license or certificate, he said. Such individuals have a hard time finding employment when moving to a state with different license requirements, and the bill would alleviate that for military families coming to Ohio. It is a “no-brainer,” Perales said.

The DoD is increasingly deciding where to locate missions based on state laws benefiting military members and families, and the bill would make Ohio stand out as a military-friendly state, giving it a “leg up” in this area. This will put Ohio ahead in potential mission and base expansion opportunities, Perales said.

Rep. Perales also said it should be “doable” for a recipient of temporary licensure to attain a permanent license, and that would make them more likely to stay in Ohio.

He also said, in response to Rep. Sobecki, that no other state has enacted such a policy and that outgoing Secretary of the Air Force Heather Wilson had personally communicated to him and others in Dayton the importance of such policies. Weinstein also said he hopes other states will follow suit, saying some spouses don’t begin a career because of fears it won’t be sustainable due to license issues.

**SB 131, Registered Veterinary Nurses**

SB 131 was introduced April 18, 2019 and proposes to change professional title of "registered veterinary technician" to "registered veterinary nurse." The bill is a reintroduction of similar legislation (HB 501 and SB 337) from the last General Assembly.

**S.1357, Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act**

Ohio US Senator Sherrod Brown reintroduced the “Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act” during national nurses’ week. The bill proposes to set minimum nurse-to-patient staffing requirements, study best practices for nurse staffing, and provide whistleblower protections to protect the right of nurses to advocate for the safety of their patients.

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Additional information and details related to the content and status of any state bill mentioned in the legislative report may be found at [https://www.legislature.ohio.gov/legislation/searchlegislation;jsessionid=17223f7a114e6ed96192eff21785?0](https://www.legislature.ohio.gov/legislation/searchlegislation;jsessionid=17223f7a114e6ed96192eff21785?0).
MEMORANDUM

TO: Members of the Advisory Committee on Advanced Practice Registered Nursing

FROM: Lisa Emrich, Program Manager

DATE: June 5, 2019

SUBJECT: Practice Unit: Sample/Summary of APRN Questions Received

The Board’s Practice Unit responds to various questions received from licensees and the public. Below is a sample list of summarized questions received since April 29, 2019.

1. How do I access the list of approved medications for APRN prescribing?

2. Could you please clarify the Continuing Education needed to renew my APRN for this year? I know I need 24 for my RN, do I need that for the APRN too?

3. Does my collaborating physician need to co-sign each chart that is reviewed per Nursing Board requirement?

4. Where can I locate the scope of practice for FNP in Ohio? I specifically want to know about the scope of FNP working in an intensive care unit. Are we allow to insert central lines, chest tubes, arterial lines, etc?

5. Does the Collaborating Physician of an APRN have to be of the same specialty?

6. Does the Collaborating Physician have to work at the same location as the APRN?
7. I passed my AANP FNP exam in May and I am unsure of what I need to do next to retrieve a certification number? Is there someone I can contact to retrieve additional information to ensure I become properly certified?

8. I am an Acute Care NP and interested in aesthetic procedures such as laser hair removal, micro-needling and injectables such as Botox and dermal fillers. The spa which I am partnering is currently seeking a medical director. I understand I need a collaborating physician but I was wondering what other requirements I must meet to inject Botox.

9. Are there any defined rules indicating how long I need to be in practice as an APRN before precepting APRN students? Is it dependent on the graduate program student is attending?

10. I am seeking clarification on APRN-CNP who hold national certification in Family and their practice within the emergency department setting. I am a Family certified APRN-CNP and I just completed my AGACNP program. I work with a number of Family certified APRN-CNPs who are taking care of critically ill patients in the emergency department, performing critical care skills. I had asked about national certification about a year ago and was told to get my acute care certification. However, I am now being told that the Board is Nursing has decided to allow Family certified APRN-CNPs to care for the critically ill patients in the ER. I just want more clarification, as the acute care program that I just completed was very in depth and the knowledge that I received from the program was so intense and different from my Family APRN-CNP program, that I could not imagine providing critical care without it.

11. Can you clarify for me whether Primary care NP’s can prescribe to patients with depression?

12. I will be graduating with my psych mental health nurse practitioner degree in August 2019. Does my collaborating physician need to be a psychiatrist? Thanks,

13. I'm looking for some information regarding a nurse practitioner run med spa?
MEMORANDUM

TO:    BOARD MEMBERS
       OHIO BOARD OF NURSING

FROM:  HOLLY FISCHER
       CHIEF LEGAL COUNSEL

SUBJECT:  2019 Five Year Rule Review

DATE:   MAY 10, 2019

As reviewed at the April meeting, the following are rule chapters the Board is required to review at least once every five years, along with technical changes to individual rules that are not slated for five-year review, but are either required to be revised, or recommended to be updated, due to recent legislative action, or for technical reasons discussed below.

Attached is the proposed rule language as updated based on the Board’s review at the April Retreat. After the May meeting, the language as approved by the Board will be distributed to interested parties. An interested parties meeting will be held on June 17, 2019. The rules will be filed with the Common Sense Initiative (CSI) in early September, and with JCARR in October. A rules hearing will be conducted at the November Board meeting.

1. 5-Year Review Rule Chapters

Chapter 2 Licensing for Active Duty Military and Veterans

- Rule 2-01 (A)(3)(f), (g): Delete cross reference in (f) to Rule 4723-8-01, not necessary; delete (g), obsolete.
- Rule 2-02: No change
- Rule 2-03 (C): Delete cross reference to Rule 4723-8-01, not necessary.
- Rule 2-04: No change.

Chapter 16: Hearings

- Rule 16-01, 16-02, 16-03, 16-04, 16-05, 16-06: No change.
- Rule 16-08(A): Change “thirty” to “forty-five.”
• Rule 16-09(A): Add “solely” before procedural in line three (“relates solely to a procedural matter”).
• Rule 16-10, 16-12, 16-13: No change.

Chapter 17: Intravenous Therapy Courses for Licensed Practical Nurses
• Rule 17-01(C): Change “client” to “patient” consistent with changes made throughout Chapter 4723, OAC over the past five years.
• Rule 17-01(G): Update cross reference (should be: paragraph (N) of Rule 4723-14-01).
• Rule 17-03(C)(3): Update cross reference (should be: Section 3721.01, ORC).
• Rule 17-05: No change.
• Rule 17-06: In the header language, delete the reference to 4723.18(A)(4)(a), ORC, as that language was removed by HB 216 (131st GA) and the correct reference should be Section 4723.19, ORC. In (A), delete the 40 hour minimum for the continuing education course, as determined by the Board at the April meeting, and as recommended by the Advisory Group on Continuing Education. At the end of the Rule, add as Statutory Authority Section 4723.19, ORC.
• 17-07(A)(5): Update name of form.
• 17-07(C): For endorsement applicants, delete the last sentence regarding the Board requiring completion of continuing education in IV therapy.

Chapter 25: Nurse Education Grant Program
• Rule 25-01: No change.
• Rule 25-02(H)(2): Replace “Ohio board of regents” with “chancellor of higher education” to reflect current statutory terminology.
• Rule 25-02(L): Update cross reference to Rule 4723-5-01(C) (not X).
• Rule 25-03, 25-04, 25-05: No change.
• Rule 25-06(C): Update name of form.
• Rule 25-07: Replace “Ohio board of regents” with “chancellor of higher education” to reflect current statutory terminology.
• Rule 25-08: No change.
• Rule 25-09(A): Update name of form.
• Rule 25-10, 25-11, 25-12, 25-13, 25-14: No change.
• Rule 25-15 (B): Add clarifying language.
• Rule 25-16, 25-17, 25-18: No change.

Chapter 26: Community Health Workers
• Rule 26-01: No change.
• Rule 26-02(A)(1): Update name of form.
• Rule 26-04(A), (B)(1), (E): Update form references.
• Rule 26-04(C), (D), (E): Update language to reflect online application process for CHWs and ability to submit inactive requests electronically/online.
• Rule 26-04(H): Delete; this language is now covered by paragraph (E), as reinstatement and reactivation are now accomplished using a common application.
• Rule 26-05(D): Update form reference.
• Rule 26-06, 26-07, 26-08, 26-09, 26-10, 26-11: No change.
• Rule 26-12(A)(2)(b): Replace “Ohio board of regents” with “chancellor of higher education” to reflect current statutory terminology.
• Rule 26-13, : No change.
• Rule 26-14(A)(1), (B)(1): Update form references.

2. Technical Changes - Other Rules

• Rule 1-03: Update form references as noted above.

• Chapter 5: This Chapter is slated for 5-year review in 2021.
  o Rule 5-04(B)(4): Delete this paragraph as it covers the same information as (B)(3), and is inconsistent with Section 4723.07(B)(7), ORC, which says “may” withdraw approval, not “shall.”
  o Rule 5-10(A)(5)(b) and 5-11(A)(5)(b): As determined by the Board at the April meeting and as recommended by the Advisory Group on Nursing Education, Rule 5-10(A)(5)(b) and 5-11(A)(5)(b): Remove the requirement that preceptors have at “at least two years” experience in nursing practice.
  o Rule 5-21(E)(2): Amend this language consistent with removal of the two-year experience requirement for preceptors in Rules 5-10, 5-11.

• Rule 7-05(E)(1) and 7-06(F)(1): Staff is recommending the process for issuance of a temporary permit to RN/LPN endorsement applicants be changed to expedite issuing permits by eliminating the documentation of completion of a nursing education program requirement. The rationale is that: (a) The law, Section 4723.09(D), ORC, does not require this documentation for temporary permits; (b) Frequently the education program information is not readily available through NURSYS, which staff relies upon to confirm licensure in another state, and this delays the temporary permit process; (c) Endorsement applicants are required to provide evidence of licensure in another
NCSBN jurisdiction, which would require completion of a NCSBN-member approved education program; (d) To obtain a full license, documentation of completion of an education program is required.

- **Rule 9-10**
  - 9-10 (A), (B), (C): Staff is recommending revising the rule to include the Exclusionary Formulary for prescribing in paragraph (B), rather than referring to a Formulary that is posted online. This is based on input from JCARR in October 2018 at the time Rule 9-10 was last submitted to JCARR for review. Should the CPG recommend that drugs be added to the Formulary, i.e., that APRNs cannot prescribe certain drugs, the CPG’s recommendation would go the Board for approval, and the Board would amend Rule 9-10 to reflect the updated Formulary. The language in (C) is statutory (Section 4723.50(C), ORC).
  - 9-10(A)(13): As discussed at the April meeting, the definition of “terminal condition” is revised consistent with Medical Board Rule 4731-11-01, filed by the Medical Board in March 2019 with CSI in response to public feedback.
  - 9-10(K)(6): As discussed at the April meeting, oncologists and hematologists were added by the Medical Board in Rule 4731-11-14 (filed with CSI in March 2019) as prescribers who may exceed the 120 MED; consistently, APRNs with national certification in oncology or hematology would also be able to exceed the 120 MED for established patients. Note the language regarding pain management, hospice and palliative care is not new but reorganized within the paragraph.

- **Rule 9-13**: This is the new MAT rule, effective February 1, 2019. The following changes are included:
  - 9-13(A): Change to reflect changes in Rule 4723-9-10, i.e., the Formulary is included in rule rather than online.
  - 9-13(B): Include Certified Nurse Midwives as prescribers who can potentially engage in medication-assisted treatment. As discussed at the April meeting, effective October 24, 2018, the “Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act” (H.R. 6), was signed into law amending 21 U.S.C. § 823 to expanding the definition of “qualified other practitioners” for purposes of buprenorphine prescribing for MAT. In addition to nurse practitioners (whose eligibility was made permanent), clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives were added (for a period of five years). The addition of CNMs is supported by ACNM and OAAPN.
o 9-13(A)(7), (A)(9), (C)(2), (C)(3) - (5), (C)(6), (C)(9), (C)(10): All of the changes are made so that the Rule is consistent with the Medical Board rules for MAT (see 4731-33-01, 4731-33-03, 4731-33-04), effective April 30, 2019. H.B. 49 (132nd GA), Section 4723.51(C), ORC, requires that the Nursing Board rules for MAT and the Medical Board rules be mutually consistent.

o *Detoxification.* H.B. 49 (132nd GA) implemented Section 4723.51, ORC, requiring that the Board adopt rules for MAT that address both treatment and detoxification. As noted, Section 4723.51(C), ORC requires that the Board adopt rule language consistent with language adopted by the Medical Board. The current Medical Board draft detoxification rules are attached for Board comment (*Attachment A*). The Medical Board’s Policy Committee approved of the draft on May 8, 2019. The Board would adopt a new rule or add the detoxification language to Rule 9-13 consistent with the Medical Board’s language.

- **4723-20-01, 20-03, 20-07:** These three rules were reviewed in five-year review last year and submitted as “no change” rules. LSC advised the Board on October 22, 2018, that even if the rules had no changes, in order to update a paragraph reference in the statutory authority (which is not part of the rule itself but is included in filing materials), the rules would need to be re-filed. Rather than do this, we opted to make the correction later. The statutory reference is “4723.07(K)” due to a law change (not “L”). We would submit as “4723.07” and eliminate the subparagraph completely.
The State Medical Board of Ohio seeks public input on proposed rules several times during the rule-making process. Public input is sought after the Medical Board has conducted its initial review of rules, after rules are filed with the Common Sense Initiative Office, and at the public hearing that occurs after the rules are formally filed with the Joint Committee on Agency Rule Review. The Medical Board’s initial review of rules may result in a proposal to amend current rules, rescind current rules, make no changes to current rules, and/or adopt new rules. Comments received will be reviewed and possibly result in changes to the initially proposed language before the rules are then filed with the Common Sense Initiative Office.

At this time the Medical Board has completed its initial review of the following rules and is seeking public comment on the proposed language. The rules and a short memo are attached.

**Rule 4731-13-13:** Subpoenas for purposes of hearing

**4731-33-01:** Definitions (Applicable to medication-assisted treatment rules)

**4731-33-02:** Standards and procedures for withdrawal management for drug or alcohol addiction

The proposed rules will also be available in the near future from the Medical Board’s website under "Newly Adopted and Proposed Rules."

Deadline for submitting comments: **May 24, 2019**
Comments to: Sallie Debolt, Senior Counsel
State Medical Board of Ohio
Sallie.Debolt@med.ohio.gov

Respectfully,

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Withdrawal 4731-13-13
manag...ion.pdf memo...ion.pdf
Section 4731.056, Ohio Revised Code, requires the Medical Board to adopt a rule that establishes standards and procedures to be followed by physicians in the use of drugs approved by the FDA for use in medication-assisted treatment, including detoxification. Section 4730.55, ORC, requires the adoption of such rule applicable to physician assistants.

Attached to this memo are proposed amended rule 4731-33-01, Definitions, and new rule 4731-33-02, Standards and procedures for withdrawal management for drug or alcohol addiction. The physician assistant rules will be virtually the same, only with reference to "physician assistant" instead of "physician." The draft rules reflect the input of the Ohio Board of Nursing staff and the Ohio Department of Mental Health and Addiction Services.

Rule 4731-33-01 is amended by adding definitions for "Withdrawal management" and "Ambulatory detoxification." The exemptions for providers of ambulatory detoxification are the same as the exemptions for office-based opioid treatment.

New rule 4731-33-02:

Paragraph (A): Requires the physician to inform the patient that detoxification is not treatment for substance use disorder. The paragraph also spells out the actions that must be taken to comply with Section 3719.04, ORC.

**Paragraph (B): Ambulatory detoxification for opioid addiction**

1. Sets out conditions under which ambulatory detoxification may be appropriate.
2. Requires the provision to be consistent with the American Society of Addiction Medicine's Level I-D or II-D level of care.
3. Requires the performance of an assessment focusing on signs and symptoms associated with opioid addiction.
4. Requires a biomedical and psychosocial evaluation of the patient.
5. Requires a review of the patient's OARRS report.
6. Requires information be given to the patient concerning risks of relapse and of overdose.
7. Requires an individualized treatment plan.
8. Requires patient counseling to be offered when the treatment is expected to last less than six months.
9. Requires periodic urine and/or other toxicological screenings, but is not specific as to frequency. Requires the physician to consider referral of a patient who has a positive screen.
10. Lists permissible and not permissible drugs that may be used; sets limits on the number of days allowed for prescriptions for take-home medications.
11. Requires the physician to offer a prescription for a naloxone kit.
12. Requires steps to reduce the chances of diversion.
Paragraph (C) Ambulatory detoxification from benzodiazepines or other sedatives

Requires compliance with paragraph (A) of the rule and TIP 45.

(1) Stipulates the conditions under which ambulatory detoxification maybe provided.
(2) Requires an assessment using a scale such as the “Clinical Institute Withdrawal Assessment for Benzodiazepines.”
(3) Requires a biomedical and psychosocial evaluation of the patient.
(4) Requires that the patient be instructed not to drive during treatment.
(5) Requires regular assessment to include urine and/or toxicological screenings. Requires steps to reduce chances of diversion.

Paragraph (D) Ambulatory detoxification from alcohol

Requires compliance with paragraph (A) of the rule and TIP 45.

(1) Sets standards for when ambulatory detoxification may be appropriate.
(2) Requires an assessment focusing on signs and symptoms associated with alcohol use disorder.
(3) Requires a biomedical and psychosocial evaluation.
(4) Requires on-going urine and/or other toxicological screenings.
(5) Requires that the physician recommend that the patient who successfully completes withdrawal enter a long-term treatment program.

Comments on the proposed rule may be sent by May 24, 2019 to: Sallie.Debolt@med.ohio.gov
4731-33-01 Definitions.

(A) "Office-based opioid treatment" or "OBOT" means medication-assisted treatment, as that term is defined in this rule, in a private office or public sector clinic that is not otherwise regulated, by practitioners authorized to prescribe outpatient supplies of medications approved by the United States food and drug administration for the treatment of opioid addiction or dependence, prevention of relapse of opioid addiction or dependence, or both. OBOT includes treatment with all controlled substance medications approved by the United States food and drug administration for such treatment. OBOT does not include treatment that occurs in the following settings:

(1) A state or local correctional facility, as defined in section 5163.45 of the Revised Code;

(2) A hospital, as defined in section 3727.01 of the Revised Code;

(3) A provider certified to provide residential and inpatient substance use disorder services, including withdrawal management, by the Ohio department of mental health and addiction services;

(4) An opioid treatment program certified by SAMHSA and accredited by an independent SAMHSA-approved accrediting body; or

(5) A youth services facility, as defined in section 103.75 of the Revised Code.

(B) "SAMHSA" means the United States substance abuse and mental health services administration.

(C) "Medication-assisted treatment" means alcohol or drug addiction services that are accompanied by medication that has been approved by the United States food and drug administration for the treatment of substance use disorder, prevention of relapse of substance use disorder, or both.

(D) "Substance use disorder" includes misuse, dependence, and addiction to alcohol and/ or legal or illegal drugs, as determined by diagnostic criteria in the "Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition" or "DSM-5."

(E) "OARRS" means the "Ohio Automated Rx Reporting System" drug database established and maintained pursuant to section 4729.75 of the Revised Code.

(F) For purposes of the rules in Chapter 4731-33 of the Administrative Code:

(1) "Qualified behavioral healthcare provider" means the following who is practicing within the scope of the professional license:
(a) Board certified addictionologist, board certified addiction psychiatrist, or psychiatrist, licensed under Chapter 4731. of the Revised Code;

(b) Licensed independent chemical dependency counselor-clinical supervisor, licensed independent chemical dependency counselor, licensed chemical dependency counselor III, licensed chemical dependency counselor II, or licensed chemical dependency counselor assistant licensed under Chapter 4758. of the Revised Code;

(c) Professional clinical counselor, licensed professional counselor, licensed independent social worker, licensed social worker, or marriage and family therapist, licensed under Chapter 4757. of the Revised Code;

(d) Advanced practice registered nurse, licensed as a clinical nurse specialist under Chapter 4723. of the Revised Code, who holds certification as a psychiatric mental health clinical nurse specialist issued by the American nurses credentialing center.

(e) Advanced practice registered nurse, licensed as a nurse practitioner under Chapter 4723. of the Revised Code, who holds certification as a psychiatric mental health nurse practitioner issued by the American nurses credentialing center;

(f) Psychologist, as defined in division (A) of section 4732.01 of the Revised Code, licensed under Chapter 4732. of the Revised Code; or

(g) An advanced practice registered nurse, licensed under Chapter 4723. of the Revised Code, who holds subspecialty certification as a certified addiction registered nurse-advanced practice issued by the addictions nursing certification board.

(2) Nothing in this paragraph shall be construed to prohibit a physician assistant licensed under Chapter 4730. of the Revised Code who practices under a supervision agreement with a board certified addiction psychiatrist, board certified addictionologist, or psychiatrist who is licensed as a physician under Chapter 4731. of the Revised Code, from providing services within the normal course of practice and expertise of the supervising physician, including addiction services, other mental health services, and physician delegated prescriptive services in compliance with Ohio and federal laws and rules.

(G) "Community addiction services provider," has the same meaning as in section 5119.01 of the Revised Code.
(H) "Community mental health services provider," has the same meaning as in section 5119.01 of the Revised Code.

(I) "Induction phase," means the phase of opioid treatment during which maintenance medication dosage levels are adjusted until a patient attains stabilization.

(J) "Stabilization phase," means the medical and psychosocial process of assisting the patient through acute intoxication and withdrawal management to the attainment of a medically stable, fully supported substance-free state, which may include the use of medications.

(K) "Withdrawal management" or "detoxification" means the process of safely removing addictive substances from the body. It includes the term "medically-assisted stabilization," which aims to reduce discomfort and potential physical harm for individuals who are experiencing withdrawal. Withdrawal management does not constitute substance abuse treatment or rehabilitation.

(L) "Ambulatory detoxification" means withdrawal management delivered in a medical office, public sector clinic, or urgent care facility by trained practitioners authorized to prescribe outpatient supplies of drugs approved by the United States food and drug administration for the treatment of addiction, prevention of relapse of drug addiction, or both. Ambulatory detoxification is the provision of medically supervised evaluation, withdrawal management, and referral services without extended onsite monitoring. Ambulatory detoxification does not include withdrawal management that occurs in the following settings:

(1) A state or local correctional facility, as defined in section 5163.45 of the Revised Code;

(2) In-patient treatment in a hospital, as defined in section 3727.01 of the Revised Code;

(3) A provider certified to provide residential and inpatient substance use disorder services, including withdrawal management, by the Ohio department of mental health and addiction services;

(4) An opioid treatment program certified by SAMHSA and accredited by an independent SAMHSA-approved accrediting body; or

(4) A youth services facility, as defined in section 103.75 of the Revised Code.
Rule 4731-33-02 Standards and procedures for withdrawal management for drug or alcohol addiction.

(A) Prior to providing ambulatory detoxification, as that term is defined in rule 4731-33-01 of the Administrative Code, for any substance use disorder the physician shall inform the patient that ambulatory detoxification alone is not substance abuse treatment. If the patient prefers substance abuse treatment, the physician shall comply with the requirements of section 3719.064 of the Revised Code, by completing all of the following actions:

(1) Both orally and in writing, give the patient information about all drugs approved by the U.S. Food and Drug Administration for use in medication-assisted treatment. That information was given shall be documented in the patient's medical record.

(2) If the patient agrees to enter opioid treatment and the physician determines that such treatment is clinically appropriate, the physician shall refer the patient to an opioid treatment program licensed or certified by the Ohio department of mental health and addiction services to provide such treatment or to a physician, physician assistant, or advanced practice registered nurse who provides treatment using Naltrexone or who holds the DATA 2000 waiver to provide office-based treatment for opioid use disorder. The name of the program, physician, physician assistant, or advanced practice registered nurse to whom the patient was referred, and the date of the referral shall be documented in the patient record.

(B) Ambulatory detoxification for opioid addiction.

(1) The physician shall provide ambulatory detoxification only when all of the following conditions are met:

(a) A positive and helpful support network is available to the patient.

(b) The patient has a high likelihood of treatment adherence and retention in treatment.

(c) There is little risk of medication diversion.

(2) The physician shall provide ambulatory detoxification under a defined set of policies and procedures or medical protocols consistent with American Society of Addiction Medicine's Level I-D or II-D level of care, under which services are designed to treat the patient's level of clinical severity, to achieve safe and comfortable withdrawal from a mood-altering drug, and to effectively facilitate the patient's transition into treatment and recovery. The ASAM Criteria, Third Edition, can be obtained from the website of the American Society of Addiction Medicine at https://www.asam.org/. A copy of the ASAM Criteria may be reviewed at the Medical Board office, 30 East Broad Street, Third Floor, Columbus, Ohio, during normal business hours.

(3) Prior to providing ambulatory detoxification, the physician shall perform an assessment of the patient. The assessment shall include a thorough medical history and physical examination. The assessment must focus on signs and symptoms
associated with opioid addiction and include assessment with a nationally recognized scale, such as one of the following:

(a) Objective Opioid Withdrawal Scale ("OOWS");
(b) Clinical Opioid Withdrawal Scale ("COWS"); or
(c) Subjective Opioid Withdrawal Scale ("SOWS").

(4) Prior to providing ambulatory detoxification, the physician shall conduct a biomedical and psychosocial evaluation of the patient, to include the following:

(a) A comprehensive medical and psychiatric history;
(b) A brief mental status exam;
(c) Substance abuse history;
(d) Family history and psychosocial supports;
(e) Appropriate physical examination;
(f) Urine drug screen or oral fluid drug testing;
(g) Pregnancy test for women of childbearing age and ability;
(h) Review of the patient’s prescription information in OARRS;
(i) Testing for human immunodeficiency virus;
(j) Testing for hepatitis B;
(k) Testing for hepatitis C; and
(l) Consideration of screening for tuberculosis and sexually-transmitted diseases in patients with known risk factors.

(m) For other than toxicology tests for drugs and alcohol, appropriate history, substance abuse history, and pregnancy test, the physician may satisfy the assessment requirements by reviewing records from a physical examination and laboratory testing of the patient that was conducted within a reasonable period of time prior to the visit. If any part of the assessment cannot be completed prior to the initiation of treatment, the physician shall document the reason in the medical record.


(6) The physician shall inform the patient about the following before the patient is undergoing withdrawal from opioids:
(a) The detoxification process and potential subsequent treatment for substance use disorder, including information about all drugs approved by the United States food and drug administration for use in medication-assisted treatment;

(b) The risk of relapse following detoxification without entry into medication-assisted treatment;

(c) The high risk of overdose and death when there is a relapse following detoxification;

(d) The safe storage and disposal of the medications.

(7) The physician shall not establish standardized routines or schedules of increases or decreases of medications but shall formulate a treatment plan based on the needs of the specific patient.

(8) For persons projected to be involved in withdrawal management for six months or less, the physician shall offer the patient counseling as described in paragraphs (F) and (G) of rule 4731-33-03 of the Administrative Code.

(9) The physician shall require the patient to undergo urine and/or other toxicological screenings during withdrawal management in order to demonstrate the absence of use of alternative licit and/or illicit drugs. The physician shall consider referring a patient who has a positive urine/and or toxicological screening to a higher level of care, with such consideration documented in the patient's medical record.

(10) The physician shall comply with the following requirements for the use of medication:

(a) The physician may treat the patient's withdrawal symptoms by use of any of the following drugs as determined to be most appropriate for the patient.

(i) Buprenorphine without naloxone (buprenorphine mono-product) when a buprenorphine/naloxone combination product is contraindicated, with the contraindication documented in the patient record;

(ii) A drug specifically FDA approved for the alleviation of withdrawal symptoms;

(iii) An alpha-2 adrenergic agent along with other non-narcotic medications as recommended in the American Society of Addiction Medicine's National Practice Guideline (https://www.asam.org/);

(iv) A combination of buprenorphine and low dose naloxone (buprenorphine/naloxone combination product).

(b) The physician shall not use any of the following drugs to treat the patient's withdrawal symptoms:

(i) Methadone;
(ii) Anesthetic agents

(c) The physician shall comply with the following:

(i) The physician shall not initiate treatment with buprenorphine to manage withdrawal symptoms until between twelve and eighteen hours after the last dose of short-acting agonist such as heroin or oxycodone, and twenty-four to forty-eight hours after the last dose of long-acting agonist such as methadone. Treatment with a buprenorphine product must be in compliance with the United States food and drug administration approved "Risk Evaluation and Mitigation Strategy" for buprenorphine products, which can be found on the United States food and drug administration website at the following address:

(ii) The physician shall determine on an individualized basis the appropriate dosage of medication to ensure stabilization during withdrawal management.

(a) The dosage level shall be that which is well tolerated by the patient.
(b) The dosage level shall be consistent with the minimal standards of care.

(iii) In withdrawal management programs of thirty days or less duration, the physician shall not allow more than one week of unsupervised or take-home medications for the patient.

(iv) In withdrawal management programs of more than thirty days duration, the physician may allow the patient to have the opportunity for up to thirty days of take-home medications.

(11) The physician shall offer the patient a prescription for a naloxone kit.

(a) The physician shall ensure that the patient receives instruction on the kit's use including, but not limited to, recognizing the signs and symptoms of overdose and calling 911 in an overdose situation.

(b) The physician shall offer the patient a new prescription for naloxone upon expiration or use of the old kit.

(c) The physician shall be exempt from this requirement if the patient refuses the prescription. If the patient refuses the prescription the physician shall provide the patient with information on where to obtain a kit without a prescription.

(12) The physician shall take steps to reduce the chances of medication diversion by using the appropriate frequency of office visits, pill counts, and weekly checks of OARRS.

(C) The physician who provides ambulatory detoxification with medication management for withdrawal from benzodiazepines or other sedatives shall comply with paragraph (A) of this
rule and "TIP 45, A Treatment Improvement Protocol for Detoxification and Substance Abuse Treatment" by the Substance Abuse and Mental Health Services Administration available from the Substance Abuse and Mental Health Services Administration website at the following link: https://store.samhsa.gov/ (Search for “TIP 45”)

(1) The physician shall provide ambulatory detoxification with medication management only when a positive and helpful support network is available to the patient whose use of benzodiazepines was mainly in therapeutic ranges and who does not have polysubstance dependence. The patient should exhibit no more than mild to moderate withdrawal symptoms, have no comorbid medical condition or severe psychiatric disorder, and no past history of withdrawal seizures or withdrawal delirium.

(2) Prior to providing ambulatory detoxification, the physician shall perform and document an assessment of the patient that focuses on signs and symptoms associated with benzodiazepine or other sedative use disorder and include assessment with a nationally recognized scale, such as the "Clinical Institute Withdrawal Assessment for Benzodiazepines" ("CIWA-A").

(3) Prior to providing ambulatory detoxification, the physician shall conduct and document a biomedical and psychosocial evaluation of the patient meeting the requirements of paragraph (B)(4) of this rule.

(4) The physician shall instruct the patient not to drive or operate dangerous machinery during treatment.

(5) During the ambulatory detoxification, the physician shall regularly assess the patient during the course of treatment so that dosage can be adjusted if needed.

(a) The physician shall require the patient to undergo urine and/or other toxicological screenings during withdrawal management in order to demonstrate the absence of use of alternative licit and/or illicit drugs.

(b) The physician shall document consideration of referring the patient who has a positive urine and/or toxicology screening to a higher level of care.

(c) The physician shall take steps to reduce the chances of diversion by using the appropriate frequency of office visits, pill counts, and weekly checks of OARRS.

(D) The physician who provides ambulatory detoxification with medication management of withdrawal from alcohol addiction shall comply with paragraph (A) of this rule and "TIP 45, A Treatment Improvement Protocol for Detoxification and Substance Abuse Treatment" by the Substance Abuse and Mental Health Services Administration available from the Substance Abuse and Mental Health Services Administration website at the following link: https://store.samhsa.gov/ (Search for “TIP 45”)

(1) The physician shall provide ambulatory detoxification from alcohol with medication management only when a positive and helpful support network is available to the patient who does not have a polysubstance dependence. The patient should exhibit no more than mild to moderate withdrawal symptoms, have no comorbid medical
conditions or severe psychiatric disorders, and no past history of withdrawal seizures or withdrawal delirium.

(2) Prior to providing ambulatory detoxification, the physician shall perform and document an assessment of the patient. The assessment must focus on signs and symptoms associated with alcohol use disorder and include assessment with a nationally recognized scale, such as the "Clinical Institute Withdrawal Assessment for Alcohol-revised" ("CIWA-AR").

(3) Prior to providing ambulatory detoxification, the physician shall perform and document a biomedical and psychosocial evaluation meeting the requirements of paragraph (B)(4) of this rule.

(4) During the course of ambulatory detoxification, the physician shall assess the patient regularly:
   
   (a) The physician shall adjust the dosage as medically appropriate;
   
   (b) The physician shall require the patient to undergo urine and/or other toxicological screenings in order to demonstrate the absence of illicit drugs;
   
   (c) The physician shall document the consideration of referring a patient who has a positive urine and/or toxicological screening to a higher level of care;

(5) The physician shall recommend that the patient who is successfully treated for alcohol withdrawal symptoms enter a long-term treatment program to maintain abstinence.
MEMORANDUM

TO: Amol Soin, M.D., Chair, Policy Committee
    Members, Policy Committee

FROM: Kimberly C. Anderson, Chief Legal Counsel

RE: Subacute and Chronic Pain Rules

DATE: March 7, 2019

The rule regarding prescribing for subacute and chronic pain, Rule 4731-11-14, Ohio Administrative Code, became effective on December 23, 2018. In the past few weeks, Board staff has become aware that the rule is having some negative impact for patients diagnosed with non-terminal cancer and patients diagnosed with terminal conditions.

The comments regarding the patients diagnosed with non-terminal cancer are summarized by a letter we received from the Ohio Hospital Association, which is attached. In summary, these patients may have severe pain requiring dosages which exceed 120MED and they are unable to quickly obtain appointments with board certified pain management specialists or board certified hospice and palliative care specialists. In order to address this issue, I have revised the rule to exempt board certified hematologists and board certified oncologists from that portion of the rule. The definitions are included in the attached revised Rule 4731-11-01, Ohio Administrative Code.

Board staff has also received comments from physicians indicating that the definition of terminal condition is causing delays for those patients. Patients diagnosed with a terminal condition are exempted from the rule, but the definition of terminal condition comes from Section 2133.01 of the Revised Code, which requires a second opinion. I have changed the definition of terminal condition to eliminate the need for a second opinion.

In order to reduce delay in making these changes, I recommend filing the revised rules directly with the Common Sense Initiative rather than requiring an initial circulation to interested parties. The Medical Board became aware of these issues through feedback from interested parties.

Action Requested: Request the full Board to approve filing the rules, as amended, with the Common Sense Initiative.
Hi Sallie and Klm. I hope you are doing well. I wanted to make you aware of a concern we are hearing from hospitals regarding the recently-implemented chronic pain rules. This is not a concern we heard about prior to the rule being finalized, but appears to have become a concern as members have worked to implement the new rules.

The specific provision at issue is the requirement that a physician may not prescribe a dosage in excess of 120 MED unless the physician is board certified in pain medicine or hospice/palliative care or has received a written recommendation to exceed 120 MED from a physician who is board certified as such. OAC 4731-11-14(E).

According to some hematology/oncology physicians, this requirement is delaying appropriate pain treatment for cancer patients who are above this MED limit, because of the delay in obtaining (and in some cases inability to obtain) a written recommendation from a physician who is board certified in pain medicine or hospice/palliative care (because of a shortage of such doctors in some communities, and long wait times to see them). Though the rules do not apply to terminal cancer patients, there are many cancer patients who are not terminal whose pain during treatment is very intense and whose routine treatment could exceed 120 MED. In fact, some terminal patients would be expected to experience less pain than nonterminal patients because the terminal patients are not undergoing (sometimes) painful treatments.

We understand these rules just recently became effective, but we wanted to share with you some feedback we are hearing from the hospital community to inform you and the Board of the experience "on the ground" in implementing the rules. As we continue to hear concerns from members on these rules and others we will share them with you, so that if there is an opportunity to refine the rules in the future because of additional implementation concerns, that feedback can be taken into account.

I would be happy to discuss this further.

Thanks for your consideration of this concern.

Sean

Sean McGlone | Senior Vice President and General Counsel
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Ohio Hospital Association

155 E. Broad St., Suite 301
Columbus, OH 43215-3640
Mission: OHA exists to collaborate with member hospitals and health systems to ensure a healthy Ohio.

Connect with OHA:
4723-2-01  Definitions.

(A) For purposes of Chapters 4723-1 to 4723-27 of the Administrative Code, and except as otherwise provided, the following definitions shall apply:

(1) "Active duty service member" means any member of the armed forces of the United States performing active duty under title 10 of the United States Code.

(2) "Armed forces" means the armed forces of the United States, including the army, navy, air force, marine corps, coast guard, or any reserve components of those forces; the national guard of any state; the commissioned corps of the United States public health service; the merchant marine service during wartime; such other service as may be designated by congress; or the Ohio organized militia when engaged in full-time national guard duty for a period of more than thirty days.

(3) "Applicant" means an individual who applies to the board for a license, temporary permit, or certificate, or renewal, reinstatement or reactivation of a license or certificate, to practice as:

(a) A registered nurse or licensed practical nurse;

(b) A dialysis technician intern;

(c) A certified dialysis technician;

(d) A medication aide;

(e) A community health worker;

(f) An advanced practice registered nurse as defined in paragraph (A) of rule 4723-8-01 of the Administrative Code; or

(g) An advanced practice registered nurse with prescriptive authority.

(4) "Service member" means any person who is serving in the armed forces.

(5) "Merchant marine" includes the United States army transport service and the United States naval transport service.

(6) "Veteran" means any person who has completed service in the armed forces, including the national guard of any state, or a reserve component of the armed
forces, who has been discharged under honorable conditions from the armed forces or who has been transferred to the reserve with evidence of satisfactory service.
Processing applications from service members, veterans, or spouses of service members or veterans.

(A) The board shall include questions on all applications for licensure, certification, or biennial renewal of licensure or certification, that inquire as to whether the applicant is:

(1) A service member;

(2) A veteran; or

(3) The spouse or surviving spouse of a service member or veteran.

(B) If the applicant responds affirmatively to any of the questions discussed in paragraph (A) of this rule, the board shall:

(1) Route the application to a board staff member who is responsible for monitoring the application and communicating with the applicant regarding the status of the application, including informing the applicant of any documentation needed for the board to process the application;

(2) Expedite the processing of the application, even if the application was received later in time than other applications that are pending processing;

(3) Provide information to applicants if the applicant or their spouse will be imminently deployed, regarding available fee and continuing education waivers, as discussed in rule 4723-2-03 of the Administrative Code;

(4) Request that the applicant submit documentation to the board demonstrating that the applicant is a service member, veteran, or spouse or surviving spouse of a service member or veteran; and

(5) Track, on an annual basis, the total number of applications submitted by service members, veterans, or spouses or surviving spouses of service members or veterans, and the average number of business days expended by the board to process those applications.

(C) For purposes of paragraph (B)(4) of this rule, acceptable forms of documentation include:

(1) A copy of a document issued by the armed forces showing the applicant is a service member or veteran, or that the applicant's spouse was a service
member or veteran; and

(2) If the applicant is a spouse or surviving spouse of a service member or veteran, a copy of a document showing that the applicant and the service member or veteran are spouses according to the law of any state or country.
4723-2-03 Fee waivers available to service members, veterans, or spouses of service members or veterans.

(A) A licensed practical nurse or registered nurse, who submits a renewal application after September fifteenth or later, or whose license lapsed, due to the licensee’s service in the armed forces, shall be eligible for renewal and reinstatement without payment of the late application fee required by division (A)(10) of section 4723.08 of the Revised Code, and the reinstatement fee required by division (A)(15) of section 4723.08 of the Revised Code, if the following are met:

(1) The licensee presents the board with satisfactory evidence that, not more than six months prior to the date the evidence is submitted to the board, the licensee or certificate holder was honorably discharged or separated under honorable conditions;

(2) The licensee is not suffering a mental or physical impairment that may affect the individual’s ability to provide safe care; and

(3) The licensee meets the requirements for license or certificate renewal required by section 4723.24 of the Revised Code.

(B) A licensed practical nurse or registered nurse, who submits a renewal application after September fifteenth or later, or whose license lapsed, due to the licensee’s spouse’s service in the armed forces, shall be eligible for renewal and reinstatement without payment of the late application fee required by division (A)(10) of section 4723.08 of the Revised Code, and the reinstatement fee required by division (A)(15) of section 4723.08 of the Revised Code, if the following are met:

(1) The licensee presents the board with satisfactory evidence that the licensee did not renew their license because their spouse’s military service caused them to be absent from the state of Ohio;

(2) The licensee presents the board satisfactory evidence that, not more than six months prior to the date the evidence is submitted to the board, the licensee’s spouse was honorably discharged or separated under honorable conditions; and

(3) The licensee meets the requirements for license renewal required by section 4723.24 of the Revised Code.

(C) An advanced practice registered nurse, as defined in paragraph (A) of rule 4723:8-01 of the Administrative Code, who submits a renewal application after September fifteenth or later, or whose license lapsed, due to the licensee’s service in the armed
forces, shall be eligible for renewal and reinstatement without payment of the late application fee required by division (A)(10) of section 4723.08 of the Revised Code, and the reinstatement fee required by division (A)(15) of section 4723.08 of the Revised Code, if the following are met:

(1) The licensee presents the board with satisfactory evidence that, not more than six months prior to the date the evidence is submitted to the board, the licensee was honorably discharged or separated under honorable conditions;

(2) The licensee is not suffering a mental or physical impairment that may affect the individual's ability to provide safe care; and

(3) The licensee meets the requirements for license renewal required by section 4723.42 of the Revised Code.

(D) An advanced practice registered nurse, who submits a renewal application after September fifteenth or later, or whose license lapsed, due to the licensee's spouse's service in the armed forces, shall be eligible for renewal and reinstatement without payment of the late application fee required by division (A)(10) of section 4723.08 of the Revised Code, and the reinstatement fee required by division (A)(15) of section 4723.08 of the Revised Code, if the following are met:

(1) The licensee presents the board with satisfactory evidence that the licensee did not renew their certificate because their spouse's military service caused them to be absent from the state of Ohio;

(2) The licensee presents the board satisfactory evidence that, not more than six months prior to the date the evidence is submitted to the board, the licensee's spouse was honorably discharged or separated under honorable conditions; and

(3) The licensee meets the requirements for license renewal required by section 4723.42 of the Revised Code.

(E) A dialysis technician certificate holder, who submits a renewal application on March first or later, or whose certificate lapsed, due to the holder's service in the armed forces, shall be eligible for renewal and reinstatement without payment of the late application fee required by division (A)(10) of section 4723.08 of the Revised Code, and the reinstatement fee required by division (A)(15) of section 4723.08 of the Revised Code, if the following are met:

(1) The certificate holder presents the board with satisfactory evidence that, not
more than six months prior to the date the evidence is submitted to the board, the certificate holder was honorably discharged or separated under honorable conditions;

(2) The certificate holder is not suffering a mental or physical impairment that may affect the individual's ability to provide safe care; and

(3) The certificate holder meets the requirements for certificate renewal required by section 4723.77 of the Revised Code and rule 4723-23-05 of the Administrative Code.

(F) A dialysis technician certificate holder, who submits a renewal application on March first or later, or whose certificate lapsed, due to the holder's spouse's service in the armed forces, shall be eligible for renewal and reinstatement without payment of the late application fee required by division (A)(10) of section 4723.08 of the Revised Code, and the reinstatement fee required by division (A)(15) of section 4723.08 of the Revised Code, if the following are met:

(1) The certificate holder presents the board with satisfactory evidence that the certificate holder did not renew their certificate because their spouse's military service caused them to be absent from the state of Ohio;

(2) The certificate holder presents the board satisfactory evidence that, not more than six months prior to the date the evidence is submitted to the board, the certificate holder's spouse was honorably discharged or separated under honorable conditions; and

(3) The certificate holder meets the requirements for license renewal required by section 4723.77 of the Revised Code and rule 4723-23-05 of the Administrative Code.

(G) A community health worker certificate holder, who submits a renewal application on April first or later, or whose certificate lapsed due to the holder's service in the armed forces shall be eligible for renewal and reinstatement without payment of the late application fee required by paragraph (C) of rule 4723-26-04 of the Administrative Code and division (A)(10) of section 4723.08 of the Revised Code, and the reinstatement fee required by paragraph (H)(2) of rule 4723-26-04 of the Administrative Code and division (A)(15) of section 4723.08 of the Revised Code if the following conditions are met:

(1) The certificate holder presents the board with satisfactory evidence that, not more than six months prior to the date the evidence is submitted to the board,
the certificate holder was honorably discharged or separated under honorable conditions; and

(2) The certificate holder is not suffering a mental or physical impairment that may affect the individual's ability to provide safe care.

(H) A community health worker certificate holder, who submits a renewal application on April first or later, or whose certificate lapsed, due to the holder's spouse's service in the armed forces shall be eligible for renewal and reinstatement without payment of the late application fee required by paragraph (C) of rule 4723-26-04 of the Administrative Code and division (A)(10) of section 4723.08 of the Revised Code, and the reinstatement fee required by paragraph (H)(2) of rule 4723-26-04 of the Administrative Code and division (A)(15) of section 4723.08 of the Revised Code, if the following are met:

(1) The certificate holder presents the board with satisfactory evidence that the holder did not renew their certificate because their spouse's military service caused them to be absent from the state of Ohio;

(2) The certificate holder presents the board satisfactory evidence that, not more than six months prior to the date the evidence is submitted to the board, the holder's spouse was honorably discharged or separated under honorable conditions; and

(3) The certificate holder meets the requirements for certificate renewal required by section 4723.85 of the Revised Code.

(I) A medication aide certificate holder who submits a renewal application after March first, or whose certificate lapsed due to the holder's service in the armed forces shall be eligible for renewal and reinstatement by paying the renewal fee set forth in paragraph (A)(2) of rule 4723-27-10 of the Administrative Code without payment of the late application fee set forth in paragraph (A)(3) of rule 4723-27-10 of the Administrative Code and division (A)(10) of section 4723.08 of the Revised Code or the reinstatement fee specified in paragraph (A)(4) of rule 4723-27-10 of the Administrative Code, if the following conditions are met:

(1) The certificate holder presents the board with satisfactory evidence that not more than six months prior to the date the evidence is submitted to the board, the certificate holder was honorably discharged or separated under honorable conditions; and

(2) The certificate holder is not suffering a mental or physical impairment that may
affect the individual's ability to provide safe care.

(J) A medication aide certificate holder who submits a renewal application after March first, or whose certificate lapsed, due to the holder's spouse's service in the armed forces shall be eligible for renewal and reinstatement without payment of the late application fee required by paragraph (C) of rule 4723-27-05 of the Administrative Code and division (A)(10) of section 4723.08 of the Revised Code, and the reinstatement fee required by paragraph (I)(2) of rule 4723-27-05 of the Administrative Code and division (A)(15) of section 4723.08 of the Revised Code, if the following are met:

(1) The certificate holder presents the board with satisfactory evidence that the holder did not renew their certificate because their spouse's military service caused them to be absent from the state of Ohio;

(2) The certificate holder presents the board satisfactory evidence that, not more than six months prior to the date the evidence is submitted to the board, the holder's spouse was honorably discharged or separated under honorable conditions; and

(3) The certificate holder meets the requirements for certificate renewal required by rule 4723-27-05 of the Administrative Code and section 4723.651 of the Revised Code.
Military duty time extension and factors to be considered.

(A) Upon receipt of an application from a licensed nurse, dialysis technician, certified community health worker, or medication aide that is accompanied by proper documentation certifying that the individual has been called to active duty during a current or prior reporting period, and certifying the length of that active duty, the individual shall receive an extension of the current continuing education reporting period equal to the total number of months spent in active duty during the current reporting period. For purposes of this rule, any portion of a month served on active duty shall be considered one full month.

(B) In determining whether the requirements of this chapter are met, the board shall consider relevant education, training, or service completed by a licensee or certificate holder as a member of the armed forces.
General information.

(A) For the purpose of this chapter of the Administrative Code:

(1) "Days" means calendar days.

(2) "Board hearing committee" means a standing committee of not less than three board members, appointed by the board at a public meeting, to conduct administrative hearings and provide a report and recommendation to the board as set forth in rule 4723-16-13 of the Administrative Code.

(3) "Hearing examiner" means the attorney appointed by the board to conduct a hearing pursuant to section 119.09 of the Revised Code.

(4) "Respondent" means the person who is requesting or has requested a hearing as provided in Chapter 119. of the Revised Code.

(5) "Representative of record" means the respondent or legal counsel for respondent who has filed a notice of appearance in accordance with rule 4723-16-02 of the Administrative Code or the assistant attorney general representing the state of Ohio.

(6) "Telecommunication" means communication by telephone conference or videoconference.

(B) The compilation of all time periods set forth in this chapter of the Administrative Code shall be in accordance with section 1.14 of the Revised Code.

(C) Procedures for filing, or mailing a motion or notice related to a board hearing shall comply with the following:

(1) Any notice specifying the date, time, and place for a hearing mailed by the board shall be mailed by certified mail, or regular mail with a certificate of mailing, to respondent and, if applicable, respondent's representative of record.

(2) The mailing date of any document mailed by the board, including but not limited to, a notice of opportunity or adjudication order, shall be the date appearing on the certified mail receipt or certificate of mailing.

(3) A document is filed with the board when the document is received and time stamped at the board office located in Columbus, Ohio. Documents emailed
or faxed after normal board business hours will be time stamped as received by the board the following business day.

(4) A document may be filed by hand-delivery, mail, email or facsimile. If multiple copies of the same document are filed, only the first to be received by the board will be time stamped and retained by the board.

(D) A certified copy of a conviction, plea of guilty to, judicial finding of guilt, judicial finding of eligibility for pretrial diversion or similar program, or judicial finding of eligibility for intervention in lieu of conviction related to a felony or misdemeanor from a court of competent jurisdiction shall be conclusive proof of the commission of all elements of the felony or misdemeanor.

(E) The Ohio Rules of Evidence may be taken into consideration by the board, board hearing committee or the hearing examiner in determining the admissibility of evidence but shall not be controlling. The board, board hearing committee or hearing examiner may permit the use of electronic or photographic means for presentation of evidence.
Hearing representation and appearances.

(A) Respondents may be self represented or may be represented by an attorney, or attorneys, admitted to the practice of law in Ohio, and holding a current, active license to practice in Ohio.

(B) When respondent is represented by an attorney or attorneys, the attorney or attorneys each shall file a written notice of appearance with the board. The attorney or attorneys who have filed a notice of appearance with the board shall be considered by the board as the representative of record unless and until a written notice of withdrawal is filed with the board or until written notice of termination of representation is filed by respondent.

(C) A representative of record may present respondent's position, arguments, or contentions in writing rather than appearing in person at any hearing, provided the board has not subpoenaed respondent to appear at the hearing, and provided respondent has timely requested a hearing.

(D) Respondent is not required to appear in person at any hearing provided the board has not subpoenaed the respondent to appear at the hearing. For good cause shown, respondent may appear by telecommunication. Respondent's representative of record shall not be permitted to appear by telecommunication under any circumstance.

(E) The office of the attorney general shall identify one attorney from that office as the representative of record for purposes of service pursuant this chapter of the Administrative Code. Each assistant attorney general representing the board shall file his or her appearance in writing.

(F) Except as otherwise provided in Chapter 119. of the Revised Code, communications from the board, board hearing committee or hearing examiner shall be sent to the representative of record for each party.
Hearing continuances and motions for extensions of time.

(A) The board, board hearing committee, or hearing examiner may continue a hearing upon its or their own motion in order to more efficiently and effectively conduct its business, unless the circumstances establish that a continuance would not be in the interest of public safety.

(B) Upon written or oral motion of a representative of record, the board, board hearing committee or hearing examiner may continue the hearing. If a continuance is granted, the board, board hearing committee or the hearing examiner shall immediately establish a new hearing date unless otherwise agreed by the representatives of record.

(C) A hearing shall not be continued upon motion by a representative of record unless a showing of reasonable cause and due diligence is shown. Before granting a continuance, consideration shall be given to the harm to the public that may result from a delay in the proceedings.

(D) A motion for continuance filed by a representative of record fewer than five calendar days prior to the scheduled date of the hearing shall not be granted unless it is demonstrated that an extraordinary situation exists that could not have been anticipated and that would justify the granting of a continuance.

(E) Except as otherwise provided in Chapter 119. of the Revised Code or rules of the board, any motion or request for an extension of time in which to file a motion, brief, or objection, unless made upon the record at the hearing, shall be made in writing and filed with the board.

(F) No motion for an extension of time shall be granted by the board, board hearing committee or the hearing examiner unless:

1. The representative of record filing the motion makes a showing of reasonable cause and due diligence; and

2. If the extension of time will result in a delay in the proceedings, the representative of record can show that no harm to the public will result from the delay in the proceedings.

(G) In making a determination about harm to the public, the board, board hearing committee or the hearing examiner may consider whether the respondent holds an active license or certificate to practice in Ohio.

(H) If notice of opportunity for hearing has been given to respondent according to section
119.07 of the Revised Code, and respondent has timely requested a hearing, if respondent has failed to participate in prehearing conferences, or otherwise has failed to respond to the board hearing committee or hearing examiner, the hearing date shall not be continued based solely on the respondent's lack of participation or response.
4723-16-04  Motions.

(A) Except as otherwise provided in Chapter 119. of the Revised Code, any motion, unless made upon the record at a hearing or as an oral motion for continuance in accordance with rule 4723-16-03 of the Administrative Code, shall be in writing and filed with the board.

(B) A written motion shall state the relief sought and shall be accompanied by a memorandum stating the grounds for the motion and citing the authorities relied upon. A motion shall be made no later than fourteen days before the scheduled date of the hearing, unless one of the following applies:

(1) The case involves a summary suspension issued pursuant to section 4723.281 of the Revised Code; or

(2) The board, board hearing committee or hearing examiner expressly grants an exception.

(C) A response to a motion must be filed within ten days after service of a motion, or within the time frame established by the board, board hearing committee or hearing examiner. The party who made the original motion may reply to a response to a motion only with the permission of the board, board hearing committee or hearing examiner.

(D) The board, board hearing committee or hearing examiner shall issue a ruling on a written motion, after considering all memoranda and supporting documentation filed with the motion, in writing, and issue copies of the ruling to each representative of record. The board, board hearing committee or hearing examiner shall include in each written ruling a short statement setting forth the reason for the ruling.

(E) The ruling on all oral and written motions made at a hearing shall be included in the record of the hearing. The board, board hearing committee or hearing examiner may also take motions made during a hearing under advisement and issue a written ruling at a later time.

(F) Except as otherwise provided in this chapter or Chapter 119. of the Revised Code, rulings on all motions filed after the report and recommendation is issued are to be decided by the board.
Prehearing processes.

(A) Any representative of record may serve upon the opposing representative of record a written request for a list of witnesses and copies of proposed exhibits intended to be introduced at hearing. Except in the case of summary suspensions, the opposing representative of record shall supply a list and copies to the requesting representative within a reasonable time, but not less than fourteen days before the hearing date.

(B) In cases of summary suspensions, the exchange of lists of witnesses and proposed exhibits intended to be introduced at hearing shall be completed as soon as possible, but not less than three days before the hearing date.

(C) If a representative of record fails to comply with a request for, or scheduling order requiring the timely exchange of, a list of witnesses, expert witness reports, if any, or copies of proposed exhibits, the opposing representative of record may request, and, absent extraordinary circumstances, the board, board hearing committee or hearing examiner shall grant, a motion to exclude from the hearing the testimony and proposed exhibits that were the subject of request.

(D) Upon written motion of any representative of record or upon the initiative of the board, board hearing committee or the hearing examiner, the board, board hearing committee or hearing examiner shall issue a scheduling order that may include but need not be limited to:

(1) A schedule for exchange of proposed hearing exhibits;

(2) A schedule for identifying lay and expert witnesses; and

(3) A schedule for the exchange of written reports, if any, from expert witnesses.

(E) If expert witness testimony is proposed, the expert may submit a written report. A written report by an expert shall set forth the opinions that the expert will testify about and the basis for the opinions. In order to be admitted as evidence at hearing, the written report must be provided to the opposing representative of record not less than thirty days before the hearing date. The expert may also testify as a fact witness.

(F) At any time before a hearing, with or without motion from a representative of record, the board, board hearing committee or hearing examiner may schedule a prehearing conference. The conference may be in person or by telecommunication. No witness testimony shall be taken during a prehearing conference. A prehearing conference may be held for reasons including but not limited to:
(1) Settlement negotiation;

(2) Identification of issues;

(3) Obtaining stipulations and admissions;

(4) Agreements limiting the number of witnesses;

(5) Discussion of proposed exhibits and witness lists;

(6) Estimating the time necessary for the hearing; and

(7) Discussion of any other matter tending to expedite the proceedings.

(G) The board, board hearing committee or hearing examiner may issue orders related to preparation for the hearing and the conduct of the hearing that facilitate the just and efficient disposition of the subject of the hearing. Orders may include, but are not limited to, requirements that by a date specified, a party or both parties submit:

(1) Legal briefs regarding the relevancy of proposed testimony or evidence;

(2) Legal briefs regarding a point of law; or

(3) Written opening statements and closing arguments.

(H) Any document that is a patient record or that contains information that is required to be kept confidential according to any state or federal law may, for purposes of the administrative hearing only, be provided to a representative of record or to a witness in the proceeding, but shall not be disseminated to any other person unless the confidential information is redacted.
Witnesses.

(A) A witness may be accompanied and advised by legal counsel. Participation by counsel for a witness other than the respondent, shall be limited to the protection of that witness's rights. The legal counsel shall neither examine nor cross-examine any witness.

(B) Pursuant to section 119.09 of the Revised Code, the board may institute contempt proceedings or file a motion to compel if a witness refuses to answer a question ruled proper at a hearing or disobeys a subpoena.

(C) A representative of record may move for, or the hearing examiner or board hearing committee may order, a separation of witnesses at the hearing.

(D) Each witness who appears before the board in response to a subpoena shall receive the fees and mileage provided for under section 119.094 of the Revised Code.

(E) For purposes of efficiency, the hearing examiner or board hearing committee may order that witnesses be called to testify out of order, by telecommunication, or by deposition.
Evidence or factors to be considered by the board.

(A) The board, board hearing committee or hearing examiner shall admit evidence of any prior action taken by the board against respondent. The evidence shall include a copy of the board adjudication order, including all records incorporated within the order, and the notice of opportunity for hearing, or a copy of any consent agreement entered between the board and respondent, including all records incorporated within the consent agreement. The board, board hearing committee or hearing examiner may admit other records related to prior board action against respondent if the evidence offered is:

(1) To prove notice to respondent that particular conduct was unacceptable;

(2) To prove a continuing problem justifying harsher discipline than might otherwise be warranted in the case;

(3) To demonstrate respondent's disregard for compliance with the laws regulating the practice of nursing or for the actions of the board; or

(4) For purposes of impeachment.

(B) When making a decision regarding disciplinary action, the board shall consider:

(1) Prior action taken by the board against respondent;

(2) Respondent's prior completion of the alternative program for substance use disorder, chemical dependency, as set forth in paragraph (C) of rule 4723-6-04 of the Administrative Code, or prior completion of the practice intervention and improvement program, as set forth in paragraph (E) of rule 4723-18-09 of the Administrative Code.

(C) When making a decision regarding disciplinary action, the board may consider factors including, but not limited to, the following:

(1) Whether the act is willful, intentional, irresponsible, or unintentional;

(2) Whether the respondent failed to cooperate with the board investigation;

(3) Whether the respondent provided false, misleading or deceptive information to the board or board staff;

(4) The frequency of occurrence of the act at issue;
(5) Whether the act represents a pattern of commissions or omissions;

(6) The outcome of the actions of a licensee or certificate holder; or

(7) The level of harm or potential harm to a patient.
4723-16-08 Subpoenas for purpose of hearing.

(A) Upon written request, filed at least thirty-four days before the hearing date, the board shall issue a subpoena for purposes of hearing to compel the attendance and testimony of a witness, or production of books, records or papers, at the hearing. The board, board hearing committee or hearing examiner may approve a subpoena request filed less than thirty days before the hearing date only upon a showing by the requestor of good cause for the short time frame.

(B) Each subpoena request shall specify the name and address of the individual to be served, or the books, records or papers to be produced and name and address of the person who is to appear at the hearing to produce the books, records or papers. The board shall not be responsible for determining the address of any individual named in a subpoena.

(C) Unless a subpoena is challenged as described in paragraph (E) of this rule, the board shall issue each subpoena requested within fourteen days of request. Subpoenas shall be directed to the sheriff of the county where the witness resides and returned in the same manner as a subpoena in a criminal case, as specified in section 119.09 of the Revised Code.

(D) Upon agreement of the parties, the board, board hearing committee or hearing examiner may approve an alternative means of obtaining a witness’s testimony, including, but not limited to, affidavit, deposition or testimony by telecommunication.

(E) Upon written motion filed according to rule 4723-16-04 of the Administrative Code, the board, board hearing committee or hearing examiner may order any subpoena quashed or modified for good cause shown. Good cause may be shown for reasons including but not limited to:

1. The total number of subpoenas requested by a party is unreasonable and a showing of necessity has not been made;

2. A subpoena does not provide a reasonable time to comply;

3. A subpoena requires disclosure of information that is privileged or confidential under law and no exception or waiver applies;

4. A subpoena for books, records or papers does not specify dates or time frames or specifies dates or time frames that are unreasonable or not relevant to the incidents described in the notice of opportunity for hearing; or
(5) A subpoena subjects a witness to undue burden. For purposes of this rule, the board, board hearing committee or hearing examiner may approve an alternative means of obtaining a witness's testimony, including but not limited to, affidavit, deposition, or testimony by telephone or other means of telecommunication. If no reasonable means can be used to alleviate an undue burden on a witness, the board, board hearing committee or hearing examiner may quash the subpoena. A finding of an undue burden requires the showing of an extraordinary hardship that is more than the usual and expected inconvenience of attending a hearing. In considering whether a burden is undue, the board, board hearing committee or hearing examiner shall consider the magnitude of the burden on the witness and the materiality of the witness's testimony.

(F) In the event the number of subpoenas requested appears to be unreasonable, the board hearing committee or hearing examiner may require a showing of necessity for the witnesses or records, and in the absence of such showing, may limit the number of subpoenas.

(G) At any point after a hearing has begun, the board, board hearing committee or hearing examiner may order that a subpoena be issued to compel the attendance and testimony of a witness or production of books, records or papers.
4723-16-09  Ex parte communication.

(A) No representative of record shall communicate with a board member or hearing examiner concerning a pending adjudication without the participation of the opposing representative of record, unless the communication relates solely to a procedural matter.

(B) No board member or hearing examiner shall engage in communication with or on behalf of any representative of record without the participation of the opposing representative of record, unless the communication relates to a procedural matter.

(C) A board member or hearing examiner shall disclose to the representatives of record and members of the board, any communication or attempted communication that appears to violate paragraph (A) or (B) of this rule. Such disclosure shall be made prior to the completion of deliberations on the pending adjudication.
Settlements.

(A) Any matter that is the subject of an investigation may be settled at any time by the board.

(B) A settlement shall be authorized on behalf of the board by the supervising member for disciplinary matters. In cases assigned for hearing, the parties may inform the board hearing committee or the hearing examiner that a settlement has been reached in lieu of proceeding with the hearing, and the board hearing committee or hearing examiner may continue the hearing pending ratification of the agreement by the board.

(C) A settlement agreement shall be in writing and shall be submitted for ratification to the board.

(D) A settlement agreement shall not be effective until the agreement is ratified by the board and signed by respondent, respondent's legal counsel, in any, and the president of the board.
4723-16-12  Request to address the board regarding a hearing.

(A) A representative of record may be permitted to address the board at the time of the board’s consideration of the report and recommendation, provided that prior to addressing the board, the representative of record has filed a written request with the board not less than seven days before the board meeting.

(B) If a representative of record addresses the board, the opposing representative of record shall also be given an opportunity to address the board. The representative of record who submitted a request to address the board first shall make the initial presentation before the board, and if both parties submit a request on the same date, the respondent of record for the state of Ohio shall make the initial presentation.

(C) Each representative of record who addresses the board shall be given not more than seven minutes in which to do so. The representative of record may request that time for rebuttal be deducted from their allotted time.
Authority and duties of board hearing committee or hearing examiners.

(A) Adjudication hearings may be conducted before the board, a board hearing committee or a hearing examiner appointed by the board.

(B) The hearing examiner shall be licensed to practice law in Ohio and may be an employee of the board or an independent contractor.

(C) The board hearing committee shall be composed of at least three board members, and one or more alternates, appointed by the board at a public meeting, to serve for a term of one year. One board hearing committee member shall preside and be responsible for conduct of the hearing. The presiding board member shall also be responsible for approving the report and recommendation discussed in paragraph (H) of this rule. The board hearing committee may request advice on legal questions from a staff attorney employed by the board, or an attorney with whom the board contracts as a hearing examiner, related to procedural or evidentiary questions or in preparation of the report and recommendation. This legal consultation shall not be deemed an ex parte communication.

(D) All hearings shall be open to the public, but the board hearing committee or hearing examiner conducting a hearing may close the hearing to the extent necessary to protect compelling interests or to comply with statutory requirements. In the event this occurs, the board hearing committee or hearing examiner shall state on the public record the reasons for closing the hearing.

(E) If the hearing examiner or board hearing committee determines that permitting broadcasting, televising, recording or the taking of photographs in the hearing room would not distract participants, impair the dignity of the proceedings, violate patient confidentiality or otherwise materially interfere with the achievement of a fair administrative hearing, the broadcasting, televising, recording or taking of photographs during hearing proceedings open to the public may be permitted under the following conditions and upon request:

(1) Requests for permission for the broadcasting, televising, recording or taking of photographs in the hearing room shall be made in writing and submitted to the hearing examiner or board hearing committee prior to the start of the hearing, and shall be made part of the record of the proceedings;

(2) Written permission is granted prior to the start of the hearing by the hearing examiner or board hearing committee and is made part of the record of the proceedings;

(3) The filming, videotaping, recording or taking of photographs of witnesses who
object shall not be permitted; and

(4) Any film, video, photograph or audio recording created during a hearing, except for an audio recording made by the court reporter hired by the board to prepare the stenographic hearing record, shall not be part of the record of the proceeding.

(F) The board hearing committee or hearing examiner shall conduct hearings so as to prevent unnecessary delay, maintain order and ensure the development of a clear record. The authority of the board hearing committee or hearing examiner conducting a hearing includes, but is not limited to, the following:

(1) Administering oaths or affirmations;

(2) Ordering that subpoenas be issued or that depositions in lieu of live testimony be conducted;

(3) Examining witnesses and directly witnesses to testify;

(4) Making rulings on admissibility of evidence;

(5) Making rulings on procedural motions, whether such motions are oral or written;

(6) Holding prehearing conferences, as discussed in rule 4723-16-05 of the Administrative Code;

(7) Requesting briefs, before, during or after a hearing;

(8) Issuing scheduling orders for exchange of documents and filing deadlines;

(9) Determining the order of the hearing;

(10) Requiring or disallowing oral or written opening statements and closing arguments;

(11) Consolidating two or more matters involving the same respondent into one hearing;
(12) Preparing entries, proposed findings, and reports and recommendations to the board, as discussed in paragraph (H) of this rule; and

(13) Based upon a conflict in schedule, complexity of the issues involved, or for reasons of administrative efficiency, the board hearing committee may reassign the matter to a hearing examiner, or a hearing examiner may reassign to another hearing examiner or to the board hearing committee.

(G) The board hearing committee or hearing examiner may recommend in the report and recommendation that factual or legal allegations set forth in the notice of opportunity for hearing issued to respondent be dismissed, however, the authority of the board hearing committee or hearing examiner does not include authority to grant motions for dismissal of, or to otherwise dismiss, factual or legal allegations, or to modify, compromise or settle factual or legal allegations.

(H) Within one hundred twenty days of the date an adjudication hearing is closed, the board hearing committee or hearing examiner assigned to the case shall submit a written report to the board setting forth the proposed findings of fact and conclusions of law, or in the case of the board hearing committee, conclusions, and a recommendation of action to be taken by the board. A copy of the written report shall be mailed by certified mail to representatives of record for both parties. Either party may, within ten days of receipt of the report and recommendation, file written objections. Written objections, if filed in a timely manner, shall be considered by the board in determining whether to approve, modify or reject the report and recommendation.

(I) At a board meeting scheduled after the time for filing objections to a report and recommendation has passed, the board may approve, modify or reject the report and recommendation of the board committee or hearing examiner. Members of the board hearing committee that heard a case shall abstain from voting on a matter heard as members of the board hearing committee.
Definitions.

For the purposes of this chapter, the following definitions shall apply:

(A) "Adult" means anyone who is eighteen years of age or older.

(B) "Antibiotic" means a medication, including an anti-infective or anti-fungal, administered to inhibit the growth of, or destroy, microorganisms in the treatment or prevention of infectious disease.

(C) "Direction" means communication of a plan of care, based upon assessment of the client/patient by the registered nurse, or licensed physician, dentist, optometrist, or podiatrist, that establishes the parameters for providing care or performing a procedure. Unless otherwise provided by law, the registered nurse, or licensed physician, dentist, optometrist, or podiatrist shall be available on site to assess and evaluate the client/patient's response to the plan of care.

(D) "Initiate" means to start or to begin.

(E) "Maintain" means to administer or regulate an intravenous infusion according to the prescribed flow rate.

(F) "Piggyback" means an intermittent or secondary intravenous infusion.

(G) "OBN Approver" has the same meaning as in paragraph (4)(N) of rule 4723-14-01 of the Administrative Code.
Intravenous therapy procedures.

(A) Except as provided in paragraph (B) of this rule, a licensed practical nurse shall not perform any of the following intravenous therapy procedures:

(1) Initiate or maintain any of the following:

(a) Blood or blood components;

(b) Solutions for total parenteral nutrition;

(c) Cancer therapeutic medications including, but not limited to, cancer chemotherapy or an anti-neoplastic agents;

(d) Investigational or experimental medications;

(e) Solutions administered through any central venous line or arterial line or any other line that does not terminate in a peripheral vein, except as provided in paragraph (B)(1) of this rule;

(f) An intravenous piggyback infusion, except as provided in paragraph (B)(3) of this rule.

(2) Discontinue a central venous, arterial, or any other line that does not terminate in a peripheral vein;

(3) Initiate or discontinue a peripherally inserted central catheter, or any catheter that is longer than three inches;

(4) Program or set any function of a patient controlled analgesic;

(5) Mix, prepare or reconstitute any medication for intravenous therapy, except as provided in paragraph (B)(4) of this rule;

(6) Administer medications by an intravenous route, except as provided in paragraph (B)(3) of this rule;

(7) Inject medications by a direct intravenous route, except as provided in paragraph (B)(5) of this rule;

(8) Change tubing on an arterial line, a central venous line, or on any line that does
not terminate in a peripheral vein;

(9) Change an intermittent infusion device, unless the tip of the connected intravenous catheter terminates in a peripheral vein.

(B) A licensed practical nurse authorized by the board to perform intravenous therapy procedures, may perform the following procedures only for individuals aged eighteen or older and only when directed to do so by a licensed physician, dentist, optometrist, podiatrist, or registered nurse in accordance with section 4723.18 of the Revised Code:

(1) Administer the following solutions, or combinations of the solutions, through a venous line:

(a) Five per cent dextrose and water;

(b) Five per cent dextrose and lactated ringers;

(c) Five per cent dextrose and normal saline;

(d) Normal saline;

(e) Lactated ringers;

(f) 0.45 per cent sodium chloride and water;

(g) 0.2 per cent sodium chloride and water; or

(h) 0.3 per cent sodium chloride and water.

(2) Administer any of the solutions set forth in paragraph (B)(1) of this rule that contain vitamins or electrolytes after a registered nurse initiates the first infusion of the solution containing vitamins or electrolytes.

(3) Initiate or maintain an intermittent or secondary intravenous infusion containing an antibiotic;

(4) Prepare or reconstitute an antibiotic additive to be administered through an intravenous infusion;
(5) Inject heparin or normal saline to flush an intermittent infusion device or heparin lock, including, but not limited to, bolus or push;

(6) Change tubing on an intermittent infusion device and on an intravenous line if the line terminates in a peripheral vein;

(7) Place a venous access catheter, no longer than three inches in length, in the hand, forearm or antecubital space, followed by the placement of a saline or heparin lock, either for purposes of intermittent infusions, or to initiate infusions of any of the solutions set forth in paragraph (B)(1) of this rule; or

(8) Stop an infusion of blood or blood component, or turn off the function of a patient-controlled analgesic device when a complication arises.

(C) A licensed practical nurse authorized by the board to perform intravenous therapy procedures may perform the procedures set forth in paragraph (B) of this rule only if one of the following requirements are met:

(1) The licensed practical nurse is directed to perform intravenous therapy by a licensed physician, dentist, optometrist, or podiatrist who is present and readily available at the facility where the intravenous therapy procedure is performed;

(2) The licensed practical nurse is directed to perform intravenous therapy by a registered nurse who has personally performed an on-site assessment of the individual to receive intravenous therapy, and that registered nurse or another registered nurse is readily available at the site where the intravenous therapy procedure is performed; or

(3) If the intravenous therapy procedures are performed in a home as defined in section 3721.01 3721.40 of the Revised Code, or in an intermediate care facility for individuals with intellectual disabilities as defined in section 5124.01 of the Revised Code, a registered nurse who directs the authorized licensed practical nurse to perform intravenous therapy is either:

(a) On the premises of the home or facility; or

(b) Accessible by some form of telecommunication.

(D) A licensed practical nurse may perform any of the intravenous therapy procedures specified in paragraph (E) of this rule without receiving authorization to perform
intravenous therapy from the board of nursing under section 4723.18 of the Revised Code, if both of the following apply:

(1) The licensed practical nurse acts at the direction of a registered nurse or a licensed physician, dentist, optometrist, or podiatrist and the registered nurse, physician, dentist, optometrist, or podiatrist is on the premises where the procedure is to be performed or accessible by some form of telecommunication; and

(2) The licensed practical nurse can demonstrate the knowledge, skills, and ability necessary to perform the procedure safely.

(E) The intravenous therapy procedures that a licensed practical nurse may perform in accordance with paragraph (D) of this rule are limited to the following:

(1) Verification of the type of peripheral intravenous solution being administered;

(2) Examination of a peripheral infusion site and the extremity for possible infiltration;

(3) Regulation of a peripheral intravenous infusion according to the prescribed flow rate;

(4) Discontinuation of a peripheral intravenous device at the appropriate time; and

(5) Performance of routine dressing changes at the insertion site of a peripheral venous or arterial infusion, peripherally inserted central catheter infusion, or central venous pressure subclavian infusion.
4723-17-05 Standards for intravenous therapy continuing education course personnel.

(A) An application for approval of a faculty-directed continuing education intravenous therapy course must demonstrate that the person submitting the continuing education course for approval:

(1) Holds a current, valid Ohio license as a registered nurse;

(2) Possesses a baccalaureate degree with a major in nursing;

(3) Has a minimum of two years experience in the practice of nursing as a registered nurse; and

(4) Has formal education or practical experience in adult education.

(B) Except as provided in paragraph (C) of this rule, the minimum faculty qualifications for teaching a continuing education course in intravenous therapy for a licensed practical nurse are:

(1) Completion of a board-approved registered nursing education program, or a registered nursing education program approved by another national council of state boards of nursing jurisdiction;

(2) A current, valid Ohio license to practice nursing as a registered nurse; and

(3) A minimum of two years experience in the practice of nursing as a registered nurse that includes substantial direct clinical experience in intravenous therapy.

(C) A licensed health care professional who is not a registered nurse may teach a portion of the intravenous therapy continuing education course provided:

(1) The licensed health care professional teaches at the direction of a registered nurse instructor; and

(2) The licensed health care professional teaches information that is consistent with the professional's educational preparation and licensed scope of practice.
Minimum curriculum requirements.

According to division (A)(4)(a) of section 4723.18 of the Revised Code, the minimum curriculum for a continuing education course in intravenous therapy, required by section 4723.19 of the Revised Code, for licensed practical nurses shall be a course that:

(A) Shall include is composed of a minimum of forty hours of instruction that includes, but is not limited to, the following components:

1. Policies and procedures of both the Ohio board of nursing and the employing agency relating to intravenous therapy and accountability and responsibility of the licensed practical nurse in the performance of limited intravenous therapy procedures;

2. Support and psychological preparation for the individual receiving intravenous therapy as well as the family members and significant others;

3. Anatomy and physiology of the peripheral veins used for venipuncture;

4. Procedure for venipuncture, collection of equipment, site selection, palpation of veins, and skin preparation;

5. Procedures for adding intravenous solutions to existing infusions, hanging intravenous solutions, changing intravenous tubing, performing intravenous dressing changes and flushing and converting peripheral intermittent infusion devices;

6. Relationships between intravenous therapy and the body's homeostatic and regulatory functions;

7. Signs and symptoms of local and systemic complications in the administration of fluids and guidelines for management of these complications as well as preventive measures;

8. Identification of various types of equipment used in administering intravenous therapy with content related to criteria for use of each and means of troubleshooting for malfunction;

9. Formulas used to calculate flow rate;

10. Principles and practices of prevention of disease transmission, as set forth in Chapter 4723-20 of the Administrative Code, and as related to intravenous
therapy;

(11) Glossary of common terminology pertinent to intravenous therapy;

(12) Documentation of intravenous therapy procedures;

(13) Demonstration of successful application of knowledge and skills to clinical practice by skills testing at least all of the components included in paragraphs (A)(8) and (A)(9) of this rule.

(14) A review of Chapter 4723. of the Revised Code and the rules of the board with respect to the role, accountability, and responsibility of the licensed practical nurse in intravenous therapy;

(15) Anatomy and physiology of the cardiovascular system as related to homeostasis;

(16) Anatomy and physiology of the respiratory system as related to homeostasis;

(17) Signs and symptoms of local and systemic complications in the administration of antibiotics;

(18) Guidelines for the management of complications arising from the intravenous administration of antibiotics;

(19) Procedures for reconstituting and administering intravenous antibiotics via piggyback that include, but are not limited to, pharmacology, compatibilities, and flow rates;

(20) Procedures for maintaining a central line for infusing only the solutions specified in section 4723.18 of the Revised Code;

(21) A review of prohibited practices as set forth in section 4723.18 of the Revised Code; and

(22) A review of the role of the registered nurse, licensed physician, dentist, optometrist, or podiatrist who is directing the licensed practical nurse to perform an intravenous therapy procedure with reference to how the role may differ depending upon the setting in which the intravenous therapy is being provided.
(B) Provides an opportunity to the nurses to develop proficiency in limited intravenous therapy procedures and related nursing care. Practice of all skill components and skills testing shall be done in either supervised clinical practice or while supervised in the laboratory.
Proof of completion of an approved course in intravenous therapy.

[Comment: Information regarding the availability and effective date of the materials incorporated by reference in this rule can be found in paragraph (G) of rule 4723-1-03 of the Administrative Code.]

(A) In order to be approved or reapproved as a faculty-directed intravenous therapy continuing educational activity, in addition to the requirements contained in Chapter 4723-14 of the Administrative Code, an applicant for approval, or a provider seeking re-approval, shall have and implement written policies addressing the following:

(1) The level of achievement that a nurse must maintain in order to successfully complete the course in intravenous therapy and to obtain proof of completion of the course;

(2) Periodic evaluation of the nurse's progress in the course by an instructor of the course;

(3) A testing component that measures a nurse's competency related to intravenous therapy;

(4) A process for issuing a certificate of completion to nurses who have successfully completed the approved intravenous therapy course; and

(5) Submission of an "Application to Perform IV Therapy in Ohio as a LPN and Certification of CE Course Completion" to the board, on a form provided by the board located at https://www.nursing.ohio.gov/forms.htm (revised 2013), of documentation documenting each nurse's completion of the approved intravenous therapy course.

(B) Upon receiving satisfactory documentation that a licensed practical nurse has successfully complete an approved intravenous therapy course, the board shall approve such nurse as authorized to provide intravenous therapy.

(C) When a licensed practical nurse who has been licensed by endorsement in Ohio provides documentation satisfactory to the board of having successfully completed an intravenous therapy course in another state that substantially meets the requirements of this chapter, the board may approve such nurse as authorized to provide intravenous therapy. The board may require, prior to approval, that the nurse successfully complete a continuing education activity that includes course content covering Chapter 4723- of the Revised Code, and the rules of the board related to the role, accountability and responsibility of the licensed practical nurse.
in intravenous therapy.
Purpose of nurse education grant program.

The board shall award grants to nurse education programs that have partnerships with health care facilities, community health agencies, patient centered medical homes or other education programs to establish or support partnerships that will increase the enrollment capacity of the nurse education programs. Methods of increasing a program's enrollment capacity may include hiring faculty and instructional personnel or purchasing educational equipment and materials if the grant applicant can clearly demonstrate that additional faculty and instructional personnel, or equipment and materials, are directly related and necessary to increasing the enrollment capacity of the nurse education program.
For purposes of this chapter, the following definitions apply:

(A) "Nurse education program" means a prelicensure nurse education program approved by the board of nursing under section 4723.06 of the Revised Code, or a postlicensure nurse education program approved by the board of regents under section 3333.04 of the Revised Code.

(B) "Health care facility" means:

(1) A hospital registered under section 3701.07 of the Revised Code;

(2) A nursing home licensed under section 3721.02 of the Revised Code, or by a political subdivision certified under section 3721.09 of the Revised Code;

(3) A county home or a county nursing home as defined in section 5155.31 of the Revised Code that is certified under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, amended;

(4) A freestanding dialysis center;

(5) A freestanding inpatient rehabilitation facility;

(6) An ambulatory surgical facility;

(7) A freestanding cardiac catheterization facility;

(8) A freestanding birthing center;

(9) A freestanding or mobile diagnostic imaging center;

(10) A freestanding radiation therapy center.

(C) "Partnership" means a written agreement between a nurse education program and one or more health care facilities, community health agencies, patient centered medical homes or other education programs, that is signed by the legal signatory for each party and that shows how the partnership will increase the enrollment capacity of the nurse education program or programs.

(D) "Community health agency" means any program or agency that provides or contracts to provide health care services and is not a health care facility as defined in
paragraph (B) of this rule.

(E) "Board" means the Ohio board of nursing.

(F) "Nurse education grant program" means the program established in division (B) of section 4723.063 of the Revised Code.

(G) "Faculty and instructional personnel" means:

(1) For prelicensure nursing education programs, persons who satisfy the standards for faculty and instructional personnel as set forth in rules 4723-5-10 and 4723-5-11 of the Administrative Code; or

(2) For postlicensure nursing education programs, persons who satisfy standards established by the credentialing organization that accredits the program in accordance with paragraph (H) of this rule.

(H) "Education program" means a program approved or accredited by any of the following:

(1) The Ohio board of nursing under section 4723.06 of the Revised Code;

(2) The Ohio board of regentschancellor of higher education under section 3333.04 of the Revised Code;

(3) The Ohio department of education under section 3313.90 of the Revised Code;

(4) The state board of career colleges and schools under section 3332.05 of the Revised Code;

(5) The higher learning commission of the north central association of colleges and schools;

(6) The accrediting council for independent colleges and schools; or

(7) Any other national or regional post-secondary education accreditation entity recognized by the board.

(I) "Grantee" means a nurse education program to which the board has awarded a grant
from the nurse education grant program.

(J) "Administrator of the program" has the same meaning as set forth in paragraph (A) of rule 4723-5-01 of the Administrative Code.

(K) "Patient centered medical home" is an advanced model of primary care in which care teams attend to the multifaceted needs of patients, providing whole person comprehensive and coordinated patient centered care.

(L) "Preceptor" has the same meaning as set forth in paragraph (X)(CC) of rule 4723-5-01 of the Administrative Code.
4723-25-03  Fund balance.

The board may recommend that the office of budget and management retain a percentage of money, which the office of budget and management determines to be fiscally responsible, in the nurse education grant program fund that it maintains to accomplish the goals of the nurse education grant program established in section 4723.063 of the Revised Code.
Program administrative costs.

In accordance with division (D) of section 4723.063 of the Revised Code, no more than ten per cent of the nurse education grant program funds shall be used by the board for administrative costs associated with the program.
4723-25-05 Distribution of grants to prelicensure and postlicensure nurse education programs.

(A) Except as provided in paragraphs (B), (C), and (D) of this rule, nurse education grant program funds available for distribution in a two year grant cycle shall be distributed as follows:

(1) Approximately fifteen per cent of the available funds shall be awarded in grants to prelicensure education programs for licensed practical nurses approved by the board under section 4723.06 of the Revised Code, if the program allows students, following licensure as a licensed practical nurse, to transition into a registered nursing program approved by the board during the student's second year (a one plus one program);

(2) Approximately thirty five per cent of the available funds shall be awarded in grants to prelicensure education programs for registered nurses approved by the board under section 4723.06 of the Revised Code; and

(3) Approximately fifty per cent of the available funds shall be awarded in grants to postlicensure nurse education programs approved or accredited as described in paragraph (H) of rule 4723-25-02 of the Administrative Code, for the purpose of preparing nursing faculty or instructional personnel.

(B) The board has discretion to reallocate funds among one or more of the three grant categories set forth in paragraphs (A)(1) to (A)(3) of this rule to one or more other grant categories if no grant proposals are submitted in a category, if none of the proposals received in a category meet the funding criteria established in section 4723.063 of the Revised Code, or if funds remain in a category after all eligible grant applications have been considered by the board.

(C) A nurse education program may submit one grant proposal in each of the grant proposal categories set forth in paragraphs (A)(1) to (A)(3) of this rule for the same grant cycle.

(D) Grant awards shall not exceed two hundred thousand dollars per grant, per grant cycle.

(E) While no grant is guaranteed for renewal in subsequent grant periods, the board may elect to renew a grant approved for initial funding if both of the following conditions are met:

(1) A new grant proposal is submitted within the time frame for the next grant cycle; and
(2) The new proposal meets the standards contained in the request for proposals for the next grant cycle.

(F) Total awards to a nurse education program from each of the three grant categories set forth in paragraphs (A)(1) to (A)(3) of this rule shall not exceed one million dollars between January 2, 2014 and December 31, 2023.
Eligibility criteria for funding consideration.

[Comment: Information regarding the availability and effective date of the materials incorporated by reference in this rule can be found in paragraph (G) of rule 4723-1-03 of the Administrative Code.]

To be eligible for consideration to receive nurse education program grant funds, all of the following must be satisfied:

(A) Applicant is a nurse education program as defined in division (A)(2) of section 4723.063 of the Revised Code and this chapter;

(B) Applicant has entered into a partnership with one or more health care facilities, community health agencies, patient centered medical homes, or other education programs that will result in increased enrollment capacity in the applicant's nurse education program or programs;

(C) Applicant has submitted to the board a completed "NEGP R&P" form, discussed in rule 4723-25-09 of the administrative code, by the proposal deadline date a completed proposal on the form required by the board, located at http://www.nursing.ohio.gov/forms.htm (revised February 2013), that includes all of the information and attachments the board requires to evaluate the ability of the applicant to increase its enrollment capacity if the grant proposal is approved for funding.
Publication of notice for requests for proposals.

(A) Not less than thirty days prior to issuing a request for proposals, the board shall, by regular or electronic mail, provide notice of the issuance of a request for proposals to the administrator of all nurse education programs approved by the board under section 4723.06 of the Revised Code, or approved by the board of regents chancellor of higher education under section 3333.04 of the Revised Code.

(B) In addition to the notice required in paragraph (A) of this rule, the board shall also post notice of the issuance of the request for proposals on the board's website, distribute electronic notice to all persons included on the board's electronic subscriber list, and mail notice to any persons who do not have access to electronic mail but who have requested to be placed on a courtesy mailing list maintained by the board.
Grant cycles will begin on September first of odd number calendar years and extend for a period of two years, to August thirty-first of odd number years.
Grant proposal form.

[Comment: Information regarding the availability and effective date of the materials incorporated by reference in this rule can be found in paragraph (G) of rule 4723-1-03 of the Administrative Code.]

(A) Grant applicants proposing to submit a "NEGP RFP" form to be considered for the nurse education grant program on the form required by the board, located at http://www.nursing.ohio.gov/forms.htm (revised February 2013).

(B) Information to be provided in the proposal shall be consistent with the request for proposal issued by the board and shall at minimum include the following:

1. Specifics as to how the requested grant funds will allow the nurse education program to increase its enrollment capacity and the specific role to be played by the health care facility, community health agency, or other education program with which it has entered a partnership;

2. The name of the administrator of the program employed by, or under contract with, the nurse education program who will be principally responsible for the grant and his or her academic and professional credentials;

3. A projection of the amount that the nurse education program’s enrollment capacity will be increased as a result of the grant;

4. A detailed description of how the proposal is consistent with the standards for nurse education programs set forth in Chapter 4723-5 of the Administrative Code;

5. Any faculty or instructional personnel positions to be supported with funds from the grant and how they will directly contribute to increasing the enrollment capacity of the nurse education program;

6. Type and uses of any equipment requested to be leased or purchased with funds from the grant and how it will directly contribute to increasing the enrollment capacity of the nurse education program;

7. If an applicant is a postlicensure nursing education program, how it will increase the number of faculty and instructional personnel to serve as educators in nurse education programs;

8. How the program will maintain the increased enrollment capacity in a nurse education program following conclusion of the grant funding cycle;
(9) Other sources of funding, if any, that will be used to support efforts by the nurse education program and its partnership to increase the enrollment capacity of the program; and

(10) How grant funds will be accounted for separately from other sources of funding received by the nurse education program.

(C) Grant proposals that are received by the board after the proposal deadline date will not be considered for funding during the grant cycle for which they were submitted. A nurse education program submitting a late proposal may resubmit a grant request in a subsequent grant cycle according to standards set forth in the subsequent request for proposals.
Grant review.

The board may delegate its authority, as it deems appropriate, to a committee of the board and staff members of the board, to review grants and make recommendations for funding to the full board.
Grant review criteria.

(A) Grant awards shall be made at the sole discretion of the board according to section 4723.063 of the Revised Code and the rules contained in this chapter.

(B) Preference in the award of grants shall be given to partnerships between nurse education programs and the following:

(1) Hospitals registered under section 3701.07 of the Revised Code;

(2) Nursing homes licensed under section 3721.02 of the Revised Code, or by a political subdivision certified under section 3721.09 of the Revised Code;

(3) County homes or county nursing homes as defined in section 5155.31 of the Revised Code that are certified under Title XVIII or XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, amended; and

(4) Education programs as defined in paragraph (H) of rule 4723-25-02 of the Administrative Code.

(C) Preference in the award of grants may be given to those programs seeking grant renewal that have demonstrated success in meeting the nurse education grant program goal of increasing the enrollment capacity of the applicant nurse education program.

(D) Preference in the award of grants may be given to programs that have a pass rate on the applicable nurse licensure examination that averages ninety-five per cent or higher of the national average for first time candidates in any given year for three consecutive years prior to submission of the grant proposal.

(E) Preference in the award of grants may be given to postlicensure nursing education programs that have demonstrated success in training and preparing graduate level nurses to serve as nurse educators in Ohio nurse education programs.

(F) Grants shall be awarded to prelicensure education programs for licensed practical nurses only if the program allows students, following licensure as a licensed practical nurse, to transition into a registered nursing program approved by the board during the student's second year (a one plus one program).
Use of grant funds.

(A) Grant funds shall be used solely for purposes of increasing enrollment capacity in nurse education programs.

(B) Grant funds may be used to hire or contract with:

1. Prelicensure nurse education program faculty and instructional personnel whose role will be the active supervision of one or more nursing students in a clinical setting; or

2. Faculty or instructional personnel engaged in training and preparing graduate level nurses to serve as nurse educators in Ohio nurse education programs.

(C) Grant funds may be used for the lease or purchase of equipment only when it can be demonstrated that the equipment will be directly related to an increase in enrollment capacity at a nurse education program and only when the equipment will be leased or owned by the applicant nurse education program.

(D) Grant funds may be used as matching funds for other funding sources if both of the following are satisfied:

1. Use of the funds from the other funding sources is consistent with the goal of the nurse education grant program of increasing the enrollment capacity in the nurse education program; and

2. All grant requirements continue to be met.
4723-25-13  Prohibited uses of grant funds.

(A) Grant funds shall not be used for any of the following purposes:

(1) Administrative costs associated with the nurse education program, health care facility, community health agency, other education program, or partnership;

(2) The purchase of disposable items or disposable equipment;

(3) The purchase of personal items or equipment for students participating in a nurse education program;

(4) Costs associated with travel and lodging;

(5) Costs associated with meals and entertainment;

(6) Lease or purchase of vehicles;

(7) The construction or renovation of buildings;

(8) Liquidation of bad debts;

(9) Fines, penalties, interest, or other financial payments;

(10) The compensation of nurses who will be used as preceptors for prelicensure nursing education program students, except for the actual time a preceptor spends supervising no more than two nursing students at any one time in accordance with rule 4723-5-20 of the Administrative Code;

(11) The compensation of nurses who will be used as preceptors for postlicensure nursing education program students except for the actual time a preceptor spends supervising nursing students engaged in a clinical experience at the direction of faculty or instructional personnel of the nurse education program; or

(12) Student tuition assistance.

(B) Funds used for any purposes set forth in paragraph (A) of this rule must be repaid to the board within thirty days after the grantee is provided with notice of the board's determination that grant funds had previously been, or were currently being, used for purposes prohibited by this rule.
4723-25-14

Acknowledgment of terms.

(A) After receiving notification of approval of a grant proposal, the board and the nurse education program submitting the proposal shall execute a written agreement that contains the terms and conditions of the grant.

(B) This agreement, or acknowledgment of terms, shall be signed by the administrator of the nurse education program, or grantee, and by the board. The agreement may include but need not be limited to the following terms and conditions:

1) Method for advising the board regarding a change of circumstances that may significantly impact the grantee's ability to comply with the terms of the grant;

2) Method and schedule for disbursement of funds;

3) Special reporting requirements specific to an individual grant proposal;

4) Applicability of all relevant laws, regulations, and rulings; and

5) Grantee indemnification requirements.
4723-25-15 Grantee reporting requirements.

[Comment: Information regarding the availability and effective date of the materials incorporated by reference in this rule can be found in paragraph (G) of rule 4723-1-03 of the Administrative Code.]

(A) The administrator of a Each grantee nurse education program shall submit the following annual reports to the board according to the schedule determined by the board that identify how the grant funds were used to increase the enrollment capacity of the program for each year of the grant funding cycle. Annual reports shall comply with all of the following:

(1) "NEGP Annual Report Year 1", for the first year of the grant funding cycle be completed by the administrator of the program;

(2) "NEGP Annual Report Year 2" for the second year of the grant funding cycle be submitted on the form required by the board, located at https://www.nursing.ohio.gov/forms.htm (effective 2014); and

(3) Be according to the schedule determined by the board; and

(4)(3) "NEGP Quarterly Progress Report" form identify how the grant funds were used to increase the enrollment capacity of the program.

(B) In addition to the annual report required in paragraph (A) of this rule, the administrator of the grantee nurse education program shall submit progress reports or periodic supplemental reports on the forms required by the board, located at https://www.nursing.ohio.gov/forms.htm (effective 2014), and complete questionnaires or other documents during each year of the grant funding cycle as requested by the board.

(C)(B) At any time during the grant funding cycle the board may require that the grantee provide additional information or undergo an independent audit of the grant funds and how funds are being administered by the nurse education program or its partner health care facility, community health agency, or other education program.

(1) Any independent audits requested by the board shall be paid for by the grantee nurse education program.

(2) Grant funds shall not be used to pay the expenses of an independent audit requested by the board in accordance with this paragraph.

(D)(C) All grant funds shall be administered and accounted for using generally accepted accounting principles.
Reversion of funding.

(A) Grant recipients shall return to the board any unexpended grant funds that remain at the end of the grant period.

(B) Unexpended grant funds shall also be promptly returned to the board upon receipt of notice that any of the following have occurred:

1. The grantee has failed to spend the grant funds according to the grant proposal approved by the board;

2. The grantee has failed to comply with any provision included in the acknowledgment of terms as required by rule 4723-25-14 of the Administrative Code; or

3. The grantee no longer maintains its status as a nurse education program approved by the board under section 4723.06 of the Revised Code, or by the board of regents under section 3333.04 of the Revised Code.
Grantee programs, products, or publications.

Any special programs, products, or publications developed by the grantee nurse education program shall indicate that such program, product, or publication, was funded in whole or part by a grant from the Ohio board of nursing.
Annual grantee report.

The board shall make available on an annual basis, in print or by electronic means, a current list of nurse education grant program grantees together with the following information:

(A) The amount of the grant received by each grantee;

(B) The health care facility, community health agency, patient centered medical home or other education program with which the grantee nurse education program has partnered;

(C) The amount by which the enrollment capacity of the grantee nurse education program was projected to increase;

(D) The proposed use of the grant funds;

(E) The extent to which funding of the grant proposal has resulted in an increase in the enrollment capacity of the grantee nurse education program; and

(F) Such other information the board deems appropriate.
Definition of terms.

For the purpose of this chapter, the following definitions apply:

(A) "Administrator" means the individual who is administratively responsible for a community health worker training program.

(B) "Board" means the Ohio board of nursing.

(C) "Certificate to practice" means the certificate issued by the board in accordance with section 4723.85 of the Revised Code.

(D) "Clinical experience" means a task or activity planned to meet course objectives or outcomes and to provide community health worker students with the opportunity to practice cognitive, psychomotor, and affective skills related to the delivery of care by community health workers. This experience may take place in a community setting or other appropriate site.

(E) "Community health worker" and "certified community health worker" mean an individual who satisfies both of the following:

(1) As a community representative, advocates for clients in the community by assisting them in accessing community health and supportive resources through the provision of such services as education, role modeling, outreach, home visits, or referrals; and

(2) Holds a certificate to practice issued or renewed by the board under section 4723.85 of the Revised Code.

(F) "Continuing education" means a planned learning activity that builds upon a community health worker’s precertification education program and enables a community health worker to acquire or improve skills, knowledge or behavior that promotes professional or technical development or the enhancement of career goals and is approved by the board under Chapter 4723-14 of the Administrative Code.

(G) "Curriculum" means the standard minimum curriculum to be used in a board-approved training program for community health workers as provided in rule 4723-26-13 of the Administrative Code.

(H) "Delegation" means the transfer of responsibility for the performance of selected nursing tasks from a registered nurse to a community health worker.

(I) "Didactic" means the component of an educational program that includes lecture,
verbal instruction, or other means of exchanging theoretical information between instructor and students, typically in a classroom setting.

(J) "Inactive certificate" means the status of the certificate of an individual who has made a written request that the board place the certificate on inactive status. An individual with an inactive certificate does not hold a current, valid certificate.

(K) "Laboratory experience" means an activity planned to meet course objectives or outcomes and to provide a community health worker student with the opportunity to practice cognitive, psychomotor, and affective skills in the delivery of care, that takes place in a learning resource center or other appropriate location.

(L) "Lapsed certificate" means the status of a certificate of an individual who did not meet all of the requirements of certificate renewal and has not requested prior to the renewal deadline that the board place the certificate on inactive status.

(M) "Patient" means the recipient of a nursing task delegated by a registered nurse and may include an individual, group, or community.

(N) "Registered nurse" means an individual who holds a current, valid license issued under Chapter 4723. of the Revised Code that authorizes the practice of nursing as a registered nurse.

(O) "Representative of the board" means an employee of the board or an individual designated by the board to act on its behalf.

(P) "Site visit" means an announced or unannounced visit to a community health worker training program by a representative of the board to determine whether the program meets or maintains the minimum standards require by the board.

(Q) "Supervision by a registered nurse" means initial and ongoing direction, procedural guidance, observation, and evaluation by a registered nurse who is continually available in person, or by some form of telecommunication, of the nursing tasks performed by a community health worker.
Community health worker certification.

[Comment: Information regarding the availability and effective date of the materials incorporated by reference in this rule can be found in paragraph (G) of rule 4723-1-03 of the Administrative Code.]

(A) To obtain a certificate to practice as a community health worker, an applicant who meets the qualifications set forth in division (A) of section 4723.84 of the Revised Code shall:

1. Submit a completed "Community Health Worker Application" application on the form required by the board, located at http://www.nursing.ohio.gov/forms.htm (revised October 2013);

2. Submit an application fee of thirty-five dollars; and

3. In accordance with division (A) of section 4723.091 of the Revised Code, submit a request to the bureau of criminal identification and investigation for a criminal records check. The results of the criminal records check shall:

   a. Be received by the board before a certificate can be issued; and

   b. Indicate that the individual has not been convicted of, pled guilty to, or had a judicial finding of guilt for any violation set forth in section 4723.092 of the Revised Code.

(B) The board shall issue a certificate to practice as a community health worker to applicants who satisfy the requirements of paragraph (A) of this rule, after receipt of written notice from a community health worker training program approved by the board that the applicant has successfully completed the program, and that the applicant is competent to provide care as a community health worker.

(C) If an applicant fails to meet the requirements for certification within one year from the time the board receives the application, the application shall be considered void and the fee shall be forfeited. The application shall state the circumstances under which this forfeiture may occur.

(D) A community health worker certificate shall be considered current until the next scheduled renewal period for a certified community health worker. When a certificate is issued on or after January first of an odd numbered year, that certificate shall be considered current through March thirty-first of the next odd-numbered year.
4723-26-04 Renewal of community health worker certificate.

[Comment: Information regarding the availability and effective date of the materials incorporated by reference in this rule can be found in paragraph (G) of rule 4723-1-03 of the Administrative Code.]

(A) The board shall provide on-line access to a "Community Healthworker Renewal Application" renewal application, located at http://www.nursing.ohio.gov/forms.htm (revised January 2013), to every holder of a current, valid certificate, except when the board is aware that the individual may be ineligible for certificate renewal for any reason, including those reasons set forth in section 4723.092 of the Revised Code. Failure of the certificate holder to receive an application for renewal from the board does not excuse the certificate holder from the requirements of section 4723.85 of the Revised Code and this chapter, except as provided in section 5903.10 of the Revised Code.

(B) To renew a certificate to practice as a community health worker a holder of a current, valid certificate shall:

(1) Submit a completed on-line "Community Healthworker Renewal Application" completed renewal application on the form required by the board, located at http://www.nursing.ohio.gov/forms.htm (revised January 2013);

(2) Submit a renewal fee of thirty-five dollars; and

(3) Meet the continuing education requirements set forth in rule 4723-26-05 of the Administrative Code.

(C) If a completed renewal application is not submitted on-line, postmarked, renewed on-line, or otherwise received by the board on or before March first of each odd numbered year, the application shall be considered late and a late fee of fifty dollars shall be imposed in addition to the thirty-five dollar renewal fee.

(D) A certificate holder with a current, valid certificate may request that the his or her certificate be placed on inactive status at any time by submitting to the board a written statement or electronic request asking that the certificate be placed on inactive status:

(1) At the time of renewal, by checking the appropriate box on the renewal application that indicates the certificate holder wants to place the certificate on inactive status; or

(2) At any time, by submitting to the board a written statement requesting that the
certificate be placed on inactive status.

(E) The board may reactivate an inactive certificate if an individual submits to the board all of the following:

To reactivate an inactive certificate or reinstate a lapsed certificate the certificate holder must submit:

1. A completed "Community Healthworker Reactivation and Reinstatement Application" including all required documentation;
2. Written notice requesting reactivation of the inactive certificate on the form required by the board;
3. A reactivation fee in the amount of thirty-five dollars; and
4. Verification of completion of documentation satisfactory to the board of having completed the continuing education requirements for renewal of a community health worker certificate as provided in accordance with rule 4723-26-05 of the Administrative Code.

(F) A certificate holder who has placed a community health worker certificate on inactive status is not required to pay a renewal fee unless the holder seeks to reactivate the certificate. If the certificate holder placed a certificate on inactive status after March second of the year in which the certificate was to be renewed, and notifies the board on or before March thirty-first of the same renewal year of the intent to reactivate, the certificate holder must still pay the late processing fee required by paragraph (C) of this rule.

(G) If a certificate to practice as a community health worker is not renewed by March thirty-first of each odd numbered year and the certificate holder has failed by that time to request that the certificate be placed on inactive status, the certificate will lapse.

(H) The board may reinstate a lapsed certificate to practice as a community health worker if the individual submits to the board all of the following:

1. A written request for reinstatement on the form required by the board, located at https://www.nursing.ohio.gov/forms.htm (revised 2013);
2. Payment of the thirty-five dollar renewal fee plus a lapsed fee of one hundred dollars; and
3. Documentation satisfactory to the board of having completed the continuing education requirements for renewal as provided in rule 4723-26-05 of the Administrative Code.

(I) When a community health worker certificate is inactive or lapsed, the individual
shall not represent or imply to the public that he or she is certified by the board as a community health worker.

(¶¶) An individual who continues to represent to the public that he or she is a certified community health worker during the time that his or her certificate is inactive or lapsed, may be subject to disciplinary action by the board in accordance with rule 4723-26-11 of the Administrative Code.

(¶¶) A community health worker certificate holder who is a service member or veteran, as defined in rule 4723-2-01 of the Administrative Code, or who is the spouse or surviving spouse of a service member or veteran, may be eligible for a waiver of the late application fee and the reinstatement fee according to rule 4723-2-03 of the Administrative Code.
Continuing education requirements.

[Comment: Information regarding the availability and effective date of the materials incorporated by reference in this rule can be found in paragraph (G) of rule 4723-1-03 of the Administrative Code.]

(A) Except in the case of the first renewal of a current, valid certificate to practice as a community health worker, to be eligible to renew a certificate, a community health worker shall complete fifteen contact hours of continuing education during each renewal period. For each reporting period, at least one of the required hours of continuing education must be directly related to Chapter 4723. of the Revised Code and the rules of the board in Chapters 4723-1 to 4723-27 of the Administrative Code. To qualify as continuing education directly related to Chapter 4723. of the Revised Code and the rules of the board, the continuing education must be approved by an OBN approver, or offered by an OBN approved provider unit headquarteried in the state of Ohio. For each reporting period, at least one of the required hours of continuing education must be directly related to establishing and maintaining professional boundaries. This requirement applies to the reporting period set forth in paragraph (B) of this rule.

(B) A community health worker who requests that the certificate to practice as a community health worker be placed on inactive status shall not be required to meet the continuing education requirement for the period of time the certificate is on inactive status. To reactivate the certificate the community health worker shall complete fifteen hours of continuing education that meet the requirements as set forth in paragraph (A) of this rule, during the twenty-four months immediately prior to the application for reactivation.

(C) The holder of a lapsed certificate shall complete fifteen hours of continuing education that meet the requirements of paragraph (A) of this rule during the twenty-four months immediately prior to the application for reinstatement of the certificate.

(D) A community health worker shall verify completion of the continuing education required by this rule on the "Community Health Worker Renewal Application" or "Community Health Worker Reactivation and Reinstatement Application" application for certificate renewal, reactivation or reinstatement, provided by the board, and at the discretion of the board, may be required to show proof of completion of the approved continuing education. Failure to verify or provide proof of completion shall result in ineligibility to renew, reactivate or reinstate a certificate until proof of completion of the continuing education requirements is provided to the board.

(E) A community health worker who earns more than the number of contact hours of continuing education required for a single reporting period cannot apply the excess hours to satisfy future continuing education requirements.
(F) A community health worker who is ineligible to renew or reinstate a certificate due to failure to meet the continuing education requirements, may be required to show completion of up to thirty contact hours of continuing education, that meets the requirements of this rule, before their certificate is renewed or reinstated by the board. The continuing education shall be obtained within the forty-eight months immediately prior to the application for renewal or reinstatement.

(G) A community health worker may use a waiver to satisfy the continuing education requirement only one time, and must notify the board in writing requesting the waiver. Once requested the waiver cannot be rescinded and use of the waiver shall be documented on the community health worker’s certification record.

(H) The calculation of contact hours based on credit hours earned in an academic institution shall be made according to paragraph (B) of rule 4723-14-04 of the Administrative Code.

(I) Educational activities that satisfy the requirements of this rule are the same as those set forth in rule 4723-14-05 of the Administrative Code.

(J) The board may conduct a retrospective audit of any holder of a certificate to practice as a community health worker to determine compliance with this rule. The audit shall be conducted according to rule 4723-14-07 of the Administrative Code. A community health worker shall retain proof of completion of approved continuing education for a period of six years.

(K) A community health worker certificate holder who is engaged in active military duty may be eligible for an extension of time to complete continuing education as provided in rule 4723-2-04 of the Administrative Code.
**DRAFT - NOT YET FILED**

4723-26-06  Nurse delegation to community health workers.

(A) This chapter sets forth standards for the delegation and supervision of nursing tasks performed by a community health worker at the delegation of a registered nurse.

(B) Nothing in this chapter shall be construed to prevent any person registered, certified, licensed, or otherwise legally authorized under any law in this state from engaging in the practice for which such person is registered, certified, licensed, or authorized.
4723-26-07  Prohibitions on delegation.

(A) Pursuant to division (B) of section 4723.82 of the Revised Code, a registered nurse shall not delegate to a community health worker the administration of medications.

(B) No community health worker to whom a nursing task is delegated shall delegate the nursing task to any other person.

(C) Employing a community health worker to engage in the unauthorized practice of nursing is prohibited by section 4723.03 of the Revised Code.

(D) If a community health worker delegates a nursing task, the community health worker shall be engaging in the unauthorized practice of nursing, which is prohibited by section 4723.03 of the Revised Code.

(E) If a community health worker performs a nursing task and does not comply with all the provisions set forth in this chapter, the community health worker shall be engaging in the unauthorized practice of nursing, in violation of section 4723.03 of the Revised Code.
Criteria and standards for a registered nurse delegating to a community health worker.

(A) A registered nurse may delegate a nursing task to a community health worker if all the conditions for delegation set forth in this chapter are met.

(B) Prior to delegating a nursing task to a community health worker, the delegating registered nurse shall determine each of the following:

1. That the nursing task is within the scope of practice of a registered nurse as set forth in section 4723.01 of the Revised Code;

2. That the nursing task is within the knowledge, skill, and ability of the registered nurse delegating the nursing task;

3. That the nursing task is within the training, skill, and ability of the community health worker who will be performing the delegated nursing task;

4. That appropriate resources and support are available for the performance of the nursing task, and for management of the outcome;

5. That adequate and appropriate supervision by the registered nurse of the performance of the nursing task is available in accordance with this rule; and

6. That:

   a. The nursing task requires no judgment based on nursing knowledge and expertise on the part of the community health worker performing the task;

   b. The results of the nursing task are reasonably predictable;

   c. The nursing task can be safely performed according to exact, unchanging directions, with no need to alter the standard procedures for performing the task;

   d. The performance of the nursing task does not require that complex observations or critical decisions be made with respect to the nursing task;

   e. The nursing task does not require repeated performance of nursing assessments by the delegating registered nurse; and
(f) The consequences of performing the nursing task improperly are minimal and not life threatening.

(C) Prior to delegating a nursing task to a community health worker, a registered nurse shall:

(1) Identify:

(a) The individual on whom the nursing task may be performed; and

(b) A specific time frame during which the delegated nursing task may be performed.

(2) Complete an evaluation of the conditions that relate to the delegation of the nursing task to be performed, including:

(a) An evaluation of the individual who needs nursing care;

(b) The types of nursing care the individual requires;

(c) The complexity and frequency of the nursing care needed;

(d) The stability of the individual who needs nursing care; and

(e) A review of the evaluations performed by other licensed health care professionals.

(D) The delegating registered nurse shall be accountable for the acts of delegation to and supervision of the community health worker in the performance of the delegated nursing task.

(E) If a registered nurse determines that a community health worker is not correctly performing a delegated task the registered nurse shall immediately intervene.

(F) A registered nurse shall not be responsible for the delegation of a nursing task by another licensed health care practitioner to a community health worker.
Supervision of the performance of a nursing task performed by a community health worker.

(A) When a community health worker is performing a nursing task in accordance with this chapter, supervision shall be provided by a registered nurse. For purposes of this rule, supervision includes initial and ongoing direction, procedural guidance, and observation and evaluation. The registered nurse providing the supervision for a delegated nursing task shall evaluate and document the following on an ongoing basis:

1. The degree to which the nursing care needs of the individual are being met;

2. The performance by the community health worker of the delegated nursing task;

3. The need for further instruction to the community health worker who is performing the nursing task; and

4. The need to withdraw the delegation.

(B) For purposes of providing supervision to a community health worker performing a delegated nursing task, the registered nurse must be either:

1. Continually accessible to the community health worker in person; or

2. Continually available to the community health worker by some form of telecommunication.

(C) In determining the number of community health workers that a registered nurse may supervise, the registered nurse shall consider all of the following:

1. A registered nurse may not supervise any more than five community health workers at one given time;

2. The number of clients who require nursing care and the health status of those clients;

3. The types and numbers of nursing tasks delegated to each community health worker;

4. The competency, dependability, and reliability of each community health worker to be supervised;
(5) The number of different settings in which the community health workers will be providing services and the proximity between these settings and the location of the registered nurse; and

(6) The availability of emergency aid if the registered nurse is not able to reach, in a timely manner, the setting in which the community health workers are providing services.
4723-26-10 Standards of safe care provided by the community health worker.

(A) The purpose of this chapter is to establish minimal acceptable standards of safe and effective care provided by community health workers holding a certificate issued by the board of nursing pursuant to Chapter 4723. of the Revised Code.

(B) A community health worker shall maintain knowledge of the duties, responsibilities, and accountabilities of a community health worker and shall practice in accordance with the following:

1) Laws regulating the provision of care by a community health worker as set forth in Chapter 4723. of the Revised Code;

2) Rules adopted by the board in accordance with Chapter 119. of the Revised Code; and

3) Any other applicable state or federal laws and rules.

(C) A community health worker shall perform nursing tasks in accordance with sections 4723.81 and 4723.82 of the Revised Code, only as delegated and supervised by a registered nurse holding a current, valid license issued by the board under Chapter 4723. of the Revised Code.

(D) A community health worker shall demonstrate competence and accountability in performing nursing tasks as delegated by a registered nurse, including, but not limited to, the following:

1) Consistent performance of nursing tasks as delegated by a registered nurse; and

2) Consulting with the supervising nurse in a timely manner to facilitate referral, consultation, or intervention when a community health worker identifies factors or conditions adversely affecting, or potentially affecting, a patient's health status.

(E) A community health worker shall, in a timely manner:

1) Perform the nursing tasks as delegated by a registered nurse, unless the community health worker believes or should have reason to believe any of the following:

   a) Performing the nursing task would be harmful or potentially harmful to
the patient;

(b) The nursing task is contraindicated by other documented information; or

(c) The nursing task has not been properly authorized.

(2) Clarify the direction received from the delegating nurse if the community health worker believes, or should have reason to believe, any of the following:

(a) Performing the nursing task would be harmful or potentially harmful to the patient;

(b) The nursing task is contraindicated by other documented information;

(c) The nursing task has not been properly authorized; or

(d) The condition of the patient has changed.

(F) When clarifying a nursing task the community health worker shall, in a timely manner:

(1) Consult with the supervising registered nurse to explain the cause of concern;

(2) Advise the supervising registered nurse if the community health worker decides not to perform the nursing task;

(3) Document that the supervising registered nurse was advised of the community health worker’s decision not to perform the nursing task as delegated; and

(4) Take any other actions needed to assure the safety of the patient.

(G) A community health worker shall, in a timely manner, document, report to, and consult with, the supervising registered nurse when a patient refuses to follow the health care regimen.

(H) A community health worker shall maintain the confidentiality of patient information obtained in the course of the community health worker’s duties and responsibilities. A community health worker shall communicate patient information to other members of the health care team for health care purposes only, shall access patient
information only for purposes of patient care or for otherwise fulfilling the worker's assigned job responsibilities, and shall not disseminate patient information for purposes other than patient care or for otherwise fulfilling the worker's assigned job responsibilities through social media, texting, emailing, or any other form of communication.

(I) To the maximum extent feasible, identifiable patient health care information shall not be disclosed by a community health worker unless the patient has consented to the disclosure of identifiable patient health care information. A community health worker shall report individually identifiable patient information without written consent in limited circumstances only, and in accordance with an authorized law, rule, or other recognized legal authority.

(J) A community health worker shall do all of the following to promote patient safety:

(1) Display the applicable title set forth in section 4723.82 of the Revised Code at all times when providing direct patient care, or if interacting with a patient, or health care provider on behalf of the patient, through any form of telecommunication, the community health worker shall identify their certification to the patient or healthcare provider;

(2) In a timely manner, completely and accurately document and report all client data obtained while performing nursing tasks delegated by the supervising registered nurse, and the patient's response to the care;

(3) In a timely manner, completely and accurately document and report to the supervising registered nurse all errors in, or deviations from, the delegated nursing tasks;

(4) Not falsify any patient record or other document prepared in the course of, or in conjunction with, the performance of delegated nursing tasks;

(5) Implement measures to promote a safe environment for the patient including consulting with a supervising registered nurse any time that the community health worker suspects patient abuse or neglect;

(6) Establish, delineate, and maintain professional boundaries with each patient;

(7) Refrain from all behavior that causes or may cause physical, verbal, mental, or emotional abuse or distress to a patient, or in behavior that may be reasonably interpreted to cause physical, verbal, mental, or emotional abuse or distress;
(8) Not misappropriate a patient's property, engage in behavior to seek or obtain, behavior that may reasonably be interpreted as seeking or obtaining, personal gain at the patient's expense, or engage in behavior that constitutes, or that may reasonably be interpreted as constituting, inappropriate involvement in a patient's personal relationships or financial matters;

(9) Not engage in sexual conduct or in conduct that may reasonably be interpreted as sexual, or in any verbal behavior that is seductive or sexually demeaning to a patient, or in verbal behavior that may reasonably be interpreted as seductive or sexually demeaning to a patient;

(10) Treat each patient with courtesy, respect, and with full recognition of dignity and individuality; and

(11) Provide each patient with privacy while performing delegated nursing tasks.

For purposes of paragraphs (J)(6) to (J)(9) of this rule, a patient is always considered to be incapable of giving free, full, or informed consent to the actions of a community health worker.

(K) A community health worker shall not make any false, misleading, or deceptive statements, or submit or cause to be submitted any false, misleading or deceptive information or documentation to:

(1) The board or any representative of the board;

(2) Current employers;

(3) Prospective employers when applying for positions requiring a community health worker certificate;

(4) Facilities in which, or organizations for whom, the community health worker is working a temporary or agency assignment;

(5) Other members of the patient's health care team; or

(6) Law enforcement personnel.

(L) For purposes of paragraphs (J)(6), (J)(7), (J)(8), (J)(9), and (J)(10) of this rule, a certified community health worker shall not use social media, texting, emailing, or other forms of telecommunication with, or about, a patient, for non-health care
purposes or for purposes other than fulfilling the worker's assigned job responsibilities.
2.1 Disciplinary actions against certified community health workers; investigations.

(A) The board of nursing, by the vote of a quorum, may impose one or more of the following sanctions if it finds that a person committed fraud in passing an examination required by a community health worker training program, or committed fraud, misrepresentation, or deception in applying for a community health worker certificate: deny, revoke, suspend, or place restrictions on a certificate issued by the board; reprimand or otherwise discipline a certificate holder; or impose a fine of not more than five hundred dollars per violation.

(B) By the vote of a quorum, the board may impose one or more of the following sanctions on an individual who applies for or holds, a community health worker certificate: deny, revoke, suspend, or place restrictions on a community health worker certificate, or reprimand or otherwise discipline a holder of a community health worker certificate. The sanctions may be imposed for any of the following:

1. Denial, revocation, suspension, or restriction of authority to engage in a licensed profession or practice a health care occupation, in Ohio or another state or jurisdiction, including but not limited to nursing, practice as a dialysis technician, nurse aide, community health care worker or medication aide, for any reason other than a failure to renew;

2. Performing a nursing task as a certified community health worker having failed to renew a community health worker certificate issued under Chapter 4723. of the Revised Code, or while a community health worker certificate is under suspension or inactive;

3. Conviction of, a plea of guilty to, a judicial finding of guilt of, a judicial finding of guilt resulting from a plea of no contest to, or a judicial finding of eligibility for a pretrial diversion or similar program or for intervention in lieu of conviction for, of a misdemeanor committed in the course of performing care as a certified community health worker;

4. Conviction of, a plea of guilty to, a judicial finding of guilt of, a judicial finding of guilt resulting from a plea of no contest to, or a judicial finding of eligibility for a pretrial diversion or similar program or for intervention in lieu of conviction for, any felony or any crime involving gross immorality or moral turpitude;

5. Selling, giving away, or administering drugs or therapeutic devices for other than legal and legitimate therapeutic purposes; or conviction of, a plea of guilty to, a judicial finding of guilt of, a judicial finding of guilt resulting from a plea of no contest to, or a judicial finding of eligibility for a pretrial diversion or similar program or for intervention in lieu of conviction for, violating any municipal, state, county, or federal drug law;

6. Conviction of, a plea of guilty to, a judicial finding of guilt of, a judicial finding of guilt resulting from a plea of no contest to, or a judicial finding of eligibility for a pretrial diversion or similar program or for intervention in lieu of conviction for, an act in another jurisdiction that would constitute a felony or a crime of moral turpitude in Ohio;

7. Conviction of, a plea of guilty to, a judicial finding of guilt of, a judicial finding of guilt resulting from a plea of no contest to, or a judicial finding of eligibility for a pretrial diversion or similar program or for intervention in lieu of conviction for, an act in the course of practice in another jurisdiction that would constitute a misdemeanor in Ohio;

8. Self-administering or otherwise taking into the body any dangerous drug, as defined in section 4729.01 of the Revised Code, in any way not in accordance with a legal, valid prescription issued for that individual, or self-administering or otherwise taking into the body any drug that is a schedule I controlled substance;

9. Habitual or excessive use of controlled substances, other habit-forming drugs, or alcohol or other chemical substances to an extent that impairs the individual's ability to comply with the standards of safe care established in rule 4723-26-10 of the Administrative Code;
(10) Impairment of the ability to comply with standards of safe care established in rule 4723-26-10 of the Administrative Code because of the use of drugs, alcohol or other chemical substances;

(11) Impairment of the ability to comply with standards of safe care established in rule 4723-26-10 of the Administrative Code because of a physical or mental disability;

(12) Assaulting or causing harm to a patient or depriving a patient of the means to summon assistance;

(13) Misappropriation or attempted misappropriation of money or anything of value in the course of performing care as a certified community health worker;

(14) Adjudication by a probate court of being mentally ill or mentally incompetent.

The board may restore the person's community health worker certificate upon adjudication by a probate court of the person's restoration to competency or upon submission to the board of other proof of competency;

(15) The suspension or termination of employment by the department of defense or the veterans administration of the United States for any act that violates or would violate his chapter;

(16) Violation of Chapter 4723. of the Revised Code or any rules adopted under it;

(17) Violation of any restrictions placed on a community health worker certificate by the board;

(18) Failure to use universal and standard precautions including those set forth in Chapter 4723-20 of the Administrative Code;

(19) Engaging in activities that exceed those permitted under sections 4723.61 to 4723.88 of the Revised Code or this chapter;

(20) Failure by a certified community health worker to conform to the standards of safe care established in rule 4723-26-10 of the Administrative Code;

(21) Aiding and abetting a person in that person's practice of nursing without a license, or practice as a dialysis technician or certified medication aide without a certificate issued under this chapter;

(22) Regardless of whether the contact or verbal behavior is consensual, engaging with a patient other the spouse of the certified community health worker in any of the following:

(a) Sexual contact, as defined in section 2907.01 of the Revised Code;

(b) Verbal behavior that is sexually demeaning to the patient or may be reasonably interpreted by the patient as sexually demeaning; or

(23) Assisting suicide as defined in section 3795.01 of the Revised Code.

(C) The hearings of the board shall be conducted in accordance with Chapter 119. of the Revised Code and Chapter 4723-16 of the Administrative Code. The board may appoint a hearing examiner, as provided in section 119.09 of the Revised Code, to conduct any hearing the board is authorized to hold under Chapter 119. of the Revised Code.

(D) In any instance in which the board is required under Chapter 119. of the Revised Code to give notice of an opportunity for a hearing and the applicant or certificate holder does not make a timely request for a hearing in accordance with section 119.07 of the Revised Code:

(1) The board is not required to hold a hearing, but may adopt, by vote of a quorum, a final order that contains the board's findings; and

(2) In the final order, the board may order any of the sanctions listed in paragraph (A) or (B) of this rule.
(E) If a criminal action is brought against a certified community health worker for an act or crime described in paragraphs (B)(3) to (B)(7) of this rule and the action is dismissed by the trial court other than on the merits:

(1) The board shall conduct an adjudication to determine whether the certified community health worker committed the act upon which the action was based.

(2) If the board determines on the basis of the adjudication that the certified community health worker committed the act, or if the certified community health worker fails to participate in the adjudication, the board may take action as though the certified community health worker had been convicted of the act.

(F) If the board takes action on the basis of a conviction, plea, or a judicial finding as described in paragraphs (B)(3) to (B)(7) of this rule that is overturned on appeal, the certified community health worker may, on exhaustion of the appeal process, petition the board for reconsideration of its action.

(1) On receipt of the petition and supporting court documents, the board shall temporarily rescind its action.

(2) If the board determines that the decision on appeal was a decision on the merits, it shall permanently rescind its action.

(3) If the board determines that the decision on appeal was not a decision on the merits, it shall conduct an adjudication to determine whether the certified community health worker committed the act on which the original conviction, plea, or judicial finding was based.

(a) If the board determines on the basis of the adjudication that the certified community health worker committed such act, or if the certified community health worker does not request an adjudication, the board shall reinstate its action.

(b) If the board determines that the certified community health worker did not commit such act, the board shall permanently rescind its action.

(G) The board may investigate an individual's criminal background in performing its duties under this rule and sections 4723.81 to 4723.88 of the Revised Code. As part of such investigation, the board may order the individual to submit, at the individual's expense, a request to the bureau of criminal identification and investigation for a criminal records check and check of federal bureau of investigation records in accordance with the procedure described in section 4723.091 of the Revised Code.

(H) During the course of an investigation the board may compel any certified community health worker, or applicant under section 4723.84 of the Revised Code, to submit to a mental or physical examination, or both, as required by the board and at the expense of the individual, if the board finds reason to believe that the individual under investigation may have a physical or mental impairment that may affect the individual's ability perform delegated nursing tasks. Failure of any individual to submit to a mental or physical examination when directed constitutes an admission of the allegations, unless the failure is due to circumstances beyond the individual's control, and a default and final order may be entered without the taking of testimony or presentation of evidence.

(I) If the board finds that an individual is impaired in accordance with paragraph (H) of this rule, the board shall require the individual to submit to care, counseling, or treatment approved or designated by the board, as a condition for an initial, continued, reinstated, or renewed certified community health worker certificate.

(1) The individual shall be afforded an opportunity to demonstrate to the board that the individual can begin or resume the performance of delegated nursing tasks in accordance with standards established under rule 4723-26-10 of the Administrative Code.

(2) For purposes of this paragraph, any certified community health worker or applicant under this rule shall be deemed to have given consent to submit to a mental or physical examination when directed to do so in writing by the board, and to have waived all objections to the admissibility of testimony or examination reports that constitute a privileged communication.
(J) The provisions of division (I) of section 4723.28 of the Revised Code apply to information, investigations and adjudications involving certified community health workers or applicants under sections 4723.81 to 4723.88 of the Revised Code and this chapter.

(K) The provisions of section 4723.29 of the Revised Code apply with respect to any matter that the board has authority to investigate, inquire into, or hear under sections 4723.81 to 4723.88 of the Revised Code and this chapter.

(L) When the board refuses to grant a community health worker certificate to an applicant, revokes a certificate, or refuses to reinstate a certificate, the board may specify that its action is permanent. An individual subject to permanent action taken by the board is forever ineligible to hold a community health worker certificate and the board shall not accept from the individual an application for reinstatement of the certificate or for a new certificate.

(M) No unilateral surrender of a community health worker certificate issued under Chapter 4723. of the Revised Code shall be effective unless accepted by majority vote of the board. No application for a community health worker certificate issued under Chapter 4723. of the Revised Code may be withdrawn without a majority vote of the board. The board’s jurisdiction to take disciplinary action is not removed or limited when an individual has a certificate classified as inactive or fails to renew a certificate.

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Prior Effective Dates: 02/01/2005, 02/01/2010, 02/01/2014
2.1

Standards for community health worker training programs.

(A) To be approved by the board in accordance with division (G) of section 4723.88 of the Revised Code, a community health worker training program shall employ or contract with a person to serve as program administrator. Such person shall meet one of the following criteria:

1. Hold a license or certificate to practice as one of the following health care professionals:
   
   (a) A dentist licensed under Chapter 4715. of the Revised Code;
   
   (b) A nurse licensed under Chapter 4723. of the Revised Code;
   
   (c) An optometrist licensed under Chapter 4725. of the Revised Code;
   
   (d) A pharmacist licensed under Chapter 4729. of the Revised Code;
   
   (e) A physician assistant certified under Chapter 4730. of the Revised Code;
   
   (f) A physician licensed under Chapter 4731. of the Revised Code;
   
   (g) A psychologist licensed under Chapter 4732. of the Revised Code;
   
   (h) A chiropractor licensed under Chapter 4734. of the Revised Code;
   
   (i) A nursing home administrator licensed under Chapter 4751. of the Revised Code;
   
   (j) A counselor, social worker, or marriage and family therapist licensed under Chapter 4757. of the Revised Code; or
   
   (k) A dietitian licensed under Chapter 4759. of the Revised Code.

2. Hold credentials as an education professional that are recognized by:

   (a) The Ohio department of education;
   
   (b) The Ohio board of regents or chancellor of higher education; or
   
   (c) A nationally or regionally recognized accreditation body for programs of
postsecondary education.

(B) The administrator of a community health worker training program shall be responsible for the following:

(1) Assuring that the community health worker training program establishes written policies addressing the issues set forth in paragraph (C) of this rule;

(2) Assuring that the policies of the program are implemented as written;

(3) Assuring that the nursing tasks included in the curriculum of an approved community health worker training program are taught by an individual who:

(a) Has held an Ohio license to practice registered nursing for a minimum of two years;

(b) Is not prohibited by law from teaching nursing tasks;

(c) Satisfies one of the following:

   (i) Has experience in working directly with community health workers for a minimum of six months prior to entering into an instructor role; or

   (ii) Within six months after assuming instructor responsibilities in the community health worker training program, successfully completes the community health worker program coursework.

(4) Assuring that the training program utilizes other licensed health care professionals to provide portions of the relevant classroom and clinical instruction in accordance with the professional's educational background and licensed scope of practice.

(C) A community health worker training program shall adopt and implement program policies that address all of the following:

(1) Criteria for students to enroll and continue in the program that establish a basic level of ability necessary for an individual to safely perform the essential functions of a community health worker;
(2) Criteria for student re-enrollment in the program;

(3) Criteria for successful completion of the program;

(4) A process for determining that a student has sufficient knowledge and understanding to competently provide the care and services of a community health worker including both nursing tasks and non-nursing tasks.

   (a) A registered nurse shall provide written verification that a community health worker student has been taught the skills necessary to perform delegated nursing tasks;

   (b) A registered nurse or other qualified community health worker training program instructor or administrator shall provide written verification that a student has been taught skills necessary to provide the non-nursing tasks provided by a community health worker.

(5) A process for maintaining student records including:

   (a) The date a student began the program;

   (b) The date a student completed the program; and

   (c) The competency check lists for each individual student.

(6) An accurate, timely process to provide verification to the board that a student seeking certification as a community health worker has successfully completed the approved training program;

(7) A process for program evaluation that includes feedback from students, instructors and employers of individuals who have successfully completed the community health worker training program;

(8) Designation of those persons with authority to notify the board regarding student enrollment, re-enrollment, and completion of the program;

(9) A process for addressing the unexpected vacancy of the administrator of the program; and

(10) For individuals with experience in the armed forces of the United States, or in
the national guard or in a reserve component, the program shall have a process in place to:

(a) Review the individual's military education and skills training;

(b) Determine whether any of the military education or skills training is substantially equivalent to the curriculum established in Chapter 4723-26 of the Administrative Code;

(c) Award credit to the individual for any substantially equivalent military education or skills training.

(D) When the administrator of an approved community health worker training program vacates the position or is replaced, an authorized representative of the program shall provide written notice to the board within thirty days after the position is vacated and within thirty days after a new person assumes the role.

(E) An approved training program shall not initiate a new community health worker training program unless an administrator who meets the requirements of paragraph (A) of this rule is in place.

(F) When a decision is made to close a community health worker training program, the board shall be notified in writing of the decision and provided with the following information:

(1) The tentative date of closing;

(2) The location of the program's records, including but not limited to, student records; and

(3) The name and address of the custodian of the records.
Standard curriculum for community health worker training programs.

(A) An approved curriculum for a training program for community health workers shall be the standard minimum curriculum set forth in paragraph (B) of this rule and shall satisfy all of the following:

(1) Include a program philosophy, program objectives or outcomes, course objectives or outcomes, teaching strategies, and core competencies or other evaluation methods that are:

(a) Consistent with the law regulating the practice of the community health worker;

(b) Internally consistent;

(c) Implemented as written; and

(d) Distributed to community health worker students;

(2) Include a curriculum plan showing the sequence of courses, laboratory experiences, and units of credit or number of clock hours allotted to theory and laboratory experiences; and

(3) Include a curriculum content that is a minimum of one hundred hours of didactic classroom instruction and one hundred thirty hours of clinical experience. Relevant laboratory experiences may be integrated into the curriculum.

(B) As part of the classroom instruction required in paragraph (A) of this rule, related clinical and laboratory experiences shall provide a community health worker with an opportunity to practice cognitive, psychomotor, and affective skills in the performance of a variety of basic tasks and activities with individuals or groups across the life span. Portions of the relevant clinical experience shall be provided in a community setting similar to the settings in which a community health worker will provide services.

(C) The standard minimum curriculum for community health workers shall include courses, content, and expected outcomes, relative to the defined role of the community health worker, in the following major areas:

(1) Health care, including expected competencies in the areas of:
(a) The physical, mental, emotional and spiritual impacts on health;

(b) Basic anatomy and physiology of major body systems;

(c) Substance use and affects on health;

(d) Signs indicating a change in a client's health status;

(e) Obtaining accurate vital signs;

(f) Basic cardiopulmonary resuscitation skills;

(g) Medical terminology;

(h) Documentation methods; and

(i) Utilization of local health and referral systems.

(2) Community resources, including expected competencies in the areas of:

(a) Referral methods to assist various target population groups;

(b) Utilization of community resources and their referral processes;

(c) Utilization of resources related to entitlement programs;

(d) Recognizing and reporting signs of family violence, abuse and neglect; and

(e) Recognizing and making appropriate referral for signs of mental health and addiction problems.

(3) Communication skills, including expected competencies in the areas of:

(a) Interpersonal communication skills;

(b) Effective interview techniques;
(c) Effective written communications to health care and service care providers; and

(d) Utilization of appropriate telephone technique.

(4) Individual and community advocacy, including expected competencies in the areas of:

(a) Recognition of diversity, and the role of the community health worker in an interdisciplinary team;

(b) Supporting development of self care skills in various target population groups;

(c) Utilization of skills to assure that different target population groups receive needed services; and

(d) Methods of serving as a community liaison between different target population groups and local agencies and providers.

(5) Health education, including expected competencies in the areas of:

(a) Educating on healthy lifestyle choices, including nutrition, exercise, and stress management to reduce health risk factors;

(b) Educating on adverse health consequences of smoking, drinking, and drugs of abuse;

(c) Educating on the importance of oral health care across the lifespan;

(d) Explaining basic prevention and wellness topics; and

(e) Explaining age-appropriate safety and injury prevention techniques.

(6) Service skills and responsibilities, including expected competencies in the areas of:

(a) Protocols and policies regarding:
(i) Confidentiality;

(ii) Care coordination;

(iii) Documentation;

(iv) Submission of documentation for review by a supervisor; and

(v) Release of client information.

(b) Skills necessary to carry out an effective home visit, including:

(i) Personal safety;

(ii) Emotional dynamics;

(iii) Setting appropriate boundaries with clients;

(iv) Time management; and

(v) Conflict management skills.

(c) Performance of basic clerical, computing, and office skills necessary in the role of the community health worker.

(D) The standard minimum curriculum for community health workers shall also educate students on needs throughout the span of a lifetime including the following:

(1) Content related to the family during childbearing years, including expected competencies in the areas of:

   (a) Health education related to the childbearing years; and

   (b) A basic understanding of related anatomy, physiology, and appropriate health care.

(2) Content related to the family during pregnancy, including expected competencies in the areas of:
(a) Basic anatomy, physiology, and normal signs related to pregnancy;

(b) Recognition of warning signs during pregnancy requiring immediate reporting to the registered nurse supervisor; and

(c) Health education related to pregnancy, labor, and postpartum care.

(3) Content related to the newborn, infant, and young child, including expected competencies in the areas of:

(a) Routine infant feeding and newborn care;

(b) Recognizing and reporting problems that can occur in early infancy;

(c) Immunization schedules and information regarding referral to appropriate health care facilities and practitioners;

(d) Basic methods to enhance typical child development; and

(e) Identification of potential developmental delays.

(4) Content related to adolescents including expected competencies in the areas of:

(a) Age appropriate health education;

(b) Acute and chronic illnesses including, but not limited to asthma, obesity, and eating disorders; and

(c) High risk behaviors.

(5) Content related to adults and seniors, including expected competencies in the areas of:

(a) The aging process;

(b) Prevention strategies;

(c) Recommended screenings;
(d) Top causes of morbidity and mortality by age group; and

(e) Acute and chronic illnesses of adulthood including but not limited to heart disease, cancer, stroke, diabetes, and lung disease.

(6) Content related to special health care and social needs of target population groups including:

(a) Grandparents raising grandchildren;

(b) Adults caring for aging parents; and

(c) Children and adults with disabilities.

(E) For purposes of paragraph (B) of this rule, students participating in a clinical practicum in a community setting shall be supervised by qualified instructional personnel employed by, or under contract with, the community health worker training program.

(F) It is the intent of the board that this curriculum is structured in such a way as to assure that participants who successfully complete a program that provides the curriculum may be able to utilize a portion of the credit hours earned toward additional career-related education.
4723-26-14 Procedures for obtaining approval or reapproval of community health worker training programs.

[Comment: Information regarding the availability and effective date of the materials incorporated by reference in this rule can be found in paragraph (G) of rule 4723-1-03 of the Administrative Code.]

The board shall approve and reapprove community health worker training programs as follows:

(A) A community health worker training program that seeks to be approved by the board shall submit to the board all of the following:

1. A completed "Community Health Worker Training Program Approval Application" application on a form specified by the board located at http://www.nursing.ohio.gov/forms.htm (effective May 2014);

2. Payment of a program approval fee of three hundred dollars; and

3. Any other information requested by the board.

(B) A community health worker training program seeking reapproval by the board shall submit the following to the board within ninety days prior to the expiration of its current approval:

1. A completed "Community Health Worker Training Program Re-Approval Application" reapproval application on a form specified by the board located at http://www.nursing.ohio.gov/forms.htm (effective May 2014);

2. Payment of a program reapproval fee of three hundred dollars; and

3. Any other information requested by the board.

(C) If the board determines that additional information is necessary to make a determination regarding an application for program approval or reapproval, the board shall provide written notice to the applicant requesting the information. An application will expire, and a new application must be submitted, if the requested information is not received by the board within one year of the date of the board's request.

(D) The board may conduct a site visit of a community health worker training program or applicant either prior to approving or reapproving a program application, or at any time during the two year period for which a program is approved.
(E) At a regularly scheduled board meeting the board shall review the completed application for approval or reapproval and all other relevant documentation to determine whether a program complies with standards set forth in this chapter. If the board finds that the program meets all the requirements of this chapter it shall issue its approval or reapproval, in writing, to the applicant program.

(F) Program approval shall extend for two years provided the program continues to meet the program standards set forth in this chapter.

(G) If the board determines that an application for program approval or reapproval does not demonstrate that the applicant program meets or maintains the minimum standards set forth in this chapter, the board shall send to the administrator of the program a written report that identifies the specific deficiencies. The deficiency report must notify the applicant or program of a board meeting date, not less than ninety days in the future, at which the board will make a decision regarding the application.

(H) Within thirty days after receipt of the deficiency report, the administrator of the program may submit to the board either:

(1) A written plan of correction that sets forth the steps taken by the program to meet or maintain each minimum standard identified in the report as not being met or maintained; or

(2) A written response to the report setting forth evidence that the program is meeting and maintaining each minimum standard identified in the report as not being met or maintained.

In order for the board to consider the program's response to the deficiency report, the program must submit the response not less than thirty days prior to the board meeting at which the board will consider the program's approval status.

(I) Based on the deficiency report and the program's response to the report, if any, the board may grant approval, grant provisional approval, continue approval, or propose to deny or withdraw approval of the program. The board shall deny or withdraw approval of a program according to the procedures set forth in Chapter 119. of the Revised Code. In the alternative, the board an applicant or program may enter into a consent agreement specifying terms and conditions the applicant or program must satisfy in order to achieve or maintain an approval status.

(J) If at any time a program with full approval fails to meet and maintain the minimum
standards set forth in this chapter, the board shall place the program on provisional approval. When a program is placed on provisional approval, the board shall specify the minimum standard or standards the program is not meeting or maintaining and shall establish the time period during which the program will be on provisional approval. When the time period for provisional approval has expired, the board shall reconsider the program's approval status.

(K) If a program on provisional approval continues to fail to meet or maintain minimum standards at the end of the time period established for provisional approval, the board may propose to continue provisional approval for a period of time specified by the board or may propose to withdraw approval, according to the procedures set forth in Chapter 119. of the Revised Code. In the alternative, the board and applicant or program may enter into a consent agreement specifying terms and conditions the applicant or program must satisfy in order to achieve or maintain an approval status.

(L) When a complete application for reapproval is submitted to the board in accordance with paragraph (B) of this rule, and the board fails to make a determination before the current program approval expires, the board shall issue a notice to the administrator of the program extending approval of the program until board action is taken on the reapproval application.
4723-1-03 Board records and documents.

[Comment: Information regarding the availability and effective date of the materials incorporated by reference in agency 4723 of the Administrative Code can be found in paragraph (G) of this rule.]

(A) The board shall maintain a record of all applicants for, and holders of, licenses and certificates issued by the board under Chapter 4723 of the Revised Code and any rules adopted under that chapter, in the format determined by the board.

(B) A change in name shall be submitted to the board on a "Name Change Form", dated 2016 available at http://www.nursing.ohio.gov/forms.htm, within thirty days of the change and shall be accompanied by a certified copy of one of the following documents:

(1) A marriage certificate or abstract;

(2) A dissolution or divorce decree;

(3) A court record indicating a change of name; or

(4) Documentation of a change in name consistent with the laws of the jurisdiction or foreign country where the name change occurred.

(C) A notification of a change in address shall be submitted in writing or electronically, by the licensee or certificate holder to the board within thirty days of the change.

(D) Documents submitted to the board may be returned at the discretion of the board.

(E) Wall certificates or other documents issued by the board as evidence of licensure, certification, or other authorization to practice shall not be falsified or altered.

(F) For purposes of Chapters 4723-1 to 4723-27 of the Administrative Code, when an applicant for licensure or certification, or renewal, reactivation or reinstatement of licensure or certification, submits a criminal records check completed by the bureau of criminal identification and investigation, the board shall consider the records check information to be valid for a period of one year from the date the information was received by the board. This provision shall not apply to criminal records checks required to be obtained according to the terms of board adjudication orders or consent agreements.

(G) Incorporated materials:
(1) "2016 Verification Form for Organizations Certifying Nurse Midwives (CNMs), Certified Nurse Practitioners (CNPs), Clinical Nurse Specialists (CNSs), and Certified Registered Nurse Anesthetists (CRNAs)," dated 2016, may be obtained at http://www.nursing.ohio.gov/forms.htm;

(2) "Advanced Practice Registered Nurse License Application," dated 2017, may be obtained at http://www.nursing.ohio.gov/forms.htm;

(3) "Advanced Practice Registered Nurse License Renewal Application 2019," dated 2017, may be obtained at http://www.nursing.ohio.gov/forms.htm;

(4) "Advanced Practice Registered Nurse License Reactivation and Reinstatement Application," dated 2017, may be obtained at http://www.nursing.ohio.gov/forms.htm;

(5) "Alternative Program for Chemical Dependency/Substance Use Disorders Admission Application," dated 2018, may be obtained at http://www.nursing.ohio.gov/forms.htm;

(6) "Application for Initial Approval/Reapproval of a Testing Organization that Conducts an Examination of Dialysis Technicians," dated 2015, may be obtained at http://www.nursing.ohio.gov/forms.htm;

(7) "Application to Perform IV Therapy in Ohio as a LPN and Certification of CE Course Completion," dated 2019, may be obtained at http://www.nursing.ohio.gov/forms.htm;

(8) "Community Health Worker Application," dated 2019, may be obtained at http://www.nursing.ohio.gov/forms.htm;

(9) "Community Health Worker Reactivation and Reinstatement Application," dated 2019, may be obtained at http://www.nursing.ohio.gov/forms.htm;

(10) "Community Health Worker Renewal Application," dated 2019, may be obtained at http://www.nursing.ohio.gov/forms.htm;

(11) "Community Health Worker Training Program Approval Application," dated 2019, may be obtained at http://www.nursing.ohio.gov/forms.htm;

(12) "Community Health Worker Training Program Re-Approval Application," dated 2019, may be obtained at http://www.nursing.ohio.gov/forms.htm;

(13) "Certificate of Authority Renewal/APRN License Application," dated 2017,
may be obtained at http://www.nursing.ohio.gov/forms.htm;

(8)(13) "Dialysis Technician Application," dated 2017, may be obtained at http://www.nursing.ohio.gov/forms.htm;

(9)(14) "Education Program PN Annual Report Form," dated 2018, for licensed practical nursing education programs, may be obtained at http://www.nursing.ohio.gov/forms.htm;

(10)(15) "Education Program RN Annual Report Form," dated 2018, for registered nursing education programs, may be obtained at http://www.nursing.ohio.gov/forms.htm;

(11)(16) "Education Program PN Presurvey Visit Report Form," dated 2017, for licensed practical nursing education programs may be obtained at http://www.nursing.ohio.gov/forms.htm;

(12)(17) "Education Program RN Presurvey Visit Report Form," dated 2017, for registered nursing education programs, may be obtained at http://www.nursing.ohio.gov/forms.htm;

(13) "LPN IV Therapy Application," dated 2016, may be obtained at http://www.nursing.ohio.gov/forms.htm;

(14)(18) "LPN Reactivation and Reinstatement Application," dated 2016, may be obtained at http://www.nursing.ohio.gov/forms.htm;

(15)(19) "LPN Renewal Application," dated 2018, may be obtained at http://www.nursing.ohio.gov/forms.htm;

(16)(20) "Medication Aide Application," dated 2017, may be obtained at http://www.nursing.ohio.gov/forms.htm;

(17)(21) "Medication Aide Reactivation and Reinstatement Application," dated 2016, may be obtained at http://www.nursing.ohio.gov/forms.htm;

(18)(22) "Medication Aide Renewal Application," dated 2016, may be obtained at http://www.nursing.ohio.gov/forms.htm;

(19)(23) "Medication Aide Training Program Application," dated 2016, may be obtained at http://www.nursing.ohio.gov/forms.htm;
"Medication Aide Training Program Re-Approval Application," dated 2016, may be obtained at http://www.nursing.ohio.gov/forms.htm;

"Name Change Form," dated 2016, may be obtained at http://www.nursing.ohio.gov/forms.htm;

"Nursing Licensure by Endorsement Application," dated 2016, may be obtained at http://www.nursing.ohio.gov/forms.htm;

"NEG Drinking Agreement Year 1," dated 2019, may be obtained at http://www.nursing.ohio.gov/forms.htm;

"NEG Drinking Agreement Year 2," dated 2019, may be obtained at http://www.nursing.ohio.gov/forms.htm;

"NEG Quarterly Progress Report," dated 2019, may be obtained at http://www.nursing.ohio.gov/forms.htm;

"NEG RFP," dated 2019, may be obtained at http://www.nursing.ohio.gov/forms.htm;

"Nursing Licensure by Examination Application," dated 2016, may be obtained at http://www.nursing.ohio.gov/forms.htm;

"OBN Approver Application," dated 2017, may be obtained at http://www.nursing.ohio.gov/forms.htm;

"PN New Program Proposal Application," dated 2017, may be obtained at http://www.nursing.ohio.gov/forms.htm;

"RN New Education Program Proposal Application," dated 2017, may be obtained at http://www.nursing.ohio.gov/forms.htm;

"RN Reactivation and Reinstatement Application," dated 2016, may be obtained at http://www.nursing.ohio.gov/forms.htm;

"RN Renewal Application," dated 2017, may be obtained at http://www.nursing.ohio.gov/forms.htm;

"Request for Replacement Wall Certificate Form," dated 2016, may be obtained at http://www.nursing.ohio.gov/forms.htm;
"Volunteer's Certificate Application," dated 2016, may be obtained at http://www.nursing.ohio.gov/forms.htm;

"Volunteer's Certificate Reactivation and Reinstatement Application," dated 2016, may be obtained at http://www.nursing.ohio.gov/forms.htm;

Procedure for board determination of a program's status.

(A) The board shall grant full approval status to programs holding:

(1) Full approval, if a program demonstrates to the board that it continues to meet and maintain the requirements of this chapter;

(2) Conditional approval, at the first board meeting following completion of the survey process required by division (A)(5) of section 4723.06 of the Revised Code, provided the program demonstrates to the board that it meets and maintains the requirements of this chapter;

(3) Provisional approval, if the program demonstrates to the board that it meets and maintains the requirements of this chapter.

(B) The following procedures shall be followed by the board when a program does not meet and maintain the requirements of this chapter:

(1) For a program with conditional approval, the board shall propose to withdraw conditional approval pursuant to an adjudication under Chapter 119. of the Revised Code. The adjudication may result in the continuance of conditional approval, continuance of conditional approval based on compliance with the terms and conditions of a board order or consent agreement, or withdrawal of conditional approval;

(2) For a program with full approval, the board shall place the program on provisional approval in accordance with this chapter. When a program is placed on provisional approval, the board shall specify the requirements the program has not met and maintained and shall establish the time period during which the program will be on provisional approval. The board shall reconsider the program's approval status when the program demonstrates to the board that it meets and maintains the requirements of this chapter;

(3) If a program on provisional approval continues to fail to meet and maintain the requirements of this chapter at the end of the time period established for provisional approval, the board may propose to continue provisional approval for a period of time specified by the board or may propose to withdraw approval pursuant to an adjudication under Chapter 119. of the Revised Code. The adjudication may result in the continuance of provisional approval, withdrawal of approval, or granting of full approval;

(4) If a program on provisional approval in accordance with this chapter demonstrates that an additional requirement is not being met and maintained, the board shall propose to withdraw approval pursuant to an adjudication.
under Chapter 119. of the Revised Code. The adjudication may result in the continuance of provisional approval, withdrawal of approval, or granting of full approval.

(§)(4) The board may enter into a consent agreement in lieu of conducting an adjudication under this rule that addresses the requirements of this chapter not met and maintained.

(C) The board shall provide to the administrator of the program written notice of the board's action.

(D) If a program with full approval status loses its approval, accreditation or certificate of registration from the Ohio board of regents, the Ohio department of education, the state board of career colleges and schools, or any national or regional post-secondary education accreditation entity, a representative of the board may conduct a survey visit and the board may place the program on provisional approval.

(E) If a program with full approval status fails to meet any of the following requirements, the board shall place the program on provisional approval status for a period of time:

(1) Failure to provide clinical or laboratory experience to students, as required by paragraph (F)(8) of rule 4723-5-13 of the Administrative Code for a registered nursing program, or paragraph (E)(12) of rule 4723-5-14 of the Administrative Code or paragraph (F) of rule 4723-5-14 of the Administrative Code for a practical nursing program;

(2) Failure to timely designate a qualified administrator or interim administrator according to paragraph (D) of rule 4723-5-09 of the Administrative Code;

(3) Providing or submitting false, misleading or deceptive information, documentation or statements to the board, in violation of rule 4723-5-25 of the Administrative Code; or

(4) Having pass rates on the licensure examination of less than ninety-five per cent of the national average for first-time candidates for the fourth consecutive year, as specified in paragraph (B)(4) of rule 4723-5-23 of the Administrative Code.
Qualifications of administrators, faculty, teaching assistants and preceptors for a registered nursing education program.

(A) The minimum qualifications and academic preparation for administrator, faculty, teaching assistant and preceptor appointments for a registered nursing education program are as follows:

(1) For administrator of a program:

(a) Completion of an approved registered nursing education program in a jurisdiction as defined in paragraph (R) of rule 4723-5-01 of the Administrative Code;

(b) Experience for at least five years in the practice of nursing as a registered nurse, two of which have been as a faculty member in a registered nursing education program;

(c) A master's degree with a major in nursing;

(d) Current, valid licensure as a registered nurse in Ohio; and

(e) If the program is a baccalaureate or graduate program, an earned doctoral degree;

(2) For an associate administrator of a program:

(a) Completion of an approved registered nursing education program in a jurisdiction as defined in paragraph (R) of rule 4723-5-01 of the Administrative Code;

(b) Experience for at least five years in the practice of nursing as a registered nurse, two of which have been as a faculty member in a registered nursing education program;

(c) A master's degree with a major in nursing; and

(d) Current, valid licensure as a registered nurse in Ohio;

(3) For faculty teaching a nursing course:

(a) Completion of an approved registered nursing education program in a jurisdiction as defined in paragraph (R) of rule 4723-5-01 of the
Administrative Code;

(b) Experience for at least two years in the practice of nursing as a registered nurse;

(c) A master's degree;

(i) If the individual does not possess a bachelor of science in nursing degree, the master's or other academic degree, including, but not limited to a Ph.D., shall be in nursing;

(ii) If the individual possesses a bachelor of science in nursing degree, the master's degree may be, but is not required to be, in nursing; and

(d) Current, valid licensure as a registered nurse in Ohio;

(4) For a teaching assistant as defined in paragraph (NN) of rule 4723-5-01 of the Administrative Code:

(a) Completion of an approved registered nursing education program in a jurisdiction as defined in paragraph (R) of rule 4723-5-01 of the Administrative Code;

(b) Experience for at least two years in the practice of nursing as a registered nurse;

(c) A baccalaureate degree in nursing or enrollment in a graduate level course in a program for registered nurses to obtain a master's or doctoral degree with a major in nursing; and

(d) Current, valid licensure as a registered nurse in Ohio;

(5) For a preceptor as defined in paragraph (CC) of rule 4723-5-01 of the Administrative Code:

(a) Completion of an approved registered nursing education program in a jurisdiction as defined in paragraph (R) of rule 4723-5-01 of the Administrative Code;
(b) Experience for at least two years in the practice of nursing as a registered nurse with demonstrated competence in the area of clinical practice in which the preceptor provides supervision to a nursing student;

(c) A baccalaureate degree in nursing is preferred; and

(d) Current, valid licensure as a registered nurse in the jurisdiction or foreign country where the supervision of a nursing student's clinical experience occurs.

(B) The requirements of this rule do not prohibit an individual appointed to a position prior to February 1, 2008 from continuing to serve in the position if the individual met the rule requirements for the position at the time of appointment.

(C) An individual who is a foreign educated nurse graduate, as defined in paragraph (D) of rule 4723-7-01 of the Administrative Code, shall be deemed to have met the academic preparation for an administrator, faculty, teaching assistant or preceptor for a registered nursing education program specified in paragraphs (A)(1)(a), (A)(2)(a), (A)(3)(a), (A)(4)(a), and (A)(5)(a) of this rule, if the individual has practiced nursing as a registered nurse in the state of Ohio, or in another jurisdiction of the national council of state boards of nursing, for at least two years.
Qualifications of administrators, faculty, teaching assistants and preceptors for a practical nursing education program.

(A) The minimum qualifications and academic preparation for administrator, faculty, teaching assistant and preceptor appointments for a practical nursing education program are as follows:

(1) For an administrator of a program:

(a) Completion of an approved registered nursing education program in a jurisdiction as defined in paragraph (R) of rule 4723-5-01 of the Administrative Code;

(b) At least five years of experience in the practice of nursing as a registered nurse, two of which have been as a faculty member of a registered or practical nursing education program;

(c) A master's degree;

   (i) If the individual does not possess a bachelor of science in nursing degree, the master's or other academic degree, including, but not limited to a Ph.D., shall be in nursing.

   (ii) If the individual possesses a bachelor of science in nursing degree, the master's degree may be, but is not required to be, in nursing; and

(d) Current, valid licensure as a registered nurse in Ohio;

(2) For an associate administrator of a program:

(a) Completion of an approved registered nursing education program in a jurisdiction as defined in paragraph (R) of rule 4723-5-01 of the Administrative Code;

(b) At least five years of experience in the practice of nursing as a registered nurse, including two years as a faculty member in a registered or practical nursing education program;

(c) A master's degree;

   (i) If the individual does not possess a bachelor of science in nursing
degree, the master's or other academic degree, including, but not limited to a Ph.D., shall be in nursing;

(ii) If the individual possesses a bachelor of science in nursing degree, the master's degree may be, but is not required to be, in nursing; and

(d) Current, valid licensure as a registered nurse in Ohio;

(3) For faculty teaching a nursing course:

(a) Completion of an approved registered nursing education program in a jurisdiction as defined in paragraph (R) of rule 4723-5-01 of the Administrative Code;

(b) Experience for at least two years in the practice of nursing as a registered nurse;

(c) A baccalaureate degree in nursing; and

(d) Current, valid licensure as a registered nurse in Ohio;

(4) For a teaching assistant as defined in paragraph (NN) of rule 4723-5-01 of the Administrative Code:

(a) Completion of an approved registered nursing education program in a jurisdiction as defined in paragraph (R) of rule 4723-5-01 of the Administrative Code;

(b) Experience for at least two years in the practice of nursing as a registered nurse; and

(c) Current, valid licensure as a registered nurse in Ohio;

(5) For a preceptor as defined in paragraph (CC) of rule 4723-5-01 of the Administrative Code:

(a) Completion of an approved registered or practical nursing education program in a jurisdiction as defined in paragraph (R) of rule 4723-5-01 of the Administrative Code;
(b) Experience for at least two years in the practice of nursing as a registered nurse or as a licensed practical nurse with demonstrated competence in the area of clinical practice in which the preceptor provides supervision to a nursing student;

(c) Current, valid licensure as a registered nurse or as a licensed practical nurse in the jurisdiction or foreign country where the supervision of a nursing student's clinical experience occurs.

(B) The requirements of this rule do not prohibit an individual appointed to a position prior to February 1, 2008 from continuing to serve in the position if the individual met the rule requirements for the position at the time of appointment.

(C) An individual who is a foreign educated nurse graduate, as defined in paragraph (D) of rule 4723-7-01 of the Administrative Code, shall be deemed to have met the academic preparation for an administrator, faculty, teaching assistant or preceptor for a practical nursing education program specified in paragraphs (A)(1)(a), (A)(2)(a), (A)(3)(a), (A)(4)(a), and (A)(5)(a) of this rule, if the individual has practiced nursing as a registered nurse in the state of Ohio, or in another jurisdiction of the national council of state boards of nursing, for at least two years.
Program records.

The administrator of the program shall maintain records including the following:

(A) Records for currently enrolled nursing students that include:

   (1) Admission or transfer records;

   (2) Transcripts; and

   (3) Clinical experience evaluation records for each clinical course that reflect the student's achievement of the specific behavioral and cognitive skills and outcomes to successfully complete the course and to engage in safe and effective nursing practice;

   (4) Laboratory evaluation records for each course regarding nursing care of obstetrical patients, immediate newborns and pediatric patients, where high fidelity or mid or moderate fidelity simulation is used, that reflect the student's achievement of the specific behavioral and cognitive skills and outcomes to successfully complete the course, and to engage in safe and effective nursing practice;

   (5) Laboratory experience evaluation records for each course containing laboratory hours, not referenced in paragraph (A)(4) of this rule, that reflect the student's achievement of the specific behavioral and cognitive skills and outcomes to successfully complete the course, and to engage in safe and effective nursing practice;

(B) Records for all graduates of the program that shall include complete transcripts indicating the credential granted and the date of completion of the program;

(C) Records for the program that shall include the minutes of all scheduled faculty meetings;

(D) Records for each faculty and teaching assistant currently being utilized in the program that include:

   (1) Documentation of academic credentials, including copies of official academic transcripts;

   (2) A record that includes the time periods, by month and year of employment in clinical practice, and in teaching, and the names and locations of all employers in the field of nursing and nursing education; and
(3) Verification of current, valid licensure as a registered nurse in Ohio at the time of appointment, if the record has not been reviewed during a previous survey visit by the board, and at each licensure renewal.

(E) Records for preceptors that include:

(1) Verification of current, valid licensure as a registered nurse, or, for a practical nursing education program, as a licensed practical nurse, in the jurisdiction or foreign country where the supervision of a nursing student's clinical experience occurs; and

(2) A record demonstrating competency in the area of clinical practice in which the preceptor provides supervision to a nursing student, including the names and locations of employers in the field of nursing, and with time periods of employment, by month and year, demonstrating at least two years of nursing practice, and competency in the area of clinical practice in which the preceptor provides supervision to a nursing student.
Registered nurse licensure by endorsement.

[Comment: Information regarding the availability and effective date of the materials incorporated by reference in this rule can be found in paragraph (G) of rule 4723-1-03 of the Administrative Code.]

(A) A registered nurse applicant for licensure by endorsement shall satisfy the following:

(1) Have completed a registered nursing education program approved by a jurisdiction of the national council of state boards of nursing at the time the applicant completed the program;

(2) Submit a completed "Nursing Licensure by Endorsement Application," and the license application fee required by section 4723.08 of the Revised Code;

(3) As required by section 4723.09 of the Revised Code, submit to a criminal records check completed by the bureau of criminal identification and investigation the results of which indicate that the applicant for licensure by endorsement has not been convicted of, pleaded guilty to, or had a judicial finding of guilt for any violation set forth in section 4723.092 of the Revised Code;

(4) As required by section 4723.09 of the Revised Code, not be required to register under Chapter 2950. of the Revised Code or a substantially similar law of another state, the United States, or another country; and

(5) Have been originally licensed by examination to practice as a registered nurse and meet one of the following requirements:

(a) If originally licensed by examination prior to January 1, 1953, evidence of having passed an examination;

(b) If originally licensed by examination on or after January 1, 1953, but prior to July 1, 1982, achievement of a score of at least three hundred fifty on each subject tested in the "State Board Test Pool Examination";

(c) If originally licensed by examination on or after July 1, 1982, but prior to October 1, 1988, achievement of a score of at least one thousand six hundred on the NCLEX-RN; or

(d) If originally licensed by examination on or after October 1, 1988, achievement of a "pass" score on the NCLEX-RN;
(B) In addition to meeting the requirements in paragraph (A) of this rule, prior to licensure by endorsement as a registered nurse an applicant shall:

(1) Submit evidence of successful completion of a registered nursing education program according to paragraph (A)(1) of this rule;

(2) Have submitted directly from the jurisdiction of the applicant's original licensure by examination, or electronically from the national council of state boards of nursing, verification of licensure by examination as a registered nurse, as required by paragraph (A)(4) of this rule;

(3) Have submitted verification of current, valid licensure as a registered nurse directly from any jurisdiction of the national council of state boards of nursing, or electronically by the national council of state board of nursing;

(4) Submit to the board documentation of completion of two contact hours of continuing education that is directly related to Chapter 4723. of the Revised Code or rules adopted by the board, and that meets the requirements set forth in paragraph (C) of rule 4723-14-01 of the Administrative Code for category A education; and

(5) Submit any other documentation required by the board.

(C) The board may propose to deny licensure by endorsement pursuant to an adjudication conducted in accordance with Chapter 119. of the Revised Code.

(D) According to section 4723.09 of the Revised Code, the board may issue a nonrenewable temporary permit to practice nursing as a registered nurse to a registered nurse applicant for licensure by endorsement. A temporary permit expires at the earlier of one hundred eighty days after the permit is issued, or upon licensure by endorsement.

(E) An applicant for endorsement as a registered nurse who requests a temporary permit to practice nursing as a registered nurse in Ohio shall:

(1) Submit evidence of successful completion of a registered nursing education program according to paragraph (A)(1) of this rule;

(2) Have submitted directly from the jurisdiction of the applicant's original licensure by examination, or electronically from the national council of state boards of nursing, verification of licensure by examination as a registered
nurse according to paragraph (A)(5) of this rule;

(2) Have submitted verification of current, valid licensure as a registered nurse directly from any jurisdiction of the national council of state boards of nursing, or electronically from the national council of state boards of nursing; and

(3) Submit any other documentation required by the board.

(F) The board shall immediately terminate the applicant's temporary permit upon notification of a criminal records check completed by the bureau of criminal identification and investigation that indicates the individual has been convicted of, pleaded guilty to, or had a judicial finding of guilt for any violation set forth in section 4723.092 of the Revised Code, or upon information that the permit holder is required to register under Chapter 2950. of the Revised Code or a substantially similar law of another state, the United States, or another country.

(G) If an applicant for licensure by endorsement as a registered nurse fails to meet the requirements for licensure within one year from the date the application is received, or the application remains incomplete for one year, the application shall be considered void and the fee forfeited. The application shall state the circumstances under which forfeiture may occur.
Practical nurse licensure by endorsement.

[Comment: Information regarding the availability and effective date of the materials incorporated by reference in this rule can be found in paragraph (G) of rule 4723-1-03 of the Administrative Code.]

(A) A practical nurse applicant for licensure by endorsement shall satisfy the following:

(1) Have completed:

(a) A practical nursing education program approved by a jurisdiction of the national council of state boards of nursing at the time the applicant completed the program;

(b) If the applicant has practiced and maintained current, valid licensure as a licensed practical nurse in another jurisdiction for a minimum continuous period of five years prior to the date of application, either:

(i) A registered nursing education program approved by a jurisdiction of the national council of state boards of nursing, at the time the applicant completed the program; or

(ii) A registered nursing education program not approved by a jurisdiction of the national council of state boards of nursing, for which the board has received from the program administrator or designee, or from the jurisdiction in which the applicant was originally licensed by examination as a licensed practical nurse, a copy of an official transcript or other documentation demonstrating that the applicant's educational preparation is substantially similar to that required for programs approved by the board;

(2) Submit a completed "Nursing Licensure by Endorsement Application," and the applicable license application fee required by section 4723.08 of the Revised Code;

(3) As required by section 4723.09 of the Revised Code, submit to a criminal records check completed by the bureau of criminal identification and investigation, the results of which indicate that the applicant for licensure by endorsement has not been convicted of, pleaded guilty to, or had a judicial finding of guilt for any violation set forth in section 4723.092 of the Revised Code;

(4) As required by section 4723.09 of the Revised Code, not be required to register
under Chapter 2950. of the Revised Code or a substantially similar law of
another state, the United States, or another country; and

(5) Have been originally licensed to practice as a licensed practical nurse based
upon passing a practical nurse examination and meet one of the following
requirements:

(a) If originally licensed by examination on or after July 1, 1956, but prior to
July 1, 1982, achievement of a score of at least three hundred fifty on
the "State Board Test Pool Examination";

(b) If originally licensed by examination on or after July 1, 1982, but prior to
October 1, 1988, achievement of a score of at least three hundred fifty
on the NCLEX-PN; or

(c) If originally licensed by examination on or after October 1, 1988,
achievement of a "pass" score on the NCLEX-PN.

(B) In addition to meeting the requirements in paragraph (A) of this rule, prior to
licensure by endorsement as a practical nurse an applicant shall:

(1) Submit evidence of successful completion of a practical nursing program
according to paragraph (A)(1) of this rule;

(2) Have submitted directly from the jurisdiction of the applicant's original
licensure by examination, or electronically from the national council of state
boards of nursing, verification of licensure by examination as a practical
nurse, as required by paragraph (A)(5) of this rule;

(3) Have submitted verification of current, valid licensure as a licensed practical
nurse directly from any jurisdiction of the national council of state boards of
nursing or electronically by the national council of state boards of nursing;

(4) Submit to the board documentation of completion of two contact hours of
continuing education that is directly related to Chapter 4723. of the Revised
Code or rules adopted by the board and that meets the requirements set forth
in paragraph (C) of rule 4723-14-01 of the Administrative Code for category
A education; and

(5) Submit any other documentation required by the board.
(C) Upon the request of a practical nurse applicant for licensure by endorsement who satisfies the requirements of paragraphs (A) and (B) of this rule, the board may issue a license indicating one or both of the following:

(1) The applicant is authorized to administer medication according to division (F)(3) of section 4723.01 of the Revised Code if the applicant submits documentation satisfactory to the board of having successfully completed a course or course content in basic pharmacology;

(2) The applicant is authorized to provide adult intravenous therapy according to Chapter 4723-17 of the Administrative Code if the applicant submits documentation satisfactory to the board of meeting the requirements of section 4723.18 of the Revised Code and Chapter 4723-17 of the Administrative Code;

(D) The board may propose to deny licensure by endorsement pursuant to an adjudication conducted in accordance with Chapter 119. of the Revised Code.

(E) According to section 4723.09 of the Revised Code, the board may issue a nonrenewable temporary permit to practice nursing as a licensed practical nurse to a practical nurse applicant for licensure by endorsement. A temporary permit expires at the earlier of one hundred eighty days after the permit is issued, or upon licensure by endorsement.

(F) An applicant for licensure by endorsement as a practical nurse who requests a temporary permit to practice nursing as a licensed practical nurse in Ohio shall:

(1) Submit evidence of successful completion of a nursing education program according to paragraph (A)(1) of this rule;

(2)(1) Have submitted directly from the jurisdiction of the applicant's original licensure by examination, or electronically from the national council of state boards of nursing, verification of licensure by examination as a licensed practical nurse, according to paragraph (A)(5) of this rule;

(3)(2) Have submitted verification of current, valid licensure as a licensed practical nurse directly from any jurisdiction of the national council of state boards of nursing, or electronically from the national council of state boards of nursing, and if the applicant qualifies for licensure by endorsement as a practical nurse by satisfying the requirements of paragraph (A)(1)(e) of this rule, documentation that the applicant has practiced and maintained current, valid licensure as a licensed practical nurse in another jurisdiction for a continuous
period of five years prior to the date of application; and

(4)(3) Submit any other documentation required by the board.

(G) The board shall immediately terminate the applicant's temporary permit upon notification of a criminal records check completed by the bureau of criminal identification and investigation that indicates the individual has been convicted of, pleaded guilty to, or had a judicial finding of guilt for any violation set forth in section 4723.09 of the Revised Code, or upon information that the permit holder is required to register under Chapter 2950. of the Revised Code or a substantially similar law of another state, the United States, or another country.

(H) If an applicant for licensure by endorsement as a licensed practical nurse fails to meet the requirements for licensure within one year from the date the application is received, or the application remains incomplete for one year, the application shall be considered void and the fee forfeited. The application shall state the circumstances under which forfeiture may occur.
2.1

Formulary; standards of prescribing for advanced practice registered nurses designated as clinical nurse specialists, certified nurse-midwives, or certified nurse practitioners.

(A) Definitions; for purposes of this rule and interpretation of the formulary set forth in paragraph (B) of this rule, located at http://www.nursing.ohio.gov/Practice-Prescribing.htm (effective 2017):

(1) "Acute pain" means pain that normally fades with healing, is related to tissue damage, significantly alters a patient's typical function, and is expected to be time-limited and not more than six weeks in duration.

(2) "Chronic pain" means pain that has persisted after reasonable medical efforts have been made to relieve it and continues either episodically or continuously for twelve or more weeks following initial onset of pain. It may be the result of an underlying medical disease or condition, injury, medical treatment, inflammation, or unknown cause. "Chronic pain" does not include pain associated with a terminal condition or with a progressive disease that, in the normal course of progression, may reasonably be expected to result in a terminal condition.

(3) "Extended-release or long-acting opioid analgesic" means an opioid analgesic that:

   (a) Has United States food and drug administration approved labeling indicating that it is an extended-release or controlled release formulation;

   (b) Is administered via a transdermal route; or

   (c) Contains methadone.

(4) "Family member" means a spouse, parent, child, sibling or other individual with respect to whom an advanced practice registered nurse's personal or emotional involvement may render the advanced practice registered nurse unable to exercise detached professional judgment in reaching diagnostic or therapeutic decisions.

(5) "Hospice care program" has the same meaning as in section 3712.01 of the Revised Code.

(6) "ICD-10-CM medical diagnosis code" means the disease code in the most current international classification of diseases, clinical modifications
published by the United States department of health and human services.

(7) "Opioid analgesic" has the same meaning as in section 3719.01 of the Revised Code, and means a controlled substance that has analgesic pharmacological activity at the opioid receptors of the central nervous system, including but not limited to the following drugs and their varying salt forms or chemical congeners: buprenorphine, butorphanol, codeine (including acetaminophen and other combination products), dihydrocodeine, fentanyl, hydrocodone (including acetaminophen combination products), hydromorphone, meperidine, methadone, morphine sulfate, oxycodone (including acetaminophen, aspirin, and other combination products), oxymorphone, tapentadol, and tramadol.

(8) "Medication therapy management" has the same meaning as in rules adopted by agency 4729 of the Administrative Code.

(9) "Minor" has the same meaning as in section 3719.061 of the Revised Code.

(10) "Morphine equivalent daily dose (MED)" means a conversion of various opioid analgesics to a morphine equivalent dose by the use of accepted conversion tables provided by the state board of pharmacy at: https://www.ohiopmp.gov/MED_Calculator.aspx (effective 2017).

(11) "Palliative care" has the same meaning as in section 3712.01 of the Revised Code.

(12) "Sub-acute pain" means pain that has persisted after reasonable medical efforts have been made to relieve it and continues either episodically or continuously for more than six weeks but less than twelve weeks following initial onset of pain. It may be the result of an underlying medical disease or condition, injury, medical or surgical treatment, inflammation, or unknown cause.

(13) "Terminal condition" has the same meaning as in section 2123.01 of the Revised Code means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by a physician who has examined the patient, both of the following apply:

(a) There can be no recovery;

(b) Death is likely to occur within a relatively short time if life-sustaining
treatment is not administered.

(B) The committee on prescriptive governance shall establish a recommended exclusionary formulary, located at http://www.nursing.ohio.gov/Practice-Prescribing.htm (effective 2017), that may specify the exclusion of therapeutic devices, individual drugs or subtypes of individual drugs—Exclusionary Formulary. A certified nurse practitioner, clinical nurse specialist or certified nurse midwife shall not prescribe or furnish any drug or device in violation of federal or Ohio law, or rules adopted by the board, including this rule. The prescriptive authority of a certified nurse practitioner, clinical nurse specialist and certified nurse midwife shall not exceed the prescriptive authority of the collaborating physician or pediatrician.

(C) The recommended exclusionary formulary shall not permit the prescribing or furnishing of any drug or device prohibited by federal or state law, or rules adopted by the board, including this rule.

(D) The formulary established by the committee on prescriptive governance shall be available on the Ohio board of nursing website, located at http://www.nursing.ohio.gov/Practice-Prescribing.htm (effective 2017).

(E) The committee on prescriptive governance shall review the exclusionary formulary, located at http://www.nursing.ohio.gov/Practice-Prescribing.htm (effective 2017), for additions or deletions at least twice a year, and submit the recommended exclusionary formulary to the board. After reviewing a formulary submitted by the committee, the board may either adopt the formulary as a rule or ask the committee to reconsider and resubmit the formulary. The board shall not adopt any rule that does not conform to a formulary developed by the committee.

(F) A clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner may prescribe any drug or therapeutic device in any form or route of administration if:

1. The ability to prescribe the drug or therapeutic device is within the scope of practice in the advanced practice registered nurse's specialty area;

2. The prescription is consistent with the terms of a standard care arrangement entered into with a collaborating physician;

3. The prescription would not exceed the prescriptive authority of the collaborating physician, including restrictions imposed on the physician's practice by action of the United States drug enforcement administration or the state medical board, or by the state medical board rules, including but not limited to rule 4731-11-09 of the Administrative Code;
(4) The individual drug or subtype or therapeutic device is not one excluded by the exclusionary formulary set forth in paragraph (B) of this rule, located at http://www.nursing.ohio.gov/Practice-Prescribing.htm (effective 2017);

(5) The prescription meets the requirements of state and federal law, including but not limited to this rule, and all prescription issuance rules adopted by agency 4729 of the Administrative Code;

(6) A valid prescriber-patient relationship exists. This relationship may include, but is not limited to:

(a) Obtaining a relevant history of the patient;

(b) Conducting a physical or mental examination of the patient;

(c) Rendering a diagnosis;

(d) Prescribing medication;

(e) Consulting with the collaborating physician when necessary; and

(f) Documenting these steps in the patient’s medical records;

(7) Notwithstanding paragraph (F)(D)(6) of this rule, a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner may prescribe or personally furnish a drug according to section 4723.4810 of the Revised Code to not more than a total of two individuals who are sexual partners of the advanced practice registered nurse’s patient.

(8) If the patient is a family member, acceptable and prevailing standards of safe nursing care require that the advanced practice registered nurse maintain detached professional judgment. The advanced practice registered nurse shall not prescribe to a family member unless:

(a) The advanced practice registered nurse is able to exercise detached professional judgment in reaching diagnostic or therapeutic decisions;

(b) The prescription is documented in the patient’s record.

(9) Controlled substances. For drugs that are a controlled substance:
(a) The advanced practice registered nurse has obtained a United States drug enforcement administration registration, except if not required to do so as provided in rules adopted by agency 4729 of the Administrative Code, and indicates the number on the prescription;

(b) The prescription indicates the ICD-10-CM medical diagnosis code of the primary disease or condition that the controlled substance is being used to treat. The code shall, at minimum, include the first four alphanumeric characters of the ICD-10 CM medical diagnosis code, sometimes referred to as the category and etiology (ex. M165);

(c) The prescription indicates the days' supply of the controlled substance prescription.

(d) The patient is not a family member; and

(e) The advanced practice registered nurse shall not self-prescribe a controlled substance.

Schedule II controlled substances. Except as provided in paragraph (H)(E) of this rule, a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner may prescribe a schedule II controlled substance only in situations where all of the following apply:

(1) A patient has a terminal condition;

(2) A physician initially prescribed the substance for the patient; and

(3) The prescription is for a quantity that does not exceed the amount necessary for the patient's use in a single, seventy-two hour period.

Subject to the requirements set forth in paragraphs (H)(G), (H)(L), and (H)(K) of this rule, a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner may prescribe a schedule II controlled substance, if not excluded by the exclusionary formulary set forth in paragraph (B) of this rule, located at http://www.nursing.ohio.gov/Practice-Prescribing.htm (effective 2017), if the advanced practice registered nurse issues the prescription to the patient from any of the following locations:

(1) A hospital registered under section 3701.07 of the Revised Code;
(2) An entity owned or controlled, in whole or in part, by a hospital or by an entity that owns or controls, in whole or in part, one or more hospitals;

(3) A health care facility operated by the department of mental health or the department of developmental disabilities;

(4) A nursing home licensed under section 3721.02 of the Revised Code or by a political subdivision certified under section 3721.09 of the Revised Code;

(5) A county home or district home operated under Chapter 5155. of the Revised Code that is certified under the medicare or medicaid program;

(6) A hospice care program;

(7) A community mental health agency, as defined in section 5122.01 of the Revised Code;

(8) An ambulatory surgical facility, as defined in section 3702.30 of the Revised Code;

(9) A freestanding birthing center, as defined in section 3702.141 of the Revised Code;

(10) A federally qualified health center, as defined in section 3701.047 of the Revised Code;

(11) A federally qualified health center look-alike, as defined in section 3701.047 of the Revised Code;

(12) A health care office or facility operated by the board of health of a city or general health district or the authority having the duties of a board of health under section 3709.05 of the Revised Code;

(13) A site where a medical practice is operated, but only if the practice is comprised of one or more physicians who also are owners of the practice; the practice is organized to provide direct patient care; and the clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner providing services at the site has a standard care arrangement and collaborates with at least one of the physician owners who practices primarily at that site; or
(14) A residential care facility, as defined in section 3721.01 of the Revised Code.

(4)(G) A clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner shall not issue to a patient a prescription for a schedule II controlled substance from a convenience care clinic even if the clinic is owned or operated by an entity specified in paragraph (4)(F) of this rule.

(4)(H) Acute pain. For the treatment of acute pain, a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner shall comply with the following:

(1) Extended-release or long-acting opioid analgesics shall not be prescribed for the treatment of acute pain;

(2) Before prescribing an opioid analgesic, the advanced practice registered nurse shall first consider non-opioid treatment options. If opioid analgesic medications are required as determined by history and physical examination, the prescription should be for the minimum quantity and potency needed to treat the expected duration of pain, with a presumption that a three-day supply or less is frequently sufficient;

(3) In all circumstances where opioid analgesics are prescribed for acute pain:

(a) Except as provided in paragraph (4)(H)(3)(a)(iii) of this rule, the duration of the first opioid analgesic prescription for the treatment of an episode of acute pain shall be:

(i) For adults, not more than a seven-day supply with no refills;

(ii) For minors, not more than a five-day supply with no refills. As set forth in section 4723.481 of the Revised Code, the advanced practice registered nurse shall comply with section 3719.061 of the Revised Code, including but not limited to obtaining the parent or guardian's written consent prior to prescribing an opioid analgesic to a minor;

(iii) The seven-day limit for adults and five-day limit for minors may be exceeded for pain that is expected to persist for longer than seven days based on the pathology causing the pain. In this circumstance, the reason that the limits are being exceeded and the reason that a non-opioid analgesic medication was not appropriate to treat the patient's condition shall be documented in
the patient's medical record; and

(iv) If a patient is intolerant of or allergic to an opioid medication initially prescribed, a prescription for a different opioid medication may be issued at any time during the initial seven-day or five-day dosing period, and the new prescription shall be subject to the requirements of this rule. The patient's intolerance or allergy shall be documented in the patient's medical record, and the patient advised to safely dispose of the unused medication;

(b) The patient, or a minor's parent or guardian, shall be advised of the benefits and risks of the opioid analgesic, including the potential for addiction, and the advice shall be documented in the patient's medical record; and

(c) The total morphine equivalent dose (MED) of a prescription for opioid analgesics for treatment of acute pain shall not exceed an average of thirty MED per day, except when:

(i) The circumstances set forth in paragraph (A)(3)(c) of rule 4731-11-13 of the Administrative Code exist; and

(ii) The patient's treating physician has entered a standard care arrangement with the advanced practice registered nurse that states the understanding of the physician as to when the advanced practice registered nurse may exceed the thirty MED average, and when the advanced practice registered nurse must consult with the physician prior to exceeding the thirty MED average. The standard care arrangement in this circumstance must comply with rule 4731-11-13 of the Administrative Code, and the advanced practice registered nurse must document in the patient's record the reason for exceeding the thirty MED average and the reason it is the lowest dose consistent with the patient's medical condition.

(1) The requirements of paragraph (j)(1) of this rule apply to treatment of acute pain, and do not apply when an opioid analgesic is prescribed:

(1) To a patient an individual who is in a hospice care program;

(2) To a patient an individual who is receiving palliative care;
(3) To a patient, an individual who has been diagnosed with a terminal condition, as that term is defined in paragraph (A) of this rule; or

(4) To a patient, an individual who has cancer or a condition associated with the individual's cancer or history of cancer.

(4)(I) The requirements of paragraph (4)(I) of this rule do not apply to:

(1) Prescriptions for opioid analgesics for the treatment of opioid addiction utilizing a controlled substance that is approved by the FDA for opioid detoxification or maintenance treatment; or

(2) Inpatient prescriptions as defined in rules adopted by agency 4729 of the Administrative Code.

(4)(K) Sub-acute and chronic pain. As specified in section 4723.481 of the Revised Code, for treatment of sub-acute and chronic pain, a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner shall prescribe in a manner not exceeding the prescriptive authority of the collaborating physician or podiatrist. Prescribing parameters specifically include, but are not limited to, the following requirements set forth in rule 4731-11-14 of the Administrative Code:

(1) Prior to treating, or continuing to treat sub-acute or chronic pain with an opioid analgesic, the advanced practice registered nurse shall first consider and document non-medications options. If opioid analgesic medications are required as determined by a history and physical examination, the advanced practice registered nurse shall prescribe the minimum quantity and potency needed to treat the expected duration of pain and improve the patient's ability to function;

(2) Before prescribing an opioid analgesic for sub-acute or chronic pain, the advanced practice registered nurse shall complete or update and document in the patient record assessment activities to assure the appropriateness and safety of the medication, as required by rule 4731-11-14 of the Administrative Code, including but not limited to:

(a) Completing an OARRS check in compliance with rule 4723-9-12 of the Administrative Code;

(b) Offering the patient a prescription for naloxone if the following circumstances exist:
(i) The patient has a prior history of opioid overdose;

(ii) The patient is co-prescribed a benzodiazepine, sedative hypnotic drug, carisprodal, tramadol, or gabapentin;

(iii) The patient has a concurrent substance use disorder; or

(iv) The dosage exceeds eighty MED as discussed in paragraph (M)(K)(5) of this rule;

(c) The advanced practice registered nurse shall consider offering the patient a prescription for naloxone if the dosage exceeds fifty MED as discussed in paragraph (M)(K)(4) of this rule.

(3) During the course of treatment with an opioid analgesic at doses below the average of fifty MED per day, the advanced practice registered nurse shall provide periodic follow-up assessment and documentation of the patient's functional status, the patient's progress toward treatment objectives, indicators of possible addiction, drug abuse or diversion, and any adverse drug effects.

(4) Fifty MED. Prior to increasing the opioid dosage to a daily average of fifty MED or greater, the advanced practice registered nurse shall complete and document in the patient record the activities and information set forth in rule 4731-11-14 of the Administrative Code, including but not limited to the following:

(a) Review and update the assessment completed in paragraph (M)(K)(2) of this rule if needed. The advanced practice registered nurse may rely on an appropriate assessment completed within a reasonable time if the advanced practice registered nurse is satisfied that he or she may rely on that information for purposes of meeting the requirements of Chapter 4723-8 and Chapter 4723-9 of the Administrative Code;

(b) Except when the patient was prescribed an average daily dosage that exceeded fifty MED before the effective date of this rule, document consideration of:

(i) Consultation with a specialist in the area of the body affected by the pain;
(ii) Consultation with a pain management specialist;

(iii) Obtaining a medication therapy management review by a pharmacist;

(iv) Consultation with a specialist in addiction medicine or addiction psychiatry, if aberrant behaviors indicating medication misuse or substance use disorder are noted;

(c) The advanced practice registered nurse shall consider offering the patient a prescription for naloxone if the dosage exceeds fifty MED as discussed in paragraph (M)(3)(K)(4) of this rule;

(d) During the course of treatment with an opioid analgesic at doses at or above the average of fifty MED per day, the advanced practice registered nurse shall complete and document in the patient record all of the information and activities required by rule 4731-11-14 of the Administrative Code not less than every three months.

(5) Eighty MED. Prior to increasing the opioid dosage to a daily average of eighty MED or greater, the advanced practice registered nurse shall complete and document in the patient record the activities and information set forth in rule 4731-11-14 of the Administrative Code, including but not limited to the following:

(a) A written pain management agreement shall be entered with the patient that outlines the advanced practice registered nurse's and patient's responsibilities during treatment, which requires the patient or patient guardian's agreement to all of the provisions set forth in rule 4731-11-14 of the Administrative Code;

(b) The advanced practice registered nurse shall offer the patient a prescription for naloxone;

(c) Except when the patient was prescribed an average daily dosage that exceeded eighty MED before the effective date of this rule, the advanced practice registered nurse shall obtain at least one of the following based upon the patient's clinical presentation:

(i) Consultation with a specialist in the area of the body affected by the pain;
(ii) Consultation with a pain management specialist;

(iii) A medication therapy management review by a pharmacist; or

(iv) Consultation with a specialist in addiction medicine or addiction psychiatry, if aberrant behaviors indicating medication misuse or substance use disorder are noted.

(6) One hundred twenty MED. The advanced practice registered nurse shall not prescribe a dosage that exceeds an average of one hundred twenty MED per day. This prohibition shall not apply under the following circumstances:

(a) The advanced practice registered nurse holds national certification in pain management or hospice and palliative care by a national certifying organization approved according to section 4723.46 of the Revised Code in

(i) Pain management;

(ii) Hospice and palliative care;

(iii) Oncology; or

(iv) Hematology;

(b) The advanced practice registered nurse has received a written recommendation for a dosage exceeding an average of one hundred twenty MED per day from a board certified pain medicine physician, or board certified hospice and palliative care physician, who based the recommendation on a face-to-face visit and examination of the patient. The advanced practice registered nurse shall maintain the written recommendation in the patient's record; or

(c) The patient was receiving an average daily dose of one hundred twenty MED or more prior to the effective date of this rule. However, prior to escalating the patient's dose, the advanced practice registered nurse shall receive a written recommendation as set forth in paragraph (M)(K)(6)(b) of this rule.

(7) The requirements of paragraph (M)(K) of this rule do not apply when an opioid analgesic is prescribed:
(a) To an individual, patient who is in a hospice care program;

(b) To an patient individual who has terminal cancer or another terminal condition, as that term is defined in paragraph (A) of this rule; or

(c) As an inpatient prescription as defined in rules adopted by agency 4729 of the Administrative Code.

(2) Drugs approved by the FDA but not yet reviewed and approved by the committee on prescriptive governance may be prescribed, unless later disapproved by the committee on prescriptive governance, if:

1) The drug type or subtype is not excluded on the formulary set forth in paragraph (B) of this rule, located at http://www.nursing.ohio.gov/Practice.htm (effective 2017); and

2) The collaborating physician has agreed in the standard care arrangement that the advanced practice registered nurse may prescribe drugs approved by the FDA, that meet the criteria set forth in paragraphs (2) and (2) of this rule, that have not yet been reviewed and approved by the committee on prescriptive governance.

(3) As specified in section 4723.44 of the Revised Code, a clinical nurse specialist, licensed nurse-midwife, or certified nurse practitioner shall not prescribe any drug or device to perform or induce an abortion.

(4) As specified in section 4723.44B of the Revised Code, notwithstanding the requirements of this rule, a clinical nurse specialist, licensed nurse-midwife, or certified nurse practitioner may prescribe or personally furnish naloxone.

(5) The requirements of paragraph (E)(D)(9)(c) of this rule apply to prescriptions for products that contain gabapentin.
Medication-assisted treatment.

(A) Definitions; for purposes of this rule and interpretation of the formulary set forth in rule 4723-9-10 of the Administrative Code, located at http://www.nursing.ohio.gov/Practice/Prescribing.htm (effective May 17, 2017):

(1) "Community addiction services provider" has the same meaning as in section 5119.01 of the Revised Code.

(2) "Community mental health services provider" has the same meaning as in section 5119.01 of the Revised Code.

(3) "Controlled substance," "schedule III," "schedule IV," and "schedule V" have the same meanings as in section 3719.01 of the Revised Code.

(4) "FDA" means the United States food and drug administration.

(5) "Induction phase" means the phase of opioid treatment during which maintenance medication dosage levels are adjusted until a patient attains stabilization.

(6) "Medication-assisted treatment" means alcohol or drug addiction services that are accompanied by medication that has been approved by the United States food and drug administration for the treatment of substance use disorder, prevention of relapse of substance use disorder, or both.

(7) "Office-based opioid treatment" or "OBOT" means medication-assisted treatment of opioid dependence or addiction utilizing controlled substances, in a private office or public sector clinic that is not otherwise regulated, by practitioners who are authorized to prescribe outpatient supplies of medications approved by the FDA for the treatment of opioid addiction or prevention of relapse. OBOT includes treatment with all controlled substance drugs medications approved by the FDA for such treatment. OBOT does not include treatment that occurs in the following settings:

(a) A state or local correctional facility, as defined in section 5163.45 of the Revised Code;

(b) A hospital, as defined in section 3727.01 of the Revised Code;

(c) A provider certified to provide residential and inpatient substance use disorder services, including withdrawal management, by the Ohio department of mental health and addiction services;
(d) An opioid treatment program certified by SAMHSA and accredited by an independent, SAMHSA-approved accrediting body; or

(c) A youth services facility, as defined in section 103.75 of the Revised Code.

(8) "OARRS" means the "Ohio Automated RX Reporting System" drug database established and maintained pursuant to section 4729.75 of the Revised Code.

(9) "Qualified behavioral healthcare provider" means the following who is practicing within the scope of professional licensure:

(a) A medical doctor or doctor of osteopathic medicine and surgery who holds board certification in addiction medicine or addiction psychiatry, or a psychiatrist, licensed under Chapter 4731. of the Revised Code;

(b) A licensed independent chemical dependency counselor-clinical supervisor, licensed independent chemical dependency counselor, licensed chemical dependency counselor III, licensed chemical dependency counselor II, or licensed chemical dependency counselor assistant licensed under Chapter 4758. of the Revised Code;

(c) A professional clinical counselor, licensed professional counselor, licensed independent social worker, licensed social worker, or marriage and family therapist, licensed under Chapter 4757. of the Revised Code;

(d) An advanced practice registered nurse licensed as a clinical nurse specialist or certified nurse practitioner licensed by the board, who holds national certification in psychiatric mental health, or clinical nurse specialist who was not required to obtain national certification according to section 4723.41 of the Revised Code, and whose specialty is psychiatric mental health; or

(e) A psychologist, as defined in division (A) of section 4732.01 of the Revised Code, licensed under Chapter 4732. of the Revised Code; or

(f) An advanced practice registered nurse licensed by the board who holds additional certification as a certified addictions registered nurse-advanced practice issued by the addictions nursing certification board.
Nothing in paragraph (A)(9) of this rule shall be construed to prohibit an advanced practice registered nurse who collaborates with a physician licensed under Chapter 4731. of the Revised Code and certified as an addiction psychiatrist, addictionologist, or psychiatrist, from providing services within the normal course of practice and expertise of the collaborating physician, including addiction services, other mental health services, and prescriptive services in compliance with Ohio and federal law and rules.

(10) "SAMHSA" means the United States substance abuse and mental health services administration.

(11) "Stabilization phase" means the medical and psychosocial process of assisting the patient through acute intoxication and withdrawal management to the attainment of a medically stable, fully supported substance-free state, which may include the assistance of medications.

(B) A clinical nurse specialist, certified nurse midwife, or certified nurse practitioner who holds a current valid advanced practice registered nurse license may provide medication-assisted treatment, including prescribing controlled substances in schedule III, IV or V, if the clinical nurse specialist, certified nurse midwife, or certified nurse practitioner:

(1) Complies with section 3719.064 of the Revised Code, and all federal and state laws and regulations governing the prescribing of the medication, including but not limited to incorporating into the advanced practice registered nurse's practice knowledge of Chapter 4729. of the Revised Code, and Chapter 4731. of the Revised Code and rules adopted under that Chapter that govern the practice of the advanced practice registered nurse's collaborating physician;

(2) Completes at least eight hours of continuing nursing education in each renewal period related to substance abuse and addiction. Courses completed in compliance with this requirement shall be accepted toward meeting the continuing education requirements for biennial renewal of the advanced practice registered nurse license; and

(3) Only provides medication-assisted treatment if the treatment is within the collaborating physician's normal course of practice and expertise.

(C) In addition to the requirements for medication-assisted treatment set forth in paragraph (B) of this rule, a clinical nurse specialist or certified nurse practitioner may provide OBOT under the following circumstances:
(1) The standard care arrangement statement of services offered includes OBOT;

(2) The advanced practice registered nurse performs, or confirms the completion of, and documents a patient assessment that includes all of the following:

(a) A comprehensive medical and psychiatric history;

(b) A brief mental status history;

(c) Substance abuse history;

(d) Family history and psychosocial supports;

(e) Appropriate physical examination;

(f) Urine drug screen or oral fluid drug testing;

(g) Pregnancy test for women of childbearing age and ability;

(h) Review of patient's prescription information in OARRS;

(i) Testing for human immunodeficiency virus;

(j) Testing for hepatitis B;

(k) Testing for hepatitis C;

(l) Consideration of screening for tuberculosis and sexually-transmitted diseases in patients with known risk factors.

(m) For other than the toxicology tests for drugs and alcohol, appropriate history, substance abuse history, and pregnancy test, the advanced practice registered nurse may satisfy the assessment requirements by reviewing records from a physical examination and laboratory testing of the patient that was conducted within a reasonable period of time prior to the visit.

(n) If any part of the assessment cannot be completed prior to the initiation of OBOT, the advanced practice registered nurse shall document the reasons in the medical record.
(3) The advanced practice registered nurse establishes and documents a treatment plan that includes all of the following:

(a) The advanced practice registered nurse's rationale for selection of the specific drug to be used in the medication-assisted treatment;

(b) Patient education;

(c) The patient's written, informed consent;

(d) Random urine-drug screens or oral fluid drug testing;

(e) A signed treatment agreement with the patient that outlines the responsibilities of the patient and the advanced practice registered nurse;

(f) A plan for psychosocial treatment as discussed in paragraph (C)(5) of this rule;

(4) The advanced practice registered nurse shall provide OBOT in accordance with an acceptable treatment protocol for assessment, induction, stabilization, maintenance and tapering. Acceptable protocols are any of the following:

(a) SAMSHA treatment improvement protocol publications for medication-assisted treatment available from the SAMSHA website at: 
https://store.samhsa.gov/; list/series/11name=TIP-Series Treatment Improvement Protocol

(b) "National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use," approved by the American society of addiction medicine in 20132015, and available from the website of the American society of addiction medicine at https://www.asam.org/;Ohio department of mental health and addiction services.

(5) Except if the advanced practice registered nurse is a qualified behavior healthcare provider, the advanced practice registered nurse shall refer and work jointly with a qualified behavioral healthcare provider, community mental health services provider, or community addiction services provider to determine the optimal type and intensity of psychosocial treatment for the patient and document the treatment plan in the patient record.
(a) The treatment shall at minimum include a psychosocial needs assessment, supportive counseling, links to existing family supports, and referral to community services;

(b) The treatment shall include at least one of the following interventions:

(i) Cognitive behavioral treatment;

(ii) Community reinforcement approach;

(iii) Contingency management/motivational incentives; or

(iv) Behavioral couples counseling;

(c) The treatment plan shall include a structure for renegotiation of the treatment plan if the patient does not adhere to the original plan.

(6) When clinically appropriate or and if the patient refuses treatment from a qualified behavioral healthcare provider, community mental health services provider, or community addiction services provider, the advanced practice registered nurse shall ensure that the OBOT treatment plan requires the patient to participate in a twelve step program or appropriate self-help recovery program. If the patient is required to participate in a twelve step program or self-help recovery program, the advanced practice registered nurse shall require the patient to provide documentation of on-going participation in the program.

(7) If the advanced practice registered nurse refers the patient to a qualified behavioral health service provider, community addiction services provider, or community mental health services provider, the advanced practice registered nurse shall document the referral and the advanced practice registered nurse's meaningful interactions with the provider in the patient record.

(8) The advanced practice registered nurse shall offer the patient a prescription for a naloxone kit.

(a) The advanced practice registered nurse shall ensure that the patient receives instruction on the kit's use including, but not limited to, recognizing the signs and symptoms of overdose and calling 911 in an overdose situation.
(b) The advanced practice registered nurse shall offer the patient a new prescription for naloxone upon expiration or use of the old kit.

(b)(c) The advanced practice registered nurse shall be exempt from this requirement set forth in paragraph (C)(9)(a) of this rule does not apply if the patient refuses the prescription. If the patient refuses the prescription the advanced practice registered nurse shall provide the patient with information on where to obtain a kit without a prescription.

(9) If the advanced practice registered nurse provides OBOT using buprenorphine products, the following additional requirements must be met:

(a) The provision shall comply with the FDA approved "Risk Evaluation and Mitigation Strategy" for buprenorphine products, which can be found on FDA website at the following address: https://www.accessdata.fda.gov/scripts/cder/remss/index.cfm. With the exception of those conditions listed in paragraph (C)(9)(b) of this rule, the advanced practice registered nurse who treats an opioid use disorder with a buprenorphine product shall only prescribe a combination product of buprenorphine/naloxone combination products and naloxone for use in OBOT.

(b) The advanced practice registered nurse shall prescribe buprenorphine without naloxone (buprenorphine mono-product) only in the following situations, and shall fully document the evidence for the decision to use buprenorphine mono-product in the patient's record:

(i) When the patient is pregnant or breast-feeding;

(ii) When converting the patient from methadone or a buprenorphine mono-product to a buprenorphine/naloxone combination product containing naloxone for a period not to exceed seven days;

(iii) In formulations other than tablet or film form for indications approved by the FDA;

(iv) For withdrawal management when a combination product of buprenorphine/naloxone combination product and naloxone is contraindicated, with the contraindication documented in the patient record; or

(v) When the patient has an allergy to or intolerance of a combination
product of buprenorphine/naloxone combination product and naloxone, after explaining to the patient the difference between an allergic reaction and symptoms of opioid withdrawal precipitated by buprenorphine or naloxone, and with documentation included in the patient record.

(c) Due to a higher risk of fatal overdose when buprenorphine is prescribed with other opioids, benzodiazepines, sedative hypnotics, carisoprodol, and tramadol, the advanced practice registered nurse shall only co-prescribe these substances when it is medically necessary there are extenuating circumstances, and only if:

(i) The advanced practice registered nurse verifies the diagnosis for which the patient is receiving the other drug and coordinates care with the prescriber for the other drug, including discussing with the prescriber whether it is possible to taper the drug to discontinuation. If the advanced practice registered nurse prescribing buprenorphine is the prescriber of the other drug, the advanced practice registered nurse shall taper the other drug to discontinuation, if possible if it is safe to do so. The advanced practice registered nurse shall educate the patient about the serious risks of the combined use; and

(ii) The advanced practice registered nurse documents progress in achieving the tapering plan in the patient record.

(d) During the induction phase, the advanced practice registered nurse shall not prescribe a dosage that exceeds the recommendation in the FDA approved labeling, except for medically indicated circumstances as documented in the patient record. The advanced practice registered nurse shall see the patient at least once per week during this phase.

(e) During the stabilization phase, when using any oral formulation of buprenorphine, the advanced practice registered nurse shall increase the daily dosage of buprenorphine in safe and effective increments to achieve the lowest dose that avoids intoxication, withdrawal, or significant drug craving.

(i) During the first ninety days of treatment, the advanced practice registered nurse shall prescribe no more than a two-week supply of the buprenorphine product containing naloxone.

(ii) Starting with the ninety-first day of treatment and until the
completion of twelve months of treatment, the advanced practice registered nurse shall prescribe no more than a thirty-day supply of the buprenorphine product containing naloxone.

(f) The advanced practice registered nurse shall take steps to reduce the chances of buprenorphine diversion by using the lowest effective dose, appropriate frequency of office visits, pill counts, and checks of OARRS. The advanced practice registered nurse shall also require urine drug screens, or serum medication levels, or oral fluid testing at least twice per quarter for the first year of treatment and at least once per quarter thereafter.

(g) When using any oral formulation of buprenorphine, the advanced practice registered nurse shall document in the patient record the rationale for prescribed doses exceeding sixteen milligrams of buprenorphine per day. The advanced practice registered nurse shall not prescribe a dose of buprenorphine exceeding twenty-four milligrams per day.

(h) The advanced practice registered nurse shall incorporate relapse prevention strategies into counseling or assure that they are addressed by a qualified behavioral healthcare provider who has the education and experience to provide substance abuse counseling.

(i) The advanced practice registered nurse may treat a patient using the administration of extended-release, injectable, or implanted buprenorphine under the following circumstances:

(i) The advanced practice registered nurse strictly complies with any required risk evaluation and mitigation strategy program for the drug;

(ii) The advanced practice registered nurse shall prescribe an extended-release buprenorphine product strictly in accordance with the FDA’s approved labeling for the drug’s use;

(iii) The advanced practice registered nurse documents in the patient record the rationale for the use of the extended-release product; and

(iv) The advanced practice registered nurse who orders or prescribes extended-release, injectable, or implanted buprenorphine product shall administer the drug, or require it to be administered by
another Ohio licensed health care provider acting in accordance with the scope of their professional license.

(10) If the clinical nurse specialist or certified nurse practitioner is using naltrexone to treat opioid use disorder, the advanced practice registered nurse shall comply with the following additional requirements:

(a) Prior to treating a patient with naltrexone, the advanced practice registered nurse shall inform the patient about the risk of opioid overdose if the patient ceases naltrexone and then uses opioids. The advanced practice registered nurse shall take measures to ensure that the patient is adequately detoxified from opioids and is no longer physically dependent prior to treatment with naltrexone;

(b) The advanced practice registered nurse shall use oral naltrexone only for treatment of patients who can be closely supervised and who are highly motivated;

(i) The dosage regime shall strictly comply with the FDA approved labeling for naltrexone hydrochloride tablets;

(ii) The patient shall be encouraged to have a support person assist with the administration of the medication and supervise the medication. Examples of a support person are a family member, close friend, or employer;

(c) The advanced practice registered nurse shall require urine drug screens, or serum medication levels or oral fluid testing at least every three months for the first year of treatment and at least every six months thereafter;

(d) The advanced practice registered nurse shall incorporate relapse prevention strategies into counseling or assure that they are addressed by a qualified behavioral healthcare or mental health services provider who has education and experience to provide substance abuse counseling.

(e) The advanced practice registered nurse may treat a patient with extended-release naltrexone for opioid dependence or for co-occurring opioid and alcohol use disorders.

(i) The advanced practice registered nurse should consider treatment
with extended-release naltrexone for patients who have issues with treatment adherence;

(ii) The injection dosage shall strictly comply with FDA labeling for extended-release naltrexone; and

(iii) The advanced practice registered nurse shall incorporate relapse prevention strategies into counseling or assure that they are addressed by a qualified behavioral healthcare provider or mental health services provider who has the education and experience to provide substance abuse counseling.
4723-20-01 Definitions pertaining to prevention of disease transmission and infection control.

For the purposes of this chapter, the following definitions shall apply:

(A) "Aseptic technique" means practices used to reduce or eliminate microorganisms.

(B) "Exposure-prone activity" means an activity in which there is a risk of disease transmission by virtue of any of the following:

(1) Direct contact with a disease source that includes:

(a) Airborne transmission or droplet;

(b) Eating or drinking contaminated food or water;

(c) Being bitten by an insect or other disease carrying agent;

(2) Invasive procedure;

(3) Any other direct contact with disease source, including bodily contact; or

(4) Contact with contaminated environmental surfaces.

(C) "Hand washing" as that term is used in division (K)(1) of section 4723.07 of the Revised Code is a component of hand hygiene achieved by washing and rinsing hands with non-antimicrobial soap or antimicrobial soap and water, or by using alcohol-based waterless hand sanitizers or other antimicrobial agents.

(D) "Invasive procedure" means any procedure involving manual or instrumental contact with, or entry into, any blood, body fluid, cavity, internal organ, subcutaneous tissue, mucous membrane or percutaneous wound of the human body. If percutaneous injury occurs to a licensee or certificate holder during an exposure-prone activity, the licensee's or certificate holder's blood is likely to contact the patient's body cavity, subcutaneous tissues, or mucous membranes.

(E) "Respiratory hygiene" is an element of standard precautions that requires the licensee or certificate holder to engage in source control practices to control the spread of respiratory infection, including but not limited to:

(1) Covering coughs or sneezes, promptly disposing of used tissues, and performing hand hygiene;
(2) Source control measures, including but not limited to using masks on a coughing patient when tolerated and appropriate; or

(3) Spatial separation of patients and other persons with respiratory infections in common waiting areas when possible.

(F) "Universal and standard precautions" are infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered, and include but are not limited to the following:

(1) Practices used to mitigate exposure to disease-causing agents when exposure-prone activity occurs;

(2) Hand hygiene;

(3) Disinfection and sterilization of equipment;

(4) Appropriate handling and disposal of needles and other sharp instruments; and

(5) Appropriate use of personal protective equipment, including wearing and disposal of gloves and other protective barriers or devices.
Hand hygiene.

During the delivery of healthcare, licensees and certificate holders shall follow acceptable and prevailing standard precautions for hand hygiene, including but not limited to the following:

(A) Appropriate handwashing prior to performing or participating in an exposure-prone activity and after performing or participating in an exposure-prone activity;

(B) Washing the hands and other skin surfaces immediately and thoroughly when hands have had contact with mucous membranes, blood or body fluids, secretions or excretions, or after touching contaminated items; and

(C) Washing the hands immediately after the gloves are removed; and

(D) For the purposes of this chapter, hand washing may include the use of alcohol-based waterless hand sanitizers or other antimicrobial agents. If contact with spores, such as C. difficile or bacillus anthracis, has likely occurred, the physical action of washing and rinsing hands with antimicrobial soap and water is the recommended standard precaution.
4723-20-07  Failure to use universal and standard precautions.

During the delivery of healthcare, a licensee or certificate holder who fails to follow universal and standard precautions when engaging in exposure-prone activity, as set forth in rules 4723-20-01 to 4723-20-06 of the Administrative Code, may be subject to disciplinary action according to section 4723.28 of the Revised Code.
The Economic Impact of the Expansion of Nurse Practitioner Scope of Practice for Medicaid

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Introduction: The demand for primary care services may surpass the supply of primary care providers, exacerbating challenges with access, quality, and cost in the U.S. healthcare system. Expanding the supply of, and access to, nurse practitioner (NP) care has been proposed as one method to alleviate these challenges. Aim: To estimate the impact of expanded NP scope of practice (SOP) regulations on the costs of total outpatient visits, prescription drugs, and total care days received by Medicaid beneficiaries nationwide from 1999–2011. Methods: We used a longitudinal data policy analysis framework and built a fixed-effect model, a generalized form of a difference-in-differences model, to identify the effect of changes in NP SOP regulations on the outcome variables. The models included controls for state income and unemployment rates. Results: Compared to states with reduced SOP, states with full SOP had 17% lower outpatient costs (i.e., $160.45 per beneficiary per year) and 10.9% lower prescription drug costs (i.e., $145.44 per beneficiary per year). States with restricted SOP had 11.6% higher outpatient costs (i.e., $107.31 per beneficiary per year) and 5.1% higher prescription drug costs (i.e., $67.89 per beneficiary per year). Annual total care days were 8% (i.e., 819,905.9 days) higher in states with full SOP compared to states with reduced SOP (p = .05). Conclusion: States that expand NP SOP may provide greater intensity of care (measured using total care days) to Medicaid patients without increasing total costs of care.

Keywords: Scope of practice, nurse practitioner, Medicaid, outpatient costs, prescription drug costs, total care days

Although the United States spends more on healthcare than any other country in the world, the healthcare system has struggled to ensure high-quality accessible primary care (The Commonwealth Fund, 2015). Furthermore, the demand for primary care services could soon surpass the supply of primary care providers, which could exacerbate existing challenges with access, quality, and cost (U.S. Department of Health and Human Services: Health Resources and Services Administration, 2019). To alleviate these issues and particularly to ensure that underserved populations (e.g., rural residents, Medicaid beneficiaries, etc.) have access to timely high-quality care, many stakeholders have proposed expanding the supply of, and access to, nurse practitioner (NP) care (Institute of Medicine, 2010; National Governors Association, 2012). A recent report concluded that the growing NP workforce can be a solution for the primary care crisis in the United States (Buerhaus, 2018). The NP workforce, which will increase by 93% between 2013 and 2025, represents a valuable source of primary care providers who deliver safe and effective care to patients and can help to achieve optimal patient outcomes (Newhouse et al., 2011; Poghosyan, Lucero, Rauch, & Berkowitz, 2012; U.S. Department of Health and Human Services, 2016). Indeed, primary care practices increasingly rely on the NP workforce to meet the care demand (Barnes, Richards, McHugh, & Martsolf, 2018).

However, scope of practice (SOP) regulations governing NP practice vary significantly across the United States. Twenty-three states allow NPs to practice to the fullest extent of their education and training, while the remaining states require NPs to have supervisory or collaborative relationships with physicians to deliver care or prescribe medications (American Association of Nurse Practitioners [AANP], 2018). Several organizations such as the Federal Trade Commission, the National Governors Association, and the National Academy of Medicine (formerly the Institute of Medicine) have been critical of restrictive NP SOP laws and recommend removing these regulatory restrictions to ensure the optimal use of NPs to meet the demand for care and achieve the best patient outcomes (Federal Trade Commission, 2014; Institute of Medicine, 2010; National Governors Association, 2012).

Research shows NPs provide high-quality, cost-effective care to Medicare beneficiaries (Perloff, DesRoches, & Buerhaus, 2016), and a number of studies have suggested that expanded SOP can lead to improvements in access to care as measured directly or indirectly by healthcare service utilization and provider supply (Martsolf & Kandrack, 2017). NP care might help to meet...
the growing demand for healthcare services and could also lead to cost savings for states if the SOP regulations allow NPs to practice to the fullest extent of their education and training. Simulation studies have also suggested that expanded NP SOP might lead to reductions in overall costs of healthcare services (Conover & Richards, 2015; Hooker & Muchow, 2015). Studies that have directly estimated the effect of NP SOP on costs have suggested that expanding NP SOP would either reduce or have no effect on overall cost of care (Adams & Markowitz, 2018; Kleiner, Marier, Park, & Wing, 2016; Stange, 2014).

Despite this evidence, some argue that NP SOP should be restricted and that NPs should always be supervised by physicians (American Academy of Family Physicians, 2012). One particular area of concern is that prescriptive authority could increase the cost of care and the utilization of medications. Yet, studies show that NPs having prescriptive authority does not lead to increases in prescriptions with abuse potential (Ladd, Sweeney, Guarino, & Hoyt, 2017; Schirle & McCabe, 2015). In addition, these studies suggest that state SOP regulation is not the only predictor of NP prescribing and provide important evidence that expanding NP SOP likely does not increase prescription drug costs. However, no studies to our knowledge have investigated this relationship directly. In addition, studies that have focused on the relationship between NP SOP, costs, and access have important limitations; for instance, many are single-state studies or cross-sectional in nature, which makes generalizability and causal inference difficult to assert. National studies to date have focused on all patients as opposed to Medicaid patients, which is an especially vulnerable patient population. Large national studies are needed to produce robust evidence, particularly when SOP and Medicaid policies are set at the state level and NP SOP regulation change may have a more direct impact on Medicaid patients than on other patient populations. The purpose of this study was to estimate the impact of expanded NP SOP regulations on the cost of total outpatient visits and prescription drugs as well as total care days (defined as care intensity) received by Medicaid patients nationwide. We hypothesized that NP SOP expansion in the state would result in a reduction in outpatient and prescription drug costs and an increase in care intensity for Medicaid beneficiaries. This assessment would help illuminate the impact of NP SOP on Medicaid costs and care intensity if states expand NP SOP.

**Methods**

**Design**

We used a longitudinal data policy analysis framework to identify the effect of changes in NP SOP regulations on cost of total outpatient visits and prescription drugs and care days received by Medicaid patients from 1999–2011 in all U.S. states. This framework also allowed us to compare each variable in each state before and after the policy change and control for time and time invariant differences across states. Data on outpatient visits, prescription drugs, and total number of care days were collected at the state level for each year in our sample.

**IRB Approval**

This study is part of a large investigation on NP SOP impact on NP supply, work environment, and cost of care. The overall study was approved by the Institutional Review Board of Columbia University Medical Center.

**Data Sources**

The Centers for Medicare & Medicaid Services-Medicaid Statistical Information System (CMS-MSIS) dataset contains data on total outpatient and prescription drug costs and total care days for Medicaid beneficiaries nationwide. The CMS-MSIS compiles the number of Medicaid beneficiaries in each state (and Washington, D.C.) and the dollar value of claims on a variety of healthcare services, including outpatient visits, prescription drugs, and the total number of care days on an annual basis. Beginning in 1999, all Medicaid claims data were electronically transmitted to the CMS-MSIS. The program ceased in 2011; thus, we only have data from 1999–2011.

We used the AANP’s NP state-level SOP classifications to gather measures of NP SOP (AANP, 2018). The data source lists each state and the NP SOP regulation in the state (and Washington, D.C.). This source is recommended by the National Council of State Boards of Nursing and the National Academy of Medicine as providing reliable and up-to-date information about NP SOP policy in each state.

We also used data on state personal income from the Bureau of Economic Analysis. Data on state unemployment rates from the Bureau of Labor Statistics were also obtained. The same data were also collected for Washington, D.C. Both of these variables allowed us to control for time-varying differences in each state with respect to the ability to pay for healthcare services and the quality of life for the average citizen in each state.

**Variables and Measures**

We used three key outcome variables. The first outcome variable was the total outpatient costs per Medicaid beneficiary. Using data on total dollar amount of outpatient claims for all Medicaid beneficiaries in the state annually, we computed the total outpatient costs per Medicaid beneficiary. All dollar amounts were adjusted for inflation and placed into 2012 dollars ($2012). For each state and each year in our sample (663 total observations), we divided each state’s total outpatient costs by the number of Medicaid beneficiaries in each state.

The second outcome variable was total prescription drug costs per Medicaid beneficiary. We measured this variable by dividing the total dollar amount ($2012) of prescription drug claims by the total counts of beneficiaries in each state annually. Twelve observations were missing (651 total observations) because some states do not report data on prescription drug costs.
Care intensity was the third outcome variable. It is measured by the total number of care days received by Medicaid patients in each state annually and serves as a proxy for the amount of medical services received by Medicaid patients annually (Timmons, 2017). Our data included the total number of care days received by Medicaid patients in each state annually.

Our main independent variable was NP SOP. State NP SOP was categorized according to the AANP as (a) full practice if NPs have the authority to evaluate, diagnose, order tests, initiate and manage treatments, and prescribe drugs; (b) reduced practice if a collaborative or written practice agreement is required for NPs to perform one or more elements of practice; and (c) restricted practice if supervision, delegation, or team management is required. In 2018, 23 states were full practice, 16 were reduced practice, and 12 were restricted practice. These three categories were used to construct two variables. Each state-year was coded as equal to: (a) “1” for each year of full practice and “0” otherwise and (b) “1” for each year of reduced SOP and “0” otherwise. Reduced states were coded as “0” using both of these variables. We used the variables to assess the effect of NP SOP on the outcomes using data from all states. From 1999 to 2011, Kentucky, Louisiana, New Jersey, Mississippi, and Nevada switched from “restricted” to “reduced”; Wyoming and Idaho switched from “reduced” to “full”; and Hawaii switched from “restricted” to “reduced” and then “reduced” to “full” NP SOP.

We used state personal income per capita and state unemployment rates as covariates. We divided state-level total income data by each state’s population to produce estimates of personal income per capita, which then was adjusted for inflation and placed into 2012 dollars. Unemployment rates were measured using standard Bureau of Labor Statistics definitions and is computed as the percentage of active job seekers that are unable to secure employment in the labor market.

### Data Analysis

To estimate the effect of the NP SOP change on the outcome variables, we used a fixed-effects model. The key feature of our fixed-effects models is the inclusion of binary indicator variables for each state and year. The effect of NP SOP regulations on outcomes in this model relies on within-state change in NP SOP (e.g., from “restricted” to “reduced” status) and change in the outcomes of interest. In total, we estimated three separate linear regressions, one for each outcome variable: (a) total outpatient costs per beneficiary, (b) prescription drug costs per beneficiary, and (c) care intensity. In all models, the main predictor variable included SOP, which is a vector-assessing measure of NP SOP. It was comprised of a dummy variable for “restricted” and “full” NP SOP. The category of “reduced” NP SOP is the excluded category. We also included our covariates (i.e., personal income per capita and state unemployment rates) in the models, which control for time-varying differences in health outcomes and access to care associated with economic conditions. The models were estimated using ordinary least squares. We adjusted the standard errors to account for clustering of observations within states. All regressions were performed using STATA SE/15.1.

### Results

Table 1 contains summary statistics. In our dataset, we had 651 state-year combinations. In our sample, the average cost of outpatient claims per Medicaid beneficiary was $923.50, while the average prescription drug cost per Medicaid beneficiary was $1,330.93. Across states, on average, Medicaid patients received 10,200,000 days of care annually. The mean personal income for states was $35,757, and the mean state unemployment rate was 5.8%.

Table 2 presents our estimates of the effect of NP SOP on total outpatient costs per Medicaid beneficiary and total prescription drug cost per Medicaid beneficiary. Compared to states with reduced SOP and evaluating at mean levels, states with full SOP had 17.4% lower outpatient costs (i.e., $160.45 per beneficiary per year) and 10.9% lower prescription drug costs (i.e., $145.44 per beneficiary per year). In addition, states with restricted SOP had 11.6% higher outpatient costs (i.e., $107.31 per beneficiary per year) and 5.1% higher prescription drug costs (i.e., $67.89 per beneficiary per year). Our estimates, however, were not statistically significant (both \( p > .1 \)).

We also present the effect of expanded NP SOP on Medicaid patient care intensity in Table 2. Annual total care days were 8% higher (i.e., 819,905.9 days) in states with full SOP compared to states with reduced SOP. The estimated coefficient on annual total care days was statistically significant (\( p = .05 \)). Annual total care days (in thousands) were statistically significant (\( p = .05 \)).

### Table 1

<table>
<thead>
<tr>
<th>Study Variables</th>
<th>Mean</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome Variables</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Outpatient Costs per Medicaid Beneficiary ($)</td>
<td>923.50</td>
<td>783.69</td>
</tr>
<tr>
<td>Total Prescription Drug Cost per Medicaid Beneficiary ($)</td>
<td>1,330.93</td>
<td>1,187.75</td>
</tr>
<tr>
<td>Total Care Days</td>
<td>10,200,000</td>
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<tr>
<td><strong>Covariates</strong></td>
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<tr>
<td>State Personal Income per Capita ($)</td>
<td>35,757.34</td>
<td>34,662.50</td>
</tr>
<tr>
<td>State Unemployment Rate (%)</td>
<td>5.8</td>
<td>5.3</td>
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</tbody>
</table>

Sources. Data on total outpatient costs, total prescription drug costs, and total care days are extracted from the Centers for Medicare & Medicaid Services-Medicaid Statistical Information System (CMS-MSIS). Data on personal income are from the Bureau of Economic Analysis. Data on unemployment rate are from the Bureau of Labor Statistics.

Note. All dollar amounts were adjusted for inflation and placed into 2012 dollars.
days were 343,601.9 days higher in states with restrictive SOP than in states with reduced NP SOP \( (p > .1) \).

### Discussion and Regulatory Implications

Our study is the first to use national longitudinal data to assess the impact of changing state NP SOP law on cost of care, prescription medication costs, and care intensity for Medicaid beneficiaries—a unique population that experiences significant challenges with receiving access to needed services. Taken together, our results suggest that expansion of NP SOP is associated with increases in the care intensity (measured by the annual total care days) of Medicaid patients without increasing the cost of the care provided. Medicaid patients in states with full SOP receive 8% more annual care days than in states with reduced SOP. More specifically, states that switch from reduced to full NP SOP in our sample experience this increase in annual care days. No increase in care days is observed for states switching from restricted to reduced NP SOP. This increase in care intensity was not associated with increased costs. In fact, our effect estimates for costs were negative, although they were not statistically significant. The findings are clinically significant in terms of increasing the amount of care patients receive without increasing the cost.

These findings show full SOP for NPs can lead to increases in access to care without incurring increases in costs of care for payers and society at large. Our study is consistent with previous studies that have shown expansions of NP SOP lead to significant increases in access to care measured by both patient reports and utilization of services. For example, Traczyński and Udalova (2018) found higher levels of patient-reported access to care in states with full SOP for NPs, in which NPs have both practice and prescription authority, than in states with restricted authority. Individuals in states with full SOP also had a higher probability of receiving a routine check-up. Stange (2014) found that individuals in states with less-restrictive prescriptive authority regulations for NPs had 3% more visits conditional on having at least one office-based provider.

In recent years, the availability of primary care appointments for Medicaid beneficiaries has increased (Polsky et al., 2015). This may be explained by the fact that the NP workforce has been growing significantly over the past several years, NPs are more likely to care for low-income and minority patients who are Medicaid beneficiaries, and several states expanded NP SOP (AANP, 2018; U.S. Department of Health and Human Services, 2016). Thus, removing SOP restrictions on the NP workforce may continue to promote access to care for Medicaid beneficiaries. Furthermore, a recent study found that clinics with more NPs and physician assistants provided better access to care for Medicaid patients (Richards & Polsky, 2016). However, these relationships were only found in states with full SOP for NPs, further suggesting the beneficial effect of full SOP on access to care, especially for vulnerable populations.

Policymakers have the responsibility to examine all intended and unintended effects of regulatory actions, and our results suggest they should consider the merits of increasing NP SOP. Research shows that NPs are safe and effective practitioners (Newhouse et al., 2011; Buerhaus et al., 2018). Expanding SOP will not endanger public safety. On the contrary, it will increase patients’ access to care. Our results should be of interest to policymakers concerned with increasing access to care among vulnerable populations.

### Table 2

<table>
<thead>
<tr>
<th>Predictor Variables</th>
<th>Total Outpatient Costs ($ per Medicaid Beneficiary ((p) values)</th>
<th>Total Prescription Drug Cost ($ per Medicaid Beneficiary ((p) values)</th>
<th>Total Care Days ((p) values)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NP Full Scope of Practice Compared with Reduced Scope of Practice</td>
<td>-160.45 (0.62)</td>
<td>-145.44 (0.41)</td>
<td>819,905.9 (0.05)</td>
</tr>
<tr>
<td>NP Restricted Scope of Practice Compared with Reduced Scope of Practice</td>
<td>107.31 (0.27)</td>
<td>67.89 (0.42)</td>
<td>343,601.9 (0.58)</td>
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<tr>
<td>State Personal Income per Capita ($)</td>
<td>-.017 (0.28)</td>
<td>-.013 (0.92)</td>
<td>18.1 (0.78)</td>
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<tr>
<td>State Unemployment Rate (%)</td>
<td>3.56 (0.52)</td>
<td>-6.13 (0.03)</td>
<td>6304.2 (0.87)</td>
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</tbody>
</table>

**Model Information**

<table>
<thead>
<tr>
<th>(n)</th>
<th>(R^2)</th>
<th>(n)</th>
<th>(R^2)</th>
<th>(n)</th>
<th>(R^2)</th>
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</thead>
<tbody>
<tr>
<td>663</td>
<td>.79</td>
<td>651</td>
<td>.81</td>
<td>663</td>
<td>.93</td>
</tr>
</tbody>
</table>

*Note. NP = nurse practitioner; \(n\) = state-year combination sample. All regressions include state and year fixed effects. Reduced scope of practice serves as the referent category for scope of practice estimates. \(p\) values computed using standard errors clustered by state. All dollar amounts were adjusted for inflation and placed into 2012 dollars.

*Sources. Data on costs and patient care intensity are from the Centers for Medicare & Medicaid Services-Medicaid Statistical Information System (CMS-MSIS). Data on personal income are from the Bureau of Economic Analysis. Data on unemployment rate are from the Bureau of Labor Statistics.*
patient populations as well as the costs incurred by the Medicaid program.

**Limitations and Future Research**

Our study has some limitations. The data are aggregated to the state level, and we cannot directly identify or separate care provided by NPs. This limitation may result in imprecision (higher standard errors) in our estimates of the effects of expanded NP SOP. These data also limit our estimation strategy. However, our approach is conservative. The standard errors are adjusted for state clustering.

In the future, data should be obtained that would allow identifying the provider of the care either at the individual or aggregate level. Our empirical approach also relied on the eight states that expanded NP SOP in the time period of our data set and we only had access to data from 1999–2011. Thus, we cannot estimate the impact of SOP changes after 2011. Additional research is needed using more recent data, particularly considering a major focus has been removing NP SOP restrictions after the publication of the pivotal *Future of Nursing Report* (Institute of Medicine, 2010) and Medicaid expansions (Patient Protection and Affordable Care Act, 2010). Also, a richer set of covariates over a longer period would be helpful in estimating the effects of expanded NP SOP on the cost and intensity of care delivered to Medicaid patients.

**Conclusion**

Utilizing a national longitudinal data policy analysis, we demonstrated that expanding NP SOP policy can increase patient access to care delivered to Medicaid beneficiaries without increasing costs. Our results suggest that expanding NP SOP is associated with greater care intensity without increasing the cost of care. In other words, each dollar spent on Medicaid claims provides more care to patients. Policymakers should strongly consider removing unnecessary restrictions on NP SOP to ensure Medicaid beneficiaries have access to timely cost-effective care. More research using up-to-date Medicaid claims is needed.

**References**


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Enhancing Psychiatric Mental Health Nurse Practitioner Practice: Impact of State Scope of Practice Regulations

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Introduction: Shortages of behavioral health providers, particularly prescribing clinicians, are widespread nationally. Although rapidly increasing numbers of psychiatric mental health nurse practitioners (PMHNPs) could increase access to behavioral health services, state limitations on scope of practice may restrict their ability to do so. Aim: The purpose of this comparative case study was to assess how state scope of practice regulations impact PMHNP practice in five states with different levels of nurse practitioner autonomy (full, reduced, and restricted), as categorized by the American Association of Nurse Practitioners. Methods: Site visits and interviews were conducted with 94 key informants, including state board of nursing staff, PMHNP practitioners and educators, behavioral health agency directors, and psychiatrists. State scope of practice regulations were reviewed. Thematic analysis was used to analyze qualitative data. Results: Findings indicated that scope of practice regulations affected settings and arrangements in which PMHNPs practiced. In states where physician supervision is required, PMHNPs and agency leaders reported costs and administrative burdens related to obtaining and documenting supervision. PMHNP practice was sometimes constrained by institutional restrictions not required by law. Conclusion: Mandated physician supervision of PMHNPs adds cost and diminishes accessibility to both psychiatrists and PMHNPs. Full nurse practitioner practice authority allows for more efficient utilization of PMHNPs and may increase access to services.

Keywords: Behavioral health, nurse practitioner regulations, scope of practice

Mental health and substance use disorders (SUDs) are a major public health issue in the United States. The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Behavioral Health Statistics and Quality (2018) estimated that in 2017, 11.2 million adults (18 years of age and older) in the United States had a serious mental illness and 46.6 million had any mental illness in the past year. Additionally, 3.2 million youth (12 to 17 years of age) had experienced a major depressive episode in the prior 12 months. An estimated 19.7 million Americans (12 years of age and older) had a SUD in that year. SAMHSA projects that by 2020, behavioral health disorders will surpass all physical health disorders as a major cause of disability worldwide (SAMHSA, 2018).

Factors related to healthcare reform, including increased access to health insurance and parity in mental health benefits, as well as societal issues such as the opioid epidemic, have led to a dramatic increase in the demand for mental health services. Prior to implementation of the Affordable Care Act, it was estimated that 25% of uninsured adults had a mental health and/or substance abuse condition (Garfield, Lave, & Donohue, 2010). While the expansion of insurance coverage for behavioral health reduced financial barriers and led to an increase of 5.3% in treatment among young adults with possible mental health disorders (Saloner & Lê Cook, 2014), an increase in the behavioral health workforce is needed to accommodate the numbers of newly covered individuals seeking services (Saloner & Lê Cook, 2014).

These recent changes are superimposed on a long-term lack of access to psychiatric services that has resulted in significant delays for those seeking treatment, reduced quality of care, and low patient satisfaction (National Council Medical Director Institute [NCMDI], 2017). The NCMDI (2017) also notes that the increase in screening for psychiatric and addictive disorders in primary care will continue to increase demand for access to psychiatric services.

There is a well-documented shortage of behavioral health providers, particularly for underserved areas and populations. The U.S. Department of Health and Human Services (DHHS) Bureau of Health Workforce (BHW) identified 4,700 Mental Health Care Health Professional Shortage Areas with a total population of more than 100 million people (US DHHS BHW, 2017). Approximately 62% of these areas are in rural or partially rural areas (US DHHS BHW, 2017). The NCMDI (2017) notes the psychiatrist workforce is aging and the number of psychiatrists working with public sector and insured populations declined by 10% over a 10-year period. The growing demand for behavioral health services will exacerbate these shortages, particularly for the underserved.
Psychiatric mental health advanced practice registered nurses (PMH-APRNs) are behavioral health providers with prescriptive authority who add to the number of professionals and help address this shortage. First licensed and certified as clinical nurse specialists (PMH-CNSs) and more recently as psychiatric mental health nurse practitioners (PMHNPs), PMH-APRNs have been practicing for more than 50 years (Delaney, 2017). A literature review of 14 papers on psychiatric nurses in advanced practice found their services yielded positive outcomes, especially in the detection of mental health needs in non–mental health settings (Fung, Chan, & Chien, 2014). The PMH-APRN workforce is growing and expected to surpass 17,000 by 2025 (Delaney, 2017).

PMH-CNSs have independent or dependent prescriptive authority in 38 states and the District of Columbia (National Association of Clinical Nurse Specialists, 2015), and all states allow PMHNPs to prescribe, though 10 states restrict prescribing (Delaney, 2017). Because regulation of nurse practitioner (NP) practice is more similar across states than CNS practice, and because PMH-APRN programs have moved exclusively to NP education, we focused on scope of practice for PMHNPs, which is governed by the same state regulatory framework as other NP roles.

Because PMHNPs can potentially play a significant role in improving access to behavioral health services (NCMDI, 2017), this study assessed the impact of state scope of practice regulation on the ability of PMHNPs to contribute these services to the full extent of their education and experience. Although our primary focus was PMHNPs, we included PMH-CNSs with prescriptive authority because they are a substantial portion of the PMH-APRN workforce in some states. We examined regulatory and other practice barriers that limit the potential contribution of PMHNPs, and in some cases PMH-CNSs, and make recommendations for enhancing the practice environment for PMH-APRNs. Research questions included the following:

- How does PMHNP practice vary in states by scope of practice?
- What recommendations for policy and regulatory changes can enhance the ability of PMHNPs to practice consistent with their education and experience?

**Background**

There are substantial state variations in how independently NPs can practice, which in turn affects their ability to increase access to health services. Studies indicate the general NP workforce expands in states that grant NPs independent practice authority (Xue, Ye, Brewer, & Spetz, 2016; Hooker & Muchow, 2015). Because NPs are more likely than physicians to practice in rural areas, a study by Neff et al. (2018) demonstrated there was greater access to primary care in states with autonomous NP practice after assessing the distance patients had to drive to receive care.

Another study of utilization and NP practice authority found NPs in states with full practice authority provided more mental health services than physicians in community health centers when compared with states without autonomous practice (Yang et al., 2017).

Scope of practice regulations may impact economics as well as access to care. In one of the few economic analyses focused on NP scope of practice, researchers found if a state moved to less restrictive regulation of advanced practice nurses, the state benefited from increased economic output and tax revenues (Conover & Richards, 2015). A similar study (Hooker & Muchow, 2015) predicted lower costs due to salary savings and reduced emergency department visits in states with full scope of practice for NPs.

Additional research in California, a restricted practice state, found that issues related to state scope of practice for PMHNPs included barriers to practice and full utilization of these professionals (Phoenix, Hurd, & Chapman, 2016). Reported barriers included widespread difficulty understanding regulations related to NP practice, challenges in arranging physician supervision, physician concerns about the burden of providing supervision, cost of supervision, and practice limitations such as the ability to sign certain patient care documents (Phoenix, Hurd, & Chapman, 2016). Despite these obstacles, psychiatrists, behavioral health directors, and other professional colleagues interviewed in the California study all valued the contributions of PMHNPs and thought they made unique contributions to patient care and outcomes. In addition, the economic analysis showed PMHNPs made a positive net financial contribution to the agencies where they were employed (Chapman, Phoenix, Hahn, & Strod, 2018).

In summary, previous studies on the impact of granting full practice authority to NPs are sparse, but findings from a few studies indicate both expansion of the NP workforce and greater access to care. However, few studies have focused specifically on behavioral health care and the role of PMHNPs in providing that care.

**Methods**

We used a qualitative comparative case study approach to assess and compare models and conditions of PMHNP practice in five states with varied scope of practice regulations for NPs. CNSs were included in states where PMH-CNSs have prescriptive authority. Case study involves the study of an issue across multiple research sites (Creswell, 2007, p. 73). We used the categorization of state practice environments for NPs as defined by the American Association of Nurse Practitioners (AANP, 2018) to select states for the study. This categorization of state practice regulation has three levels: full practice, reduced practice, and restricted practice. We received human subjects approval from the University of California, San Francisco.

**Setting**

We selected five states that represent different geographical regions of the United States and degrees of urbanization, as well as differ-
rent levels of NP autonomy. Selected states were Oregon, Colorado, Illinois, Massachusetts, and North Carolina.

**Sampling and Recruitment**

We began recruitment by reaching out to our state PMHNP program faculty contacts and known PMHNPs practicing in the selected states. We developed a spreadsheet of potential interviewees and sites including email and phone numbers provided by our contacts. We then reached out to selected sites and individual informants by email and/or telephone with letters of invitation and a project description.

We used snowball sampling to identify additional potential informants and visit sites within the states. Our goal was to find a mixture of practice sites by size, urban and rural setting, population size served, and behavioral health service delivery models. Thus, practice sites included community mental health clinics, county mental health services, integrated primary care clinics, psychiatric inpatient units, academic medical centers, substance abuse treatment settings, and private and group practices. We also sought to recruit informants with a variety of perspectives on PMHNP practice, including PMHNPs, agency directors, and colleagues from other behavioral health disciplines. We made a concentrated effort to recruit psychiatrists who could speak to the physician experience in required collaborative relationships.

**Data Collection and Analysis**

Interviews were conducted with individuals or small groups by our three-member research team using interview guides to increase consistency across interviews. Most interviews were conducted in person during our week-long visits to each state, but we also conducted some interviews by phone in cases where the informant was not available to meet during our visit.

All three members of the study team took detailed notes by hand or on a laptop computer. The research team included a senior analyst, a faculty member from a nonclinical department, and a faculty member from the PMHNP program. Interviews were not recorded because many of the interviews were conducted in settings not conducive to obtaining quality audio recordings.

Interview notes were summarized and reviewed by each team member. Documents reviewed included regulations posted on each state’s public board of nursing (BON) website describing the states’ scope of practice. We also compiled data provided by the American Nurses Credentialing Center (M. Horahan, personal communication, January 21, 2018) on the number of certified PMH-APRNs in each state and compared state ratios for practitioners to population to compare the current size of the PMHNP workforce in the selected states. Information about nursing workforce and regulation in each state was used to provide context and triangulate with information provided in the informant interviews.

A thematic analytic approach was used to code and analyze the key informant interview information. In this approach, data are grouped into key themes and each interview is examined to ensure that each manifestation of the theme has been accounted for and compared across interviews (Pope & Mays, 2006). Issues of potential bias were discussed as the research team conferred and reached consensus on key themes and findings. Original categories in the data arose from topics covered by our interview guide (e.g., role functions, perspectives on scope of practice), and additional data categories were added as issues were described by informants. When our study was complete, we conducted webinars for our informants in each state discussing our findings as a form of respondent validation of the study’s validity (Noble & Smith, 2015).

**Results**

We visited 40 sites with 6–10 sites/organizations and 14–28 interviews per state for a total of 94 interviews. Interviewees included state BON staff, state advanced practice nursing organization staff, directors of PMHNP education programs, program faculty, PMH-APRNs in various practice settings, agency/system directors, psychiatrists, and other health professionals who worked on teams with PMH-APRNs. Several interviewees had roles as both faculty and practitioner. About 15–20% of the interviewees worked in a solo or group private practice. There were three to four group interviews of PMHNPs in each state conducted during the early morning or lunch time breaks so as to not interfere with scheduled clinical appointments.

**Sizes of APRN-PMH Workforces in Each State**

Data on the number of certified PMHNPs and PMH-CNSs in the five states we visited were provided by the American Nurse Credentialing Center (M. Horahan, personal communication, January 21, 2018) (Table 1). Data on the number of PMH-APRNs per 100,000 population showed a wide variation, with
Massachusetts having the highest at 17.6 and Illinois having the lowest at 2.8 per 100,000 population. In most of the states visited, the PMH-APRNs were predominantly NPs, except for Massachusetts, which has a long history of PMH-CNS preparation and many active practitioners with prescriptive authority. In all other states except North Carolina, there were fewer PMH-CNS practitioners, but they have a pathway to obtaining prescriptive authority.

Scope of Practice Variation Among States

None of the states visited have a distinct scope of practice for PMH-APRNs. Massachusetts has a scope of practice for PMH-CNSs that differs from other CNSs in the state. In Colorado, regulations from the Department of Behavioral Health affect certain functions of PMH-APRN practice, such as ability to release legal mental health holds.

Oregon uses APRN as the title for advanced practitioners as recommended by the APRN Consensus Model. APRNs have had independent practice since the 1970s, prescriptive authority since 1979, and authority to prescribe Schedule 2 drugs since 1995 (Oregon State Board of Nursing, personal communication, February 13, 2017). In addition, Oregon passed a payment parity law in 2013 sponsored in part by the Oregon Nurses Association. NPs must be paid 100% of what physicians are paid for providing the same services in primary care and mental health. This applies to Medicare, Medicaid, and all commercial insurers.

In Colorado, NPs gained full practice authority in 2015 (Colorado Board of Nursing, personal communication, June 9, 2017). Prior to that, a collaboration agreement with a physician was required. Prescriptive authority for NPs requires obtaining 1,000 hours of documented mentorship with either a physician or APRN who has full prescriptive authority and experience in prescribing medications. Colorado also requires NPs to develop an “Articulated Plan for Safe Prescribing” that includes a quality assurance plan and mechanism for ongoing consultation with a physician or NP mentor. The signed plan must be kept on file and can be audited. There is no required format for the articulation agreement, but the BON has templates available.

Massachusetts is a restricted practice state for APRNs according to the AANP (2018). In 2014, the Massachusetts (BON) clarified in the regulations that restricted practice is for prescriptive authority only. The PMH-CNS scope of practice is essentially the same as for PMHNP except that PMH-CNSs must be supervised by psychiatrists while NPs can be supervised by any physician practicing in the same field. PMH-APRNs are supervised for the prescribing of controlled substances.

North Carolina is another state with a restricted scope of practice for APRNs and a requirement of collaborative practice with a physician (AANP, 2018). NPs are jointly regulated by the state BON and the medical board. Certified PMH-CNSs practice in the state, though they have never had prescriptive authority in North Carolina. Attempts to update the Nursing Practice Act in North Carolina to reduce restrictions on APRN practice in 2017 were not successful.

Illinois is currently designated by the AANP (2018) as a reduced practice state requiring supervision. However, in January 2018, new legislation was passed to allow full practice authority for NPs after they obtain 4,000 hours of supervised clinical experience. The law continues the requirement for supervision in prescribing specific controlled substances. Regulations to implement this new law are still in development.

Impact of Regulations on Practice Setting

In the states with full practice authority for NPs, Oregon and Colorado, informants reported that independence in practice was a key factor in their choice of practice setting, and in some instances is what prompted them to move to the state to practice. For this study, we were not able to assess whether there was any growth in the number of PMHNP in states with full practice authority; however, interviewees often reported this was a factor in their staying in the state or moving to another state to practice. A PMHNP who completed her graduate education in California stated she “wanted a less restrictive practice environment, so Washington and Oregon were the top two options.” In contrast, an agency leader in North Carolina noted, “PMHNPs I try to recruit are now saying, ‘I don’t want to work in a state without autonomous practice.’”

Key informants in full practice authority states reported it was relatively easy to set up private or group NP practices. In contrast, informants in the restricted states of North Carolina, Massachusetts, and Illinois cited the supervision requirement as a challenge to establishing and maintaining a private practice, citing both difficulty in finding and keeping a physician supervisor and the expense of paying for supervision.

We found more innovation in practice settings in full practice states. A PMHNP-led group practice in Oregon included six NPs practicing full- or part-time as employees working on a commission basis. The practice secured a number of contracts for behavioral health services in schools, juvenile facilities, and Medicaid-funded services, allowing for a variety of practice sites and models, which was a source of job satisfaction cited by our interviewees: “As a group we have infrastructure support, and I like the collaboration and variety of practice.”

Structure and Impact of Supervision and Collaboration

In states requiring supervision, which may be called collaboration in some state regulations (Illinois, Massachusetts, and North Carolina), the specific requirements for supervisor qualifications, frequency, mode, and documentation were quite different between states. Table 2 includes a summary description of the supervision requirements in each of the five states in the study.

Oregon has full practice authority with no supervision requirements. Interviewees noted they often developed voluntary peer collaborations to consult with each other about treatment challenges, share best practices, and continue their education in
<table>
<thead>
<tr>
<th>Detail</th>
<th>Oregon</th>
<th>Oregon</th>
<th>Illinois(^1)</th>
<th>Massachusetts(^2)</th>
<th>North Carolina(^3)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SOP Categorization</strong></td>
<td>Full SOP</td>
<td>Full SOP</td>
<td>Reduced SOP</td>
<td>Restricted SOP</td>
<td>Restricted SOP</td>
</tr>
<tr>
<td>Year Granted Full Practice Authority</td>
<td>1979</td>
<td>2015</td>
<td>2018 (at time of study, Illinois was classified as having reduced scope of practice)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Supervision/ Collaboration Language</td>
<td>N/A</td>
<td>Mentor(^b)</td>
<td>Collaborating physician</td>
<td>Supervising physician</td>
<td>Supervising physician</td>
</tr>
<tr>
<td>Supervisor Credentials</td>
<td>N/A</td>
<td>N/A</td>
<td>Physician licensed to practice medicine in all branches, or licensed podiatrist in active clinical practice.</td>
<td>Physician with training in specialty area appropriately related to APRN's area of practice. PMH-CNS supervisor must have training in psychiatry.</td>
<td>Physician with population focus, certification, and competence that mirrors or exceeds that of NP's population focus.</td>
</tr>
<tr>
<td>Supervision/ Collaboration Frequency</td>
<td>N/A</td>
<td>N/A</td>
<td>Not specified. Consultation between NP and physician can occur in person or by other electronic means.</td>
<td>Schedule II drugs must be reviewed within 96 hours.</td>
<td>Once a month for first 6 months; every 6 months thereafter.</td>
</tr>
<tr>
<td>Supervision/ Collaboration Requirements</td>
<td>N/A</td>
<td>N/A</td>
<td>1,000 hours of practice with prescribing mentor for full prescriptive authority. Articulated plan for safe prescribing kept on file, reviewed annually, and updated as necessary.</td>
<td>Written collaborative agreement describes relationship of APRN with collaborating physician. Describes categories of care, treatment, or procedures to be provided by APRN. Copy of signed, written collaborative agreement must be available to the department upon request.</td>
<td>Collaborative practice agreement identifies drugs, devices, medical treatments, tests, and procedures prescribed, ordered, and performed in NP practice sites. On-site physical presence not required; available to each other for direct communication or telecommunication. Supervisor must have DEA registration equal to or greater than that of NP. Written agreement signed by both primary supervising physician and NP, maintained in each practice site; reviewed at least yearly; available for inspection by members or agents of either board.</td>
</tr>
</tbody>
</table>

Note. APRN = advanced practice registered nurse; CNS = clinical nurse specialist; DEA = Drug Enforcement Administration; NP = nurse practitioner; PMH-CNS = psychiatric mental health clinical nurse specialist.

\(^a\) SOP categorization based on 2018 American Association of Nurse Practitioners classification.

\(^b\) For prescriptive authority only during provisional prescriptive authority. Mentor is physician or advanced practice nurse with full prescriptive authority.

Sources:
the practice. Peer consultation groups included either PMHNPs only or a mixture of PMHNPs, psychiatrists, or psychologists. Peer collaborations usually involved practitioners working in the same practice setting.

In Colorado, the “articulated plan” is supposed to facilitate consultation and professional development, but interviewees reported the documents were mostly “just to have in the file” and did not lead to real collaboration in practice. Collaboration was reported to occur much as it did in Oregon with peers with a similar type of practice or in the same practice setting.

In Massachusetts, supervision is for prescriptive authority only. The initial prescription for Schedule II drugs must be reviewed within 96 hours. Supervising physicians for NPs must be board certified in the specialty area or have hospital privileges related to the area of the NP’s practice. Supervisors of PMH-CNSs need to be board certified in psychiatry (244 CMR 4.00, 2014).

In North Carolina, “the supervising physician must be licensed with the North Carolina Medical Board with a population focus, certification and maintained competence that mirrors or exceed that of the Nurse Practitioner’s population focus to avoid limiting the Nurse Practitioners scope of practice,” (North Carolina Board of Nursing, 2018). NPs must meet with the collaborating physician once per month for the first 6 months, and every 6 months thereafter. When there is a change in physician collaborator, NPs must again meet monthly for the first 6 months. The collaborative practice agreement must specify the practices/procedures performed and the medications that can be prescribed. Progress and outcome measures need to be included and documented. The collaboration agreement needs to be signed by both parties and reviewed annually (Quality Assurance Standards, 2009).

In Illinois, regulations regarding supervision and the written agreement, prior to the new legislation, specified the collaborator as a physician or podiatrist with the meeting frequency of once per month. The practice area of the collaborating physician was described as “services the collaborating physician or podiatrist generally provides to his or her patients in the normal course of clinical medical practice” (Nurse Practice Act, n.d.).

**Perspectives on Supervision/Collaboration**

As noted earlier, in the states with full practice authority, PMH-APRN supervision is not a legal requirement. Consultation and collaboration were voluntary and designed by the individual practitioners to meet the goals of professional development and consultation on an as-needed basis.

In the states with specific supervision/collaboration requirements, perspectives on these requirements varied, primarily based on the level of experience of the PMHNP. Some newer PMHNPs felt the requirement for physician supervision meant they were guaranteed access to consultation when needed. An informant in Massachusetts said, “When I first graduated I was happy to have a collaborating doctor.” PMH-APRN interviewees with more experience were more likely to report that supervision was an administration burden, costly for the individual or organization, and did not add value to their clinical practice.

Many PMHNP interviewees in states requiring supervision noted the supervision did not typically occur as specified in the regulations. Especially with experienced PMH-APRNs, there was often a mutual unwritten understanding between the parties that the collaborating physician would be available by phone if needed, but regular meetings were not necessary. PMHNPs in a group practice in Massachusetts noted their supervision was “mostly on paper” and the physician was not routinely involved. Many interviewees described the administration of collaborative practice agreements as “busy work,” particularly in clinical sites with multiple NPs. Turnover of psychiatrists and the need to continually locate and arrange new supervisors was often reported to be a challenge, and in some cases departure of a collaborating psychiatrist from an agency meant PMHNPs had to stop seeing patients until another collaborator was found.

The significant cost of supervision, difficulty in finding a supervising/collaborating physician, and finding a new physician in the case of relocation, new job, or physician retirement were all commonly reported as challenges by PMH-APRN interviewees. One interviewee commented she knew colleagues who had to pay retainers for supervision, regardless of whether supervision occurred. PMHNP interviewees in private practice reported the average cost of supervision was as high as $1,500-$3,000 per month. Numerous informants commented on the potential for salary inequality inherent in supervision requirements. An informant in Massachusetts, whose opinion was echoed by other informants, was very vocal that scope of practice regulation was “a control issue to make sure that NPs don't get compensated as much as the doctors. Once you get rid of supervision, you’ll have more clout with the insurance companies and get reimbursed at a higher rate.” Another PMH-APRN in Massachusetts noted psychiatrists in her area are paid $150/hour while PMH-APRNs are paid $65/hour, though job duties are the same. Several North Carolina informants shared information (no longer posted) from a website in North Carolina targeting psychiatrists: “Because North Carolina’s supervision rules are modest, money earned from supervising good, experienced nurses or [physician assistants] PAs is almost passive income for the doctor. Psychiatrists earn from $10,000.00 to $15,000.00 per nurse, so a doctor supervising four full-time nurses would earn up to $60,000.00 per year in extra income.” (Carolina Partners, 2017).

Many interviewees reported that difficulty in finding a willing supervisor was a barrier to their practice in taking a new position or relocating to another part of the state, particularly rural areas where psychiatrists are in short supply. “On Cape Cod, the wait to see a psychiatrist can be 6 months. I don’t prescribe here in my practice because I could never find a supervising physician.” Psychiatrists interviewed about supervision reported a lack of understanding of the requirements in their state and some con-
cerns about their legal liability for the PMH-APRN’s practice. A psychiatrist informant in North Carolina indicated that supervising PMHNPs increases his malpractice insurance premiums because he is put in a higher risk group. Several psychiatrists described mandated collaborations as an opportunity for collegial exchange where the physician was able to learn from PMH-APRNs’ expertise as well as provide consultation.

Organizational/Facility-Based Practice Limitations

In addition to scope of practice limitations due to state regulations, interviewees also reported practice limitations that were organizational or facility based and not required by law. Examples included requirements that a physician cosign or review visit notes, more frequent supervision sessions than required by state regulations, and failure to allow PMHNPs hospital privileges. This meant inpatient assessments conducted by the PMHNP were billed under the physician’s name, not capturing the PMHNP’s contribution. Interviewees reported these types of restrictions were almost as difficult to address as scope of practice limitations.

Discussion

Our study has implications for addressing the workforce shortage in mental health and SUDs and increasing access to services in the United States. We found some PMH-APRNs considered practice authority in determining where to live and practice. While our study methods did not allow quantification of PMHNP access to authority in determining where to live and practice. While our study methods did not allow quantification of PMHNP access to care across states, interviewees reported difficulty or perceived difficulty in finding a supervising/collaborating physician as a barrier to practice, especially in rural or underserved areas. Previous research found PMH-APRNs are more likely than psychiatrists to live in rural areas (Hanrahan & Hartley, 2008). Demand for PMHNPs was reported by faculty and nurse interviewees in all five states. Most nurse interviewees stated they had 2 to 3 job offers before they completed their program. PMHNP program faculty reported they were asked to increase enrollment in their programs.

Previous research also suggests that changing scope of practice regulations toward full practice authority impacts growth in the number of APRNs in a state. A study by Reagan and Salsberry (2013) comparing growth in the number of NPs in states with differing scopes of practice found significant differences in NP growth rates, with the highest growth in states with no restrictions. While these results are not specific to PMH-APRNs, they suggest restricted practice may be a barrier to addressing the current workforce shortage in behavioral health.

Even if laws are changed to implement full practice authority, growing the number of PMH-APRNs to address workforce shortages could take several years. In New York, the scope of practice was changed in 2015 to remove the written practice agreement for NPs with more than 3,600 hours of practice. However, qualitative data collected nearly 2 years later found that there was a lack of physician knowledge about the changes in the law and that institutional restrictions in practice persisted (Poghosyan, Norful, & Laugesen, 2018).

Supervision has costs, both economic and administrative, to individuals and to organizations and may be financially motivated, as described in North Carolina. Furthermore, if the goal of scope of practice laws is to provide consultation for new practitioners, there should be less need for supervision as PMHNPs gain experience. Our study found that the actual supervision provided was often inconsistent with state requirements and did not change as PMHNPs became more experienced. This finding is consistent with prior research. Rudner and Kung (2017) found that 12% of NPs in Florida received no physician supervision, which was unrelated to the NP’s level of experience. Some NPs with little or no experience had no physician oversight, whereas some NPs with more than 20 years of experience had extensive oversight. A recent study found higher costs for supervision in rural areas (Martin & Alexander, 2019).

There is a need for further research on the economic costs and administrative burden of required supervision and the impacts on PHMNP practice and access to care for patients. Losses in productivity due to time spent on supervision that is unnecessary for improving patient care, as well as time spent arranging and documenting supervision, could be quantified in future research.

Further research is also needed on how to best meet the needs of new PMHNP practitioners for consultation and provide experienced practitioners the opportunity to confer with peers about challenging patient issues. If the goal of supervision/collaborative practice regulation is to ensure consultation, particularly for new practitioners, our study found that goal is not reliably met. In states with supervision requirements, supervision was often an on-call arrangement and face-to-face meetings were rare. The most valued consultation occurred in true collaborative sharing of practice challenges between PMHNP peers or between nurses and physicians working alongside each other in similar practices.

Limitations

One of the potential limitations of this analysis is that the selected study states and practice sites may not be representative of all national practice issues for PMH-APRNs. We selected states that represented variation in NP scope of practice but recognize each state has unique nuances within its scope.

Another limitation is the use of snowball sampling, which may miss some perspectives within each state. It is our experience when conducting a study of this nature, where practitioners are busy in practice and have very limited time available for interviews, it is important to use a snowball approach and utilize key contacts already in the state. However, because most of our initial contacts were PMHNP educators or were active in psychiatric nursing organizations, it is possible our sample was biased toward persons interested in expanding nursing’s professional autonomy. Likewise, because interviewed psychiatrists were often the physi-
cian collaborators of our PMHNP informants, their perspectives on supervising PMHNPs may not be representative of all psychiatrists. Our findings should be considered suggestive rather than conclusive.

Conclusion

PMHNPs are a growing and important component of the workforce needed to meet increased demand for behavioral health services and address well-documented shortages in the workforce. Our study found that differing scope of practice regulations across states impacted PMHNPs in choice of practice settings, perceived flexibility in job mobility, costs, and multiple concerns about supervisory requirements. Supervision requirements in restricted scope of practice states were viewed as costly and burdensome. Further research on the contribution of PMHNPs could address the specific impacts of removing scope of practice burdens on the availability of practitioners and patient access to care.

References


Susan A. Chapman, PhD, MPH, RN, FAAN, is Professor, University of California, San Francisco (UCSF), School of Nursing, Department of Social & Behavioral Sciences. Christopher Toretsky, MPH, is Senior Analyst, UCSF Philip R. Lee Institute for Health Policy Studies. Bethany J. Phoenix, PhD, RN, FAAN, is Professor, UCSF School of Nursing, Department of Community Health Systems.
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Resume  
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EDUCATION:  
1991  J.D., University of Baltimore School of Law, Baltimore, MD  
(with honors, Law Review)  
1985  M.S., University of California, San Francisco, CA  
(Adult Primary Health Care)  
1982  B.S.N., University of Oregon, Portland, OR  
(with high honors)  
1970  B.S., University of Maryland, College Park, MD  
(Journalism)  

LICENSURE/CERTIFICATION:  
State of Maryland Bar  Current  
State of Colorado Bar  Current  
State of Oregon Bar  Current  
Registered Nurse, State of Maryland  Retired the license 12/16  
Adult Nurse Practitioner, State of Maryland  Retired the license 12/15  
Adult Nurse Practitioner, American Nurses  
Credentialing Council (ANCC)  Retired the certification 12/15  

PROFESSIONAL EXPERIENCE  
Law:  
Private Practice  1992 - present  
Specializing in legal issues related  
to the administration of and delivery of  
health care. Clients include  
hospitals, medical practices, nursing homes,  
home care agencies, individual health care  
practitioners, nursing and medical  
organizations and a nursing certification  
organization.  
Franch & Jarashow (Law Clerk)  1990 - 1991  
Conducted research and analysis; assisted  
in the preparation of civil litigation cases  
State of Maryland, Attorney General's Office  1989 - 1990  
(Law Clerk)  
Conducted research and analysis in preparation  
of white collar criminal prosecution cases  

Health Care:  
Better Life Health Care Systems, Inc.  1995 - 2006  
President  
Company contracted nurse practitioner  
services to educational institutions
Nurse Practitioner Primary Care (part-time)  
St. John's College, Annapolis, MD 1996 - 2006

Director, Student Health (BLHCS Contract)

Nurse Practitioner Primary Care (part-time)  
Greater Baltimore Medical Center/Community Family Health Center, Baltimore, MD 1995 - 1996

Nurse Practitioner Primary Care (part-time)  
Open Gates Health Center, Baltimore, MD 1993 - 1995

Nurse Practitioner  
Department of Anesthesiology 1985 - 1993

The Johns Hopkins Hospital, Baltimore, MD

Nurse Intensive Care Unit 1982 - 1985

St. Mary's Hospital, San Francisco, CA

TEACHING:

Assistant Clinical Professor (part-time) 1993 -1996

Adult Primary Care  
University of Maryland, School of Nursing Baltimore, MD

EDITORIAL:

Associate Director, College Relations 1977 - 1979  
Linfield College, McMinnville, OR

Assistant Director, Public Affairs 1976 - 1977

The Johns Hopkins Medical Institutions  
Baltimore, MD

Editor, University Publications 1972 - 1976

Coordinator, University Relations  
University of Maryland College Park & Baltimore, MD

Copy Editor 1970 - 1972

Williams & Wilkins Co.  
Baltimore, MD

Reporter 1970

The Howard County Times  
Ellicott City, MD

PUBLICATIONS

Books:


Educational modules:


Other Publications:


**Presentations**

Buppert, C. (November 2018) Avoiding malpractice: Legal tips for NPs in acute care, Nurse Practitioners in Acute Care 2018, Las Vegas

Buppert, C., (November 2018) Legal aspects of prescribing, Pharmacology for Advanced Practice Clinicians, Las Vegas

Buppert, C. (October 2018) When patients don’t comply and Risks of treating family and friends, Nurse Practitioners of Oregon Conference. Portland

Buppert, C. (October 2018) Legal aspects of prescribing and The scoop on scope of practice (keynote), Nebraska Nurses Association annual meeting, La Vista, NE

American Health Lawyers Association, Fraud and Abuse Conference, Baltimore


Buppert, C. (June 2018) The role of scribes and legal implications for NPs, Webinar, AANP

Buppert, C. (June 2018) Five things all nurses need to know when precepting, East Tennessee State University, Jackson City


Buppert, C. (May 2018) Five things all NPs need to know and Risk management: Safe prescribing practices in mental health, University of Southern Indiana, Evansville


Buppert, C. (November 10, 2017) Legal aspects of prescribing, Contemporary Forums Pharmacology for Advanced Practice Clinicians, Las Vegas

Buppert, C. (October 21, 2017) Five things all APRNs need to know, Mississippi Nurses Association, Biloxi

Buppert, C. (September 15, 2017) Legal aspects of prescribing, Contemporary Forums Pharmacology for Advanced Practice Clinicians, Nashville

Buppert, C. (July 29, 2017) Legal aspects of prescribing Pharmacology for the Advanced Practice Clinician, Contemporary Forums, San Francisco

Buppert, C. (July 21-22, 2017) Employment and independent contractor contracts: When to agree and when to walk away and How Medicare is changing your reimbursement and how to make the best of it, National Nurse Practitioner Symposium, Keystone, CO


Buppert, C. (March 24, 2017) Legal aspects of prescribing, Pharmacology for the Advanced Practice Clinician, Contemporary Forums, Las Vegas
Buppert, C. (November 17, 2016) APRN and PA compliance and legal landmines, 2016 CAP2 National Summit, Chicago

Buppert, C. (November 11, 2016) Legal aspects of prescribing, Contemporary Forums Pharmacology for Advanced Practice Clinicians, Nashville

Buppert, C. (November 5-6, 2016) Malpractice liability concerns for the RN and APN in urologic practice and Employment contract negotiations, Society of Urologic Nurses and Associates, Washington, DC

Buppert, C. (October 8, 2016) Are your legal bases covered? Nurse Practitioner Council of Palm Beach County, West Palm Beach, FL

Buppert, C. (October 6, 2016) Medicare/Medicaid billing: What APNs need to know about billing errors and fraud, ISAPN, Chicago

Buppert, C. (September 30, 2016) Legal aspects of prescribing, Contemporary Forums Pharmacology for Advanced Practice Clinicians, Las Vegas

Buppert, C. (September 23, 2016) Legal issues for nurse practitioners, AANP Specialty Conference, Chicago

Buppert, C. (July 7-8, 2016) Medicare and Medicaid billing fraud and Five things all NPs need to know at National Nurse Practitioner Symposium, Keystone, CO

Buppert, C. (May 23, 2016) Legal issues for nurse practitioners, Duke Johnson & Johnson Nurse Leadership Fellowship, Chapel Hill, NC


Buppert, C. (April 1, 2016) Prescribing: Preventing legal pitfalls, Miami Valley Hospital, Dayton, OH


Buppert, C. (September 25, 2015) Five things all NPs need to know. Texas Nurse Practitioners, Dallas.


Buppert, C. (November 14, 2014) Legal aspects of prescribing at Contemporary Forums' Pharmacology for Advanced Practice Clinicians, Las Vegas

Buppert, C. (September 12, 2014) Legal aspects of prescribing at Contemporary Forums' Pharmacology for Advanced Practice Clinicians, Indianapolis

Buppert, C. (August 1, 2014) Legal aspects of prescribing at Contemporary Forums' Pharmacology for Advanced Practice Clinicians, San Francisco
Buppert, C. (July 10-11, 2014) How to start a health care practice and Ask the expert: Frequent legal questions from NPs, National Nurse Practitioner Symposium, Keystone, CO


Buppert, C. (May 22, 2014) Are your legal bases covered?, AACN National Teaching Institute, Denver

Buppert, C. (May 2, 2014) Legal aspects of prescribing, Contemporary Forums' Pharmacology for Advanced Practice Clinicians, Las Vegas


Buppert, C. (February 15, 2014) Legal issues keeping nurses awake at night, 3rd Annual Nursing Education Meeting, Justin Parker Neurological Institute, Boulder, CO

Buppert, C. (November 15, 2013) Legal aspects of prescribing, Contemporary Forums' Pharmacology 2013, Las Vegas, NV

Buppert, C. (October 17, 2013) Avoiding malpractice, Oklahoma Nurse Practitioner Conference, Midwest City, OK


Buppert, C. (August 23, 2013) Legal aspects of prescribing, Contemporary Forums' Pharmacology 2013, San Francisco

Buppert, C. (July 26-27, 2013) The 10 most recent cases against NPs: What we learn from the mistakes of others and Prescribing Controlled Drugs: How to Stay Clear of Drug Diversion, National Nurse Practitioner Symposium, Copper Mountain, CO

Buppert, C. (June 23, 2013) Electronic Health Records and HIPAA. American Psychiatric Nurses Association Clinical Psychopharmacology Institute, Reston, VA


Buppert, C. (May 3-4, 2013) Avoiding employment disasters (with Margaret Fitzgerald) and Prescribing: Preventing legal pitfalls, National Conference for Nurse Practitioners, Nashville, TN

Buppert, C. (October 2012) **Legal aspects of prescribing.** Contemporary Forums, Alexandria, VA.

Buppert, C. (October 2012) **Reimbursement for NP/PA services.** American College of Cardiology, Orlando, FL.

Buppert, C. (September 2012) **Reimbursement and NPs in Florida.** Southern Gulf Coast Nurse Practitioners, Bonita Springs, FL.

Buppert, C. (August 2012) **Legal aspects of prescribing.** Contemporary Forums, San Francisco.

Buppert, C. (July 2012) **Cover your legal bases.** Employment disasters and how to avoid them (with Margaret Fitzgerald) and **Prescribing: Preventing Legal Pitfalls.** National Nurse Practitioner Conference, Copper Mountain, CO.

Buppert, C. (June 2012) **Risk management: Safe prescribing practices in mental health.** American Psychiatric Nurses Association, Reston, VA

Buppert, C. (November 2011) **How health care providers get reimbursed.** Master’s level class at Johns Hopkins University School of Nursing, Baltimore.

Buppert, C. (November 2011) **Nurse practitioners and malpractice and Contract negotiations.** Ohio Association of Advanced Practice Nurses, Columbus.

Buppert, C. (October 2011) **Reimbursement for NPs and PA services.** Core Curriculum for the Cardiovascular Clinician. American College of Cardiology, Washington, D.C.

Buppert, C. (October 2010) **Reimbursement for NP and PA services.** Core Curriculum for the Cardiovascular Clinician, American College of Cardiology, Washington, D.C.

Buppert, C. (August, September and October 2011) **Legal aspects of prescribing.** Contemporary Forums, San Francisco, Las Vegas and Alexandria, VA.

Buppert, C. (September and October 2010) **Legal aspects of prescribing.** Contemporary Forums, Las Vegas and Alexandria, VA.

Buppert, C. (July 2010) **Legal issues for NP practice and Regulatory and Credentialing Issues** at Nurse Practitioner Symposium, Copper Mountain, CO


Buppert, C. (October 2009) **Billing, coding, compliance, and reimbursement for hospital-based acute care nurse practitioners.** Acute Care Nurse Practitioner Summit, Durham, NC

Buppert, C. (October 2009) **Avoiding malpractice pitfalls and Who’s watching NPs and why.** Advanced Practice Nurses of the Ozarks, Branson, MO

Buppert, C. (October 2009) **Reimbursement issues for NPs and PAs.** American College of Cardiology Core Curriculum, Washington, D.C.

Buppert, C. (September 2009) **Legal aspects of prescribing.** Contemporary Forums, Las Vegas

Buppert, C. (September 2009) **Avoiding malpractice as providers of specialty care.** Dermatology Nursing Institute, Washington, D.C.

Buppert, C. (September 2009) Law and nursing. Singapore General Hospital, Singapore

Buppert, C. (September 2009) Nursing documentation. National University Hospital, Singapore

Buppert, C. (September 2009) Nursing documentation. KKH Hospital, Singapore


Buppert, C. (February 2009) Legal issues surrounding physician extenders. American Bar Association Health Law Section, Orlando, FL

Buppert, C. (November 2008) Legal issues for registered nurses and advanced practice nurses. Franklin Square Hospital, Baltimore, MD

Buppert, C. (October 2008) Legal aspects of prescribing. Louisiana Association of Nurse Practitioners, Monroe, LA


Buppert, C. (September 2008) Legal issues for registered nurses and Legal issues when caring for mental health patients. Albany Medical Center, NY

Buppert, C. (September 2008) Documenting your productivity and Avoiding malpractice. California Association of Nurse Practitioners, Pasadena, CA

Buppert, C. (September 2008) Reimbursement for nurse practitioner services. Texas Nurse Practitioner Conference, Austin


Buppert, C. (November 2007) General nursing law (day-long program for RNs at Southeast Missouri Hospital), Cape Girardeau, MO


Buppert, C. (September 2007) Legal aspects of prescribing. Contemporary Forums, Las Vegas

Buppert, C. (September 2007) Are your legal bases covered? Kansas Alliance of Nurse Practitioners, Wichita

Buppert, C. (July 2007) Leveraging space in the market place for NPs, Are your legal bases covered? and Documenting your productivity. Arizona Nurse Practitioner Council, Scottsdale


Buppert, C. (March 2007) 10 things NPs need to know about reimbursement. Virginia Coalition of Nurse Practitioners, Reston.


Buppert, C. (January 2006) Billing and coding evaluation/management services and Negotiating terms of employment, University of Alabama, Birmingham, Graduate Student Seminar.

Buppert, C. (September 2005) Billing and coding and Negotiating a contract, APRNs of Central Georgia, Macon

Buppert, C. (September 2005) Negotiating terms of employment, National Conference of Gerontology Nurse Practitioners, Cleveland

Buppert, C. (July 2005) Top 10 must-do's for getting reimbursed, National Primary Care Nurse Practitioner Symposium, Keystone, CO


Buppert, C. (May 2005) Top 10 must-do's for getting reimbursed, University of Iowa Conference for Nurse Practitioners


Buppert, C. (May 2005) Up and coming practice options, Wiregrass NP Conference, Panama City, FL


Buppert, C. (March 2005) Advanced practice nursing legal issues, Scripps Cancer Center Oncology Nursing Practice Conference, San Diego


Buppert, C. (February 2005) **Scope of practice issues for nurse practitioners**, Santa Clara Valley Medical Center, San Jose, CA


Buppert, C. (January 2005) **Legal issues for nurse practitioners**, Loma Linda University Medical Center, California


Buppert, C. (September 2004) **How NPs can increase profits for their practices and Avoiding malpractice: 20 cases, 10 rules, 5 systems**, United Advanced Practice Registered Nurses of Georgia, Central Georgia Chapter, Macon.

Buppert, C. (May 2004) **The pros, cons, ifs ands and buts of incorporating a NP into a dermatology practice**, South New Jersey Dermatology Association, Marlton, NJ.


Buppert, C. (2000, October) Legal issues for PAs, NPs. Continuing education session sponsored by Ortho-McNeil Pharmaceuticals, Lewes, DE.


Buppert, C. (2000, June). The essentials of reimbursement for nurse practitioners in a managed care environment. Managed Care Learning Summit, University of Kansas School of Nursing, Kansas City.


Recent consultations
Obtaining reimbursement for nurse practitioner services -- for hospitals
Bringing NP/PA and physician relationships into compliance with Stark laws -- for hospitals
Risk management--for physician practices
Compliance with Medicare billing rules -- for hospitals and physician practices

Legislative activities
Testimony before a California Legislature Committee on the Corporate Practice of Medicine, 2016
Testimony before the Connecticut Legislature, 1998 session.
Testimony before the Maryland Legislature, 1999 session.

Professional activities
Advisory board, Duke/Johnson & Johnson Nurse Leadership Fellowship, 2015-present
Expert panelist, Medscape.com, 2000-present
Editor, Practice Management, 2010
President, Nurse Practitioner Association of Maryland, 2006-2007
Nurse Practitioner Regulation Committee, Maryland Board of Nursing, 2005- 2006
Editorial Board, American Journal for Nurse Practitioners, 1997-2007
Columnist, *Dermatology Nursing Journal*, 2008-2010
Member, Public Policy Committee, American College of Nurse Practitioners 2004-2006
Chair, Reimbursement Committee, Nurse Practitioner Association of Maryland, 1994-1997
Chair, Public Relations Committee, Anne Arundel Bar Association, 1994-95
Convened and sponsored Nurse Practitioner Think Tank, March 2000

**Honors**
Nurse practitioner of the year 2000 by *The Nurse Practitioner Journal*
Honorary member, NAPNP (National Association of Pediatric Nurse Practitioners), 2001
Distinguished visiting professor, 2002, University of Tennessee, Memphis

**Memberships**
American Health Lawyers Association
American Association of Nurse Practitioners
Health Care Compliance Association
The Association of Nurse Attorneys

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