BEFORE THE OHIO BOARD OF NURSING

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Meeting of the Advisory Committee on Advanced Practice Registered Nursing

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PROCEEDINGS

at the Ohio Board of Nursing, 17 South High Street, Suite 660, Columbus, Ohio, called at 10:00 a.m. on Monday, June 17, 2019.

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ADVISORY COMMITTEE MEMBERS PRESENT:

Erin Keels, APRN-CNP, Chairwoman  
Pamela Bolton, APRN-ACNP, APRN-CNS, Member  
Peter DiPiazza, APRN-CNP, Member  
Brian Garrett, APRN-CRNA, Member  
Jody Miniard, APRN-CNP, Member  
Sherri Sievers, APRN-CNP, Member  
Michelle Zamudio, APRN-CNM, Member

BOARD STAFF PRESENT:

Lisa Emrich, RN, Program Manager: Practice,  
Education, and Licensure  
Anita DiPasquale, Staff Attorney  
Chantelle Sunderman, Administrative Professional

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Armstrong & Okey, Inc., Columbus, Ohio (614) 224-9481
Monday Morning Session,
June 17, 2019.

CHAIRWOMAN KEELS: Good morning. Did I wake everybody up? Good morning, good morning.

Welcome to the APRN Advisory Committee on Advanced Practice Registered Nursing. I just said that twice.

My name is Erin Keels, I am the Chair of this committee, and I'd like to start out by welcoming everyone.

We'll start out with introductions, and I will get started to my left. Please tell us your name, your APRN role, and who you are representing.

MS. EMRICH: I'm Lisa Emrich. I'm Board Staff.

MEMBER DIPIAZZA: I'm Pete DiPiazza. I'm an FNP and I'm representing primary care.

MEMBER SIEVERS: Sherri Sievers. I'm an FNP. I'm representing APRN in practice.

MEMBER ZAMUDIO: Michelle Zamudio. I'm representing Certified Nurse-Midwives.

MEMBER BOLTON: Pam Bolton. I'm an Acute Care Nurse Practitioner, representing employer.

MEMBER MINIARD: I'm Jody Miniard. I'm a
Nurse Practitioner and I'm one of the faculty members representing faculty.

MEMBER GARRETT: Brian Garrett, I'm a CRNA.

CHAIRWOMAN KEELS: I'm Erin Keels. I'm a Certified Nurse Practitioner and I'm a Board member.

MS. EMRICH: If we would, we might want to recognize that a court reporter is transcribing. So everyone will need to speak --

CHAIRWOMAN KEELS: Oh, sure.

MS. EMRICH: -- to her.

CHAIRWOMAN KEELS: Sure.

So for purposes of the proceedings for the meeting, we do have a court reporter with us, so welcome. So do speak very slowly, succinctly, and loudly so she can capture our comments accurately, please and thank you.

I want to take a second to thank Pete for serving as our Vice Chair at the last meeting. Thank you. You did a great job.

MEMBER DIPIAZZA: Thank you.

CHAIRWOMAN KEELS: I will ask the Committee Members to please raise your hands to speak.

And let's say hi to the folks in the
gallery. Good morning. Would you like to introduce
yourself and who you are representing? We'll start
with the front.

MS. DZUBAK: I guess that's me. Hi, I'm
Jessica Dzubak. I'm the new Director of Nursing
Practice at Ohio Nurses Association.

CHAIRWOMAN KEELS: Thank you.

MS. DRING: I'm Jennifer Dring with
OAAPN.

MS. NEWELL: Erica Newell with OAAPN.

MS. PENCIL: I'm Kristie Pencil with
OhioHealth. I'm one of the Managers of Advanced
Practice.

MS. ROBERTS: Christina Roberts, Manager
of Advanced Practice from OhioHealth.

MS. LEAHY: Kelly Leahy, Ohio State
Association of Nurse Anesthetists.

MS. GOSH: Rupa Gosh, Nurse Practitioner
at The James Cancer Hospital.

MS. KIESLING: Marcia Kiesling, Lead
Nurse Practitioner at Aultman Hospital in Canton.

MS. SINGLETON: Jeana Singleton. I'm an
attorney with Brennan, Manna & Diamond. We serve as
counsel for the Ohio Association of Advanced Practice
Nurses.
MS. DAVIS: Jessica Davis, also with Brennan, Manna & Diamond.

MS. RANKIN: Lisa Rankin, Ohio Society of Anesthesiologists.

MR. McClAIN: Jesse McClain, Clinical Nurse Specialist, representing OAAPN.

MS. BUCKENMEYER: Summer Buckenmeyer, Nurse Practitioner, with OAAPN.

MS. HUDSON: Kate Hudson with the Ohio Hospital Association.

CHAIRWOMAN KEELS: Good morning and welcome.

A reminder to silence the things that make noise, like your phones and your pagers, please. We are being live-streamed and videotaped by a third party as an FYI. So good morning to all of you who are joining us remotely.

For those who wish to speak during the open comments, please be sure that you sign in. We will have public comments both during the a.m. session and our afternoon session. And we do have a Public Participation Guideline that I don't actually have in front of me. Is it -- is it handed out?

MS. EMRICH: Yes, it's on the table.

CHAIRWOMAN KEELS: Okay. The Public
Participation Guideline is on the handout or available for you to take a look at. Essentially we'll hold comments until during the open forum. And the Committee Charge is as follows: This 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. And for our agenda today, we have a pretty packed agenda. Next up, I want to provide some comments to kind of bring us all up-to-speed on where we've been over the last two years and longer. Those who are new to our Committee received quite thick packets to review, so I hope to summarize that for you. We'll have public comments after that. We do have a guest who will be live on the phone at 11:00 a.m., Carolyn Buppert, and then we will have some general information and updates. We will break for lunch and then we have an Interested Party Meeting that starts at 1:00 p.m. on the 4th floor. Depending on who attends that meeting and the number of comments, that may or may not be heard,
will determine how long that meeting lasts. If it's shorter, we'll come back up and start earlier.

So for those who want to, you know, be in the room when we get started and you're not sure, just kind of be close since we may start a little bit earlier.

We have proposed revised rules regarding the detoxification so we'll definitely want to review that.

We'll briefly review the Interpretive Guideline this afternoon and then end with some public comments.

MS. EMRICH: The Guideline, itself, we did not provide, so in and of itself it's not going to be reviewed.

CHAIRWOMAN KEELS: Okay. The IG itself has not been provided today in today's materials, but we'll just briefly touch on that because we're still getting feedback.

Okay? Make sense? All right, great.

So I thought I would start our meeting by sort of summarizing activity to date and sort of where we are and what we're doing and why we're doing it.

So we'll start back in 1996 which
concluded the APRN Pilot Program. At that time, the Board began issuing certificates of authority to CNPs, CNSs, CRNAs, and CNMs.

This is not in your packet, this is just some notes I prepared for myself. Sorry about that.

At that time, Ohio law included an NP statutory definition that included: "CNPs may provide preventative and primary care services, and evaluate and promote patient wellness within the nurse's specialty, consistent with the nurse's education and certification."

In 2001, the Board began issuing Certificates to Prescribe to CNPs, CNSs, and CNMs.

In 2008, the APRN Model for Consensus was published. It establishes a model for APRN regulation. It seeks to standardize the congruence of licensure, accreditation, certification and education by defining the four roles of APRNs which are the CNP, CRNA, CNM, and CNS.

It addresses structure and congruence of graduate education with resulting national certification in one or more population foci which are the neonatal, the pediatric, adult-gero, family across the lifespan, psych-mental health, women's health/gender-related.
Adult and pediatrics are subdivided into
two separate graduate education certifications which
are the primary care and acute care certifications.
The model defines APRN scope of practice
as the culmination of formal graduate or higher
degree education which includes content from the
three P's: advanced physical assessment,
pharmacology and physiology, and results in a
national certification exam in the role and
population.

Specialty practice is defined, within the
Consensus Model, as further specialization within the
population foci and is not regulated by boards of
nursing, and that word "specialty" was confusing to
many of us.

The model acknowledges there's also a
continuum of wellness and illness that requires
consultation, referrals, or handoffs as appropriate
and indicated by the patient's needs.

As a member of the NCSBN, or the National
Council of State Boards of Nursing, the Ohio Board of
Nursing was involved in the review of the Consensus
Model and found that it was consistent with existing
Ohio rule and law relative to APRNs. So the rule was
-- we did not need to do anything with those rules.
The Ohio Board of Nursing receives many questions from practicing APRNs in the state and you all received a sample of questions in your packet.

In 2016, in an effort to help guide APRNs and answer their questions, the Board of Nursing published an article in the "Momentum" in 2016.

The article was provided to assist APRNs with applying Ohio law and rules to their practice with emphasis on population of healthcare being managed and not necessarily where the care was being managed. However, the article elicited many concerns from employers and APRNs related to scope of practice.

Shortly thereafter, in 2017, House Bill 216 was passed and enacted -- and enacted. It established this APRN Advisory Committee, and our first meeting was held two years ago on June 12, 2017. As I read before, the purpose of this Committee is to advise the Board of Nursing on issues related to APRN practice.

One of the first orders of business that this Committee was charged with by the Board was to make a recommendation to either continue to follow the Consensus Model or to do something differently which would most likely lead to rulemaking in the
legislative process.

Based on feedback from this Committee and many other stakeholders and individuals, additional rulemaking is not desirable. Instead, the Committee and others agreed that developing a Guidance Document and clarifying key definitions would be much more helpful.

The committee agreed to use clear language when talking about APRN roles, population-based national certification, and specialty or specialization within your population focus.

The Committee also heard from nationally-regarded experts, Dr. Ann O'Sullivan, Barb Safriet and, today, Carolyn Buppert, to learn more about their individual perspectives and opinions about APRN scope of practice issues.

This Committee and the Board of Nursing acknowledge that Primary Care Certified Nurse Practitioners are very important to the health and wellness of our communities. The acute illnesses and conditions are well-managed by Primary Care NPs in a variety of settings.

The issue becomes at what point does the patient with the acute condition, that is high risk
to become or does become critical and/or
life-threatening, necessitate management that is
outside of the scope of practice of primary care and
within the scope of practice of acute care.

Primary Care NPs may provide consultation
specific to their area of subspecialization, for
example, endocrinology or dermatology, in a variety
of settings including emergency departments and ICUs.

Primary Care NPs may be the first
responder in a truly critical situation such as a
patient acute MI or a CVA occurring within the NP's
clinic where it's their responsibility to respond and
appropriately hand off to an acute care certified
provider. The term "acute care" has not been
well-defined.

The competencies from NONPF, or the
National Organization of Nurse Practitioner
Faculties, which are used to develop education
standards, curricula and certification exams for each
NP population, the primary care certification does
not include content or clinical practicum in the
management of critical care.

So, for clarification and guidance only,
the Committee proposed to use the CMS definition of
"critical care" and that is "That which involves
high-complexity decision-making to assess, manipulate, and support vital system functions to treat single to multiple organ system failure and/or to prevent further life-threatening deterioration of the patient's condition.

Although this care occurs within -- excuse me.

Although this care usually occurs within an intensive care unit, it is not limited to that location.

Like this definition -- excuse me again.

We like this definition as a guide because it brings some clarity and it could be used across populations.

The Committee agreed to use this definition for the limited purpose of the Guidance Document, but interested -- but input from interested parties is that they have concerns relative to the effect of using this definition in the Guidance Document on potential billing questions. Therefore, perhaps, we can find a different reference.

A definition of "acute care" by the World Health Organization was mentioned in previous meetings, but we can't seem to find that through research.
Perhaps -- excuse me.

The discussion about scope of practice overlap does not just apply to primary care and acute care. Many populations overlap one another such as the neonatal and population foci, pediatric and adult, primary care and behavioral health, adult primary care and women's health.

In lieu of additional rulemaking, a Draft Interpretive Guideline for NP practice has been developed and previously disseminated for the Committee's review and feedback. This was done in February and again in April at which time the Committee recommended some clarifying revisions.

The resultant revised draft will not be prepared until later this summer and will be disseminated at that time in advance of the October Committee meeting.

The IG Draft concentrates only on NPs and not other APRNs. This is because other APRN roles have different statutory scope of practice language and the vast majority of scope of practice questions that the Board receives are about nursing practitioners.

The Interpretive Guideline pulls all existing rule and law about the scope of practice of
NPs into one document, similar to what has been previously drafted for RN Interpretive Guidelines. It includes the CMS definition of "critical care" as a reference, but this is subject to change, as we previously discussed.

The IG includes color-coded graphs to help visually demonstrate the typical range of patient age and severity of illness for which the CNP is prepared by national certification to manage and it demonstrates where overlap between populations occur.

Where the practice parameters regarding patient age and condition begins and ends are taken from current national certification exams. The lines indicating the degree of acuity or severity of illness are placed, per the national certification description, as a quick visual reference, and the age ranges reflect developmental ranges.

References and links to the national certification content guides are also included.

The Interpretive Guidelines is a guideline that explains the application of current law and rule. It is not, itself, enforceable by the Board. Rather, it is the applicable state law and rule that is enforceable. So we were not creating
any new rule or any new laws; simply describing what currently exists.

At the last Committee meeting, feedback was provided which was appreciated and it included comments to add additional links to national-certifying organizations' standards of practice, perhaps the NONPF competencies. These should serve as the most-current references and evolve as the roles and scope of practices evolve.

It was suggested to clean up some wording, tweek the graphs to ensure consistency among primary care population foci, and to use some form of a permeable-appearing line so that we don't give the idea that there are hard lines because we know that things ebb and flow.

There was a suggestion to delete the graphs all together and use a written document, which we may still take into consideration.

Additionally, the Board of Nursing met with and received feedback from the Ohio Hospital Association and the Ohio Organization of Nurse Executives.

We reviewed the IG with them and the committees agreed that the IG was a good idea. They asked us to consider developing some FAQs and case
examples to accompany the IG. They also provided feedback to ensure that the graphs are consistent with national certification statements.

All of these comments will be incorporated into the draft and sent out to the Committee and posted for further comment planned in August and dissemination for discussion at the October meeting.

At the last meeting that was co-chaired by Pete, thank you very much, discussion was held around some topics and a few additional requests were made: To define what constitutes formal education within the population focus; mention grandfathered NPs to limit confusion; to define what constitutes clinical experience within the population focus; to consider an Interpretive Guideline for Clinical Nurse Specialists; to invite OAAPN to provide further comments on the second draft IG and other topics.

This was discussed with President Greaves and this will happen at the October meeting when the second draft has been disseminated.

And that concludes my summary, so hopefully you found that helpful.

Any questions or comments from the Committee?
(No response.)

CHAIRWOMAN KEELS: No? Okay, great.

So then we go to public comments. So I have two here.

Are there any other public comments?

I have Jeana and Jesse.

FROM THE AUDIENCE: There's one on the table.

MEMBER DIPIAZZA: There's one more.

CHAIRWOMAN KEELS: Oh, there's one more.

Sorry, I was trying to get that.

Thank you very much.

All right. Jesse representing OAAPN.

Would you like to come on down?

MR. McCLAIN: I guess so. Take the hot seat.

CHAIRWOMAN KEELS: We don't have a timer, do you?

MR. McCLAIN: I have timed it, so I know I'm not more than five.

CHAIRWOMAN KEELS: Okay.

MR. McCLAIN: I promise.

CHAIRWOMAN KEELS: Very good. So you have five minutes.

MR. McCLAIN: No problem. I think I'm at
4:30, so I think we're okay.

CHAIRWOMAN KEELS: Thank you.

MR. McCLAIN: All right, guys.

Welcome, new Committee Members, some that are returning, some that have been here for a year or so.

You're all experts in your field and I thank you for your time and dedication to be here. It's very important.

I presume you're all here to advance and protect your profession as APRNs. With the introduction of Representative Brinkman's House Bill 177, we too strive to advance our profession but, unfortunately, we have been dealing with an issue that seems to be hindering our practice because nurses are once again attacking nurses.

The Fall of 2016's "Momentum" magazine changed APRN practice. This article has impacted Ohioans' access to care and has caused tremendous stress on APRNs and hospital systems.

(Pause.)

MR. McCLAIN: Many institutions have altered hiring practices and many health systems are now hiring more PAs than APRNs.

Scare tactics have been used to motivate
APRNs to return to school or find other places of employment which is unnecessary.

In a letter the Ohio Hospital Association wrote the Attorney General, now Governor Mike DeWine, in April of 2017, stated: "There is nothing in the body of Ohio laws and regulations, federal laws and regulations, or accreditation organization standards that requires a CNP to be certified in acute care in order to provide services to patients."

No other state regulates specialty practices by APRNs. In fact, no other professional licensure board governs licensees by specialty. Physicians, chiropractors, dentists, and physician assistants are not regulated or limited by any particular specialty.

It would be an unnecessary restraint of trade to restrict what we could do based on what we learned in school. Denying the importance and impact of continuing education, clinical experience, skills and training on everyday practice is like denying the necessity of keeping up-to-date.

OHA goes on to say in their letter to the Governor that "Ohio law not only permits, but requires, a CNP's clinical experience to be considered when determining appropriate scope of
practice."

The Consensus Model specifically states scope of practice is not setting-specific. To say an FNP cannot enter into an ICU to manage their patient's chronic conditions is as ridiculous as saying an Acute Care NP cannot run an outpatient trauma clinic with stable patients.

Soon, an APRN hospitalist will need post-grad certificates in acute care, primary care, women's health and mental health in order to work and round in a hospital. Sounds ridiculous. Though they have no intention on entering these settings to specifically treat their patient's OB issue, mental health issue, or critical care issue, but this Committee has implied that the APRN and institutions cannot be trusted.

If this Committee worries about safety, there are many layers of protection already in place:

First, the APRN's scope of practice. All APRNs are quite self-aware of their own scope, as is their APRN Director within the hospital system;

Second, the hospital's credentialing system, they risk significant liability if not followed correctly;

Third, the hospital's ongoing practice
assessments required by The Joint Commission;

    Fourth, the Board of Nursing's medical
decision-making model; and

    Fifth, if the APRN does go rogue, the
Board of Nursing's disciplinary system which has been
well-vetted.

    Why add a sixth later of restriction?

    But, for almost three years, we have been
dealing with colleagues in nursing who have created
our own practice restrictions. I can't say for sure
why this is happening, but I can say the basis
derives more from fear mongering than scientific
evidence.

    The importance -- an important article by
Peter Buerhaus, published by the American Enterprise
Institute in 2018, makes the following points:

    State-level scope-of-practice
restrictions do not help protect the public from
subpar care;

    State-level scope-of-practice
restrictions provided no evidence that patients
received better quality care;

    Some organizations have justified their
support for state regulations to limit NP scope of
practice on the grounds that they are necessary to
protect the public from low-quality healthcare, but
Peter's research found no evidence of this.

In fact, his analysis found that states
with restrictions utilized more resources and made
care more expensive than states without scope
restrictions. Therefore, restricting APRNs' scope of
practice, as this Committee has discussed, would, in
fact, harm the public which is the complete
antithesis of its mission.

"U.S. News & World Report" has Ohio
ranked 36th in healthcare. 75 percent of U.S. states
have healthier populations than Ohio.

Every state with full-practice authority
for APRNs is ranked above Ohio. None of these states
regulate by specialty. Many categorize APRNs by
population focus, as Chairman Erin has stated, but
there's no mention of acute care and no mention of
primary care. They also do not mention the word
"sub-population."

This Interpretive Guideline has many
flaws and is unnecessary. It tries to help APRN-CNP
primary care practice, but fails to mention clinical
experience and training.

Why are we trying to reinvent the wheel?
Our predecessors already defined APRN
practice. In fact, Ohio Administrative Code 4723-8-01, Section (F), states: "Practice of nursing, as an Advanced Practice Nurse, means providing, to individuals and groups, nursing care that requires knowledge and skill obtained from advanced formal education, training, and clinical experience."

CHAIRWOMAN KEELS: Thank you. Thank you very much.

Does the Committee have any questions for Jesse?

MEMBER ZAMUDIO: I don't know if it's a question, but it's a comment. If we have to ask the speakers to slow down, does that impact the amount of time that they're given?

MR. McCLAIN: Well, that's unfortunately --

CHAIRWOMAN KEELS: Unfortunately.

MR. McCLAIN: I rewrote it last night at about midnight, so I'm not surprised.

CHAIRWOMAN KEELS: I appreciate it.

May I ask you a question? So when you were talking about further restrictions to scope of practice, were you referring to the Interpretive Guideline or are you talking in general terms about the Standard Care Arrangement and --
MR. McClain: The Interpretive Guideline.

I mean, the Standard Care Arrangement is already in place, we are trying to get rid of that to improve access to care, but I was referring to the Interpretive Guideline.

Chairwoman Keels: Can you tell me how you see that as being more restrictive to scope of practice when it seeks to simply clarify existing rules?

MR. McClain: It seems -- the attempt to clarify is all well and good. However, there's language that's been left out of the Interpretive Guideline such as "clinical experience."

We're trying to say that it's by national certification only, including your own 1996 definition of, you know, scope of practice for NP, but it left out the words from Ohio Administrative Code. I mean, we're totally ignoring the rule.

And it's not just Ohio Administrative Code for nursing. Other Ohio Administrative Codes have also recommended education, training, and clinical experience as that licensed professional, you know. And if we're going to draft this Interpretive Guideline, we cannot put the words down that we feel fits that mold; we have to actually
identify Ohio Administrative Code.

CHAIRWOMAN KEELS: Thank you.

Questions?

MEMBER ZAMUDIO: So when I was reading

the IG, it does mention a Master's or

Doctoral-prepared degree program. Can you, like from

an OAAPN perspective, educate me about how many NPs

are still in practice in Ohio that maybe have a

Bachelor's?

MR. McCLAIN: I mean --

MEMBER ZAMUDIO: Are there some?

MR. McCLAIN: -- there's a few. I mean

obviously that's -- I think it was '95 or '96. I'm

not entirely sure --

MEMBER ZAMUDIO: So there are some.

MR. McCLAIN: -- when it was required,

but yeah, there are some. I mean 1995 or '96, when I

think you had to have a Master's. I'm not sure. I

know some may know the exact date, but that was 23

years ago. So I mean, theoretically, those will be

retiring over the next few years, I think, but I'm

not really --

CHAIRWOMAN KEELS: And we had a

recommendation to acknowledge the grandfather.

MEMBER ZAMUDIO: Okay, great. So will
the grandfather, though, apply only to their 
educational preparation or to their current job 
function?

Will the grandfather clause apply to 
someone, like, I read somewhere where they said it 
would be kind of ridiculous to tell somebody, who has 
been in their job for 23 years, they have to go back.

CHAIRWOMAN KEELS: Right. No, we would 
not --

MEMBER ZAMUDIO: Okay.

CHAIRWOMAN KEELS: -- it would not 
require that.

Yes, Lisa.

MS. EMRICH: And just when we're talking 
about grandfathered CNPs, grandfathered CNPs have the 
same authorized scope as current CNPs, it's just what 
was grandfathered are the minimum requirements for 
them to have been now licensed as a CNP or when they 
were originally authorized by their Certificate of 
Authority.

MEMBER ZAMUDIO: Great.

CHAIRWOMAN KEELS: Thanks so much.

MR. MCCLAIN: Sorry I ran long.

CHAIRWOMAN KEELS: No worries.

Next up we have Jeana Singleton
representing OAAPN.

MS. SINGLETON: Good morning. My name is Jeana Singleton and I'm an attorney. We serve as general counsel for OAAPN. Thank you very much for your time. We appreciate it.

I was given a very simple task today. I know some of you are new, so we want to make sure you all have a copy of OAAPN's last letter on the topic of the Interpretive Guidelines which had suggested revisions from OAAPN. It also contains a copy of a letter from Ohio State with their recommendations. I've been asked to provide that so that you guys have it as you're moving forward.

And I think Jesse already touched on it, but there's a real concern, as you can tell, about making sure that clinical experience plays a role in whatever Interpretive Guideline exists because, as you all know, your national certification tests you for that point in time of what you know, but your practice will evolve over time.

So these are copies of the letter. If you have any questions about it, we'll be happy to answer it.

The only other thing is, Chairwoman Keels, you had mentioned meeting with OAAPN or
including them in discussions about reviewing the revised version of the IG. OAAPN is absolutely interested in meeting on that topic, so thank you.

CHAIRWOMAN KEELS: Thank you.

MEMBER DIPIAZZA: I do have a question for you.

MS. SINGLETION: Sure.

MEMBER DIPIAZZA: So the Committee has agreed to support or enforce, I guess, the Consensus Model, that's probably the wrong terminology, but the Consensus Model. And I know the Consensus Model doesn't identify clinical experience as meeting the requirements.

How do you propose the Board of Nursing and this Committee work with including clinical experience when the Consensus Model doesn't state that?

MS. SINGLETION: Well, I guess, first of all, the Consensus Model is not Ohio law.

MEMBER DIPIAZZA: Right.

MS. SINGLETION: And I think, too, the Consensus Model was drafted a long time ago and I think practice evolves over time.

Second, it's my understanding there's a LACE document that's out there also that does talk
about clinical experience. I think it's important to remember that.

So I would say that those are some things you need to consider and also, of course, you need to make sure you focus on Ohio law.

MEMBER ZAMUDIO: So it's been maybe a year since I read the Consensus Model but it also wasn't unanimous, right? It was only passed by --

MS. SINGLETON: Right.

MEMBER ZAMUDIO: -- about a 60-percent vote. So not --

MS. SINGLETON: Correct.

MEMBER ZAMUDIO: -- everyone agreed with the terminology.

MS. SINGLETON: Then maybe it's time to look at the Consensus Model. That's outside the scope of this discussion, --

MEMBER ZAMUDIO: Right.

MS. SINGLETON: -- of course, but I think something that was developed so many years ago probably needs to be updated, from time to time, as people see the impact on practice.

MEMBER ZAMUDIO: So from a legal perspective, Ohio would trump the Consensus Model.

MS. SINGLETON: Absolutely, yes. Ohio
law and regulations are what govern Ohio.

MEMBER ZAMUDIO: Thank you.

MS. SINGLETON: Thank you.

CHAIRWOMAN KEELS: Next up we have

Jessica Davis who is also representing OAAPN.

MS. DAVIS: Yes, if I may, excuse me. It
may be advantageous to defer until this afternoon
because my comments may not be appropriate or germane
depending upon other testimony that's stated.

CHAIRWOMAN KEELS: Okay, that's fine.

I'll keep you right here in this stack.

MS. DAVIS: Thank you.

CHAIRWOMAN KEELS: Dr. Margaret Graham
from the Ohio State University College of Nursing.

Good morning.

DR. GRAHAM: Hi. My name is Margaret
Graham. I'm the Vice Dean of the College of Nursing.
I'm a Family Nurse Practitioner and a Pediatric Nurse
Practitioner, and I'm also on the faculty in the
College of Nursing.

Your last meeting, we sent a letter
requesting your consideration of the scope of
practice for the APRN. I think maybe you have --

CHAIRWOMAN KEELS: Yes.

DR. GRAHAM: Do the new people have that?
CHAIRWOMAN KEELS: It was included in the packet, I believe. I have some. If not, we can pass it around.

MEMBER MINIARD: Jeana just distributed it.

CHAIRWOMAN KEELS: Oh, and Jeana just distributed it, too. That's fine.

DR. GRAHAM: I send my apologies from Dean Melnyk. She was hoping she would be able to address you today, but wasn't able to work with the agenda that you were able to work with just due to some former commitments that she had.

Our College has paid very close attention to all of the work that you're doing because we represent so many Advanced Practice Nurses. We have so many of our alumni practicing across the state because of the number of specialties that we have.

And so, we have -- a director from every single one of our specialties have come together, and we would like for you to think about the scope of practice for the determination of the APRN and it does include the clinical experience.

And I think that we have to think about when we started Acute Care Nurse Practitioner care programs in this state. So we have people in their
late 40s, early 50s, who completed Family Nurse
Practitioner programs or Adult Nurse Practitioner
programs who are working as hospitalists, who have
been doing that for many, many years; and expecting
them to come back and to start brand new, I think
would be -- it wouldn't be beneficial to the people
of Ohio, and I think Ohio Hospital Association has
made that very clear.

We also -- I also think we have to be
very, very careful about talking about primary care
and acute care because when we think about specialty
practices, we think about Primary Care Nurse
Practitioners have learned how to manage chronic
disease, chronic hypertension, hyperlipidemia,
diabetes. Those are all part of the cardiac
specialty practice.

So if we are going to say that Family or
Adult Nurse Practitioners can't be there, are we
saying that Acute Care Nurse Practitioners can't be
there because it's out of the hospital?

You know, I think that we start -- and I
see Erin shaking her head "no," but I think once you
start separating the hairs, the way I feel like that
we're explaining this at the Advisory Board, I think
we have to be so careful because I think we'll put
very well-educated Advanced Practice Nurses, who are practicing and have been practicing to their scope, at a great peril. And I think that will put the citizens of Ohio at great peril as far as losing many, many providers. I think we'll have people leaving the State, who can; those who can't, I think they will be very concerned about their practice.

We know that some of the hospitals got rid of some of the Advanced Practice Nurses after the "Momentum" article, and I just think that we have to think about clinical practice as an Advanced Practice Nurse.

We're not advocating that we consider clinical practice as a Registered Nurse before they go back to become an Advanced Practice Nurse.

I think we also have to think about hospital and credentialing. Hospitals that are responsible for credentialing are certainly looking at the practice of the Advanced Practice Nurse, and if we limit it to what the person had in their practice then that's going to be very limiting.

The best example I can give of that is a Family Nurse Practitioner who is doing colposcopies. We don't teach colposcopies in an FNP program but there are many formal education programs that teach
Advanced Practice Nurses colposcopies that make them very, very well educated, and it's very safe for them to do that. That's just one of many examples.

So we request that you do reconsider. I know you discussed it because I listened to the tape, but I do request that you do reconsider thinking about using clinical practice as the Advanced Practice Nurse and education and that you keep this as broad as you can so that we don't get replaced by PAs, that is happening in hospitals across this state, because we seem to be struggling so hard with the definition of our practice.

I think we have to be -- we, as educators, have to make sure that our Advanced Practice Nurses know their scope and know where they are to be practicing, but we haven't had all of these different specialties for many, many years and so I think we also have to be somewhat nimble and keep our practice as nimble as possible.

I'll be happy to take any questions that you have.

CHAIRWOMAN KEELS: Michelle and than Pam.

MEMBER ZAMUDIO: So one of the things I heard you saying was for us to remember that certification is your entry-level practice.
DR. GRAHAM: Exactly.

MEMBER ZAMUDIO: So in asking us to consider the clinical training or post-graduate clinical training, to be clear that you can stay within your population but still expand --

DR. GRAHAM: Right.

MEMBER ZAMUDIO: -- on those skills and so our document needs to reflect that.

DR. GRAHAM: And I think an example of that would be our nationally-recognized residency program in oncology at OSU. I mean I think there are many, many different examples of that that we don't want this to be narrowed.

MEMBER ZAMUDIO: You also mentioned that you had reviewed our discussions -- I wasn't here so I reviewed them as well -- and we agreed on that definition as opposed to the one that's now put forth by OSU and OAAPN. I looked back at that tape and, at the 1-minute and 10-second mark, there's no agreement on the definition. So I think we're happy to include an open discussion about the definition.

DR. GRAHAM: Thank you.

MEMBER BOLTON: Thank you for your comments, Dr. Graham.

So I think back to certification and what
happened in the certification process with the practice analysis, it's done every five years, that psychometrically-sound process that all certification organizations go through that's constantly repeated.

So I extrapolate that now to the clinical setting, and the question I have is: Without that process, how does one know that clinical practice truly reflects that this individual is competent? How do we deem that, when we don't have that process in play?

I think it's -- I think it's important. I think we all recognize that clinical practice is different all over the state. You know, with acute care and FNPs, it can be very different. So how do we maintain that person is competent?

DR. GRAHAM: Well, to answer your first question, I used to chair the Board of ANCC where we did all the psychometric, so I did that for years. But I recognize that's entry into practice, so we have to recognize that certification is entry into practice.

And, second, I think that the Board of Nursing and that educators of Advanced Practice Nurses and professional organizations for Advanced Practice Nurses have to work to make sure that
hospitals and other agencies, who are hiring Advanced Practice Nurses, recognize the importance of credentialing and recognize the importance of scope and credentialing.

And I think that we can do that and that's our responsibility, but I think that working through credentialing versus making -- truly, I think, splitting hairs over whether a person is practicing primary care or acute care if they're in a specialty practice, you know, which should that be, I mean people are already asking that question. And in those specialty practices I think both acute and primary care should be able to work in that cardiac office, you know.

So I think it's our responsibility to work to make sure that, as people are being credentialled, that that practice is there and that clinical practice is there.

But I don't think we want to put it in law or rule so that we are actually restricting the practice of the Advanced Practice Nurse so that other health professionals will be -- will be moving us out of our jobs, and I think we are seeing that happen.

MEMBER BOLTON: Being on a credentialing committee and watching that happen, the one -- what I
noticed is that, you know, before an APRN was
represented on that committee there was -- it was
really blind by the committee to decide whether or
not that person was competent.

So in going back through that, I would
ask you what are those documents that you would
suggest, from a credentialing and privileging
perspective, that you would use to define whether
that person was competent?

DR. GRAHAM: Well, I think that if we're
looking at procedures that we look -- I mean certain
procedures have to, you know, be checked off, they
have to have so many that have to be done, and I
don't know that we want that to be prescribed by the
Board of Nursing, but I think we certainly want the
Board of Nursing and professional organizations and
others.

And you're exactly right, we have to have
Advanced Practice Nurses on the credentialing
committees. I mean those are things we need to
advocate for, but I think that those have been
designed well in some of the large institutions
across the state in order to make sure there is
safety, I mean, because safety is the bottom line, I
think.
MEMBER BOLTON: Would you see the competency documents as one of those documents that would be used to --

DR. GRAHAM: I think it can be used, but I think, as was discussed earlier, there certainly wasn't full agreement on the competency document, but I -- I -- I think we have to be careful that the documents that we have are recognizing quality and recognizing safety and I don't think anyone wants to compromise that.

MEMBER BOLTON: Absolutely.

DR. GRAHAM: But I think we have to be really careful not to overprescribe so that we are restricting practice for Advanced Practice Nurses, because I think the healthcare needs in the State of Ohio are too great to do that.

So in no way do we think the scope of practice determination for the APRN would in any way compromise safety or quality, but overprescribing this role is, I think, going to compromise advanced practice nursing practice.

MEMBER BOLTON: Thank you.

CHAIRWOMAN KEELS: Sherri is next.

MEMBER SIEVERS: Just a couple comments.

I also recently was the Chair of the
Content Expert Panel that rewrote the FNP exam which just came out May 22nd, and so just to give you an example --

DR. GRAHAM: And it's a big job.
MEMBER SIEVERS: It was a big job. It was lots of trips to Washington, D.C.
And as part of that, our instructions, as we were building the ANCC exam for FNPs, was to remember it was entry-level.

And if you think we only wrote 600 questions that are going to be used in two exams over the next four years, you really get the message that this is entry-level.

There's no way we could write a question that represented every clinical scenario that is appropriate for the FNP to work in, so it's that entry-level. The rest of it, we really count on them continuing their knowledge base once they get into a clinical setting in their clinical practice.

And I think the colposcopy example was a wonderful one. You know, I did pap smears in my training and it's within my scope as an FNP, but I certainly would need some additional clinical mentoring by someone if I were to do it now.

So yes, clinical practice and those exams
are updated, but they cannot possibly represent every knowledge point that is within the scope for those certifications.

The other thing --

MEMBER BOLTON: Can I just clarify that?
MEMBER SIEVERS: Yeah, sure.
MEMBER BOLTON: So I was using that as the entry level.

MEMBER SIEVERS: Right.
MEMBER BOLTON: I think my question was how do you extrapolate that to the experienced RN or the experienced APRN. So that was my --

MEMBER SIEVERS: Right. I think as you are in practice and you build, you know, you build on different examples and scenarios and your practice can change to within the scope, but it can -- you can be experts in many different parts of those different areas. Like, if you were in the women's health for pap smears and primary care, you would need more training for that.

The other thing is as far as the institutions, you know, the Joint Commission has the Ongoing Professional Practice Evaluation or OPPE process which I think you were alluding to --

DR. GRAHAM: Right.
MEMBER SIEVERS: -- as part of credentialing, and so building measures within the Joint Commission rules to really evaluate practice and really have your finger on the pulse of what people are competent -- maintaining competency, that is the OPPE task is to be part of that process.

So I think that could help, too, in competencies and just having ways to evaluate, good ways to evaluate folks in practice, so that's some of the things we kind of have done over the years, but . . .

CHAIRWOMAN KEELS: Thank you.

Dr. Graham, if I may, thank you for coming. I was very happy to see you because I wanted to ask you a question about the letter that Dean Melnyk sent on behalf of the College which was requesting that the Committee consider putting some clarification around formal education and clinical experience.

And so, my question was: Is this within the population focus?

So, for instance, I think we all acknowledge that certification exams validate entry-level knowledge competency, but then in many places you need to have transition-to-practice
programs or continuing education, CME, skills, you know, procedure labs, so on and so forth, to maintain your competency to gain and build upon that expertise.

Is that what this letter was requesting or was it something separate such as a post-graduate residency or fellowship or other training program that would then prepare an APRN for management outside of the scope of practice?

Because I think that's what the Consensus Model is really trying to limit which is, say, an FNP or a Primary Care Certified Nurse Practitioner would attend a course or a training program and then feel competent or deemed able to manage the care of critically-ill patients.

DR. GRAHAM: I don't think that we think that Acute Care Nurse Practitioners should be doing primary care necessarily, or Primary Care Nurse Practitioners should necessarily be doing acute care if they have just entered into practice.

We would like to see people practice according to the scope that they have been educated to, but we have Advanced Practice Nurses, across the state, who have many varied experiences.

The other thing that I don't think that
we in any way would support would be saying that
every single Advanced Practice Nurse needs a
residency or transition into practice. There's no
funding for that. That's the medical model. The
medical model pays their residents; we don't not.

We could not establish that in the State
of Ohio and have -- I mean we think about the amount
of tuition dollars in debt these APNs have,
approximately 150,000 by the time they finish their
APN program, depending on which one they go to.

And then we add -- we require
additional, you know, transition to practice or
residency. I think to require that or to suggest
that should be required would not provide the access
that we need for either the APN or through the
patients.

So I think that what we have to do is we
have to think about where the person -- the
experiences that they have had. Some of them will
have the opportunity for residency. I mentioned the
one in oncology that we have at the James. We have
Adult Nurse Practitioners and Acute Care Nurse
Practitioners going into that year-long program. So
that's why I say I think we have to be careful that
we don't make it so narrow that things like that
can't happen.

In the best of all worlds, we'll all be working in the area we specialized in and then we have opportunities to increase our skills in that specialty, and the colpo is one of the examples of that.

But I think we have to remember several things and that is we haven't always had all these specialties. We have people, they started when they were Family Nurse Practitioners, 25 years ago, you know, and they were 25. Now they're 50. They still have 20 more years to practice.

I think we have to be careful that we're not closing opportunities for people who have been practicing for a long time, and that we keep opportunities for new graduates so that they can increase their skills and increase their knowledge and their ability and not be fearful of their practice because we are making it so restrictive.

CHAIRWOMAN KEELS: And I think the Interpretive Guideline seeks to help individual APRNs, as well as organizations, understand scope of practice.

And I think based on some of our -- some of the feedback from especially OHA and OONE that an
FAQ may be a way to help clarify what the terms "clinical experience" and "education" mean relative to staying within your scope but continuing to build upon your expertise.

I also think that the whole reason we're having this conversation is because there tends to be lots of questions around NP scope of practice, and we need to be able to help our graduates and our practicing APRNs understand that, and so I don't know if you have other ideas about how we can do that, aside from this Interpretive Guideline and maybe FAQs.

Because we know we heard we don't want to make more law, we don't want to make it more restrictive, we simply want to -- and "simply" is in quotation marks because it has not been simple -- but how can we use what we've got and make it more clear.

DR. GRAHAM: I think there's several ways that can be done.

One is I think some of the questions have centered around nurses who are working in hospitals. And so I think we can take the responsibility to make sure that we educate the administration, and some of that could be through the nurse execs. You know, most nurse execs aren't Advanced Practice Nurses,
they are leaders and executives working in that
organization. I think working more with the Hospital
Association.

I think for us to make sure that our
scope is understood is our responsibility. I don't
think that we can turn to the Hospital Association or
the American Nurses Executives, you know, the nurse
execs or the OONE, I don't -- I think that's the
responsibility for the APRN.

What we do at Ohio State is we try to
make sure that every single person who applies to any
of our 11 different specialties knows what those are
and so we do a little video so they recognize that.

And then, you know, occasionally people
will get into their program and "Oh, this isn't for
me, I think I would rather do this," so we try to
help them change, if at all possible, into the
correct one that more matches their desires and their
skills and their abilities.

And then we try to make sure when they
graduate that they take positions that match their
scope of practice. I mean, we work a lot of that in
the very last semester and I think that's our
responsibility as educators.

We can't stop them from taking the path,
but I think that's where working with hospitals and
other executives to help them understand this is what
your position description is, you are really looking
for this type of APN versus this type of APN.

And I think we have to do that, I think
we have to take that responsibility to do that, but I
don't think we want to do that through law or rule, I
think that's not going -- that won't serve as well, I
don't think.

CHAIRWOMAN KEELS: I think we have to
take a pause here so we can key up our next speaker.

Thank you so much.

DR. GRAHAM: Thank you.

CHAIRWOMAN KEELS: We really appreciate
your time.

Chris, we need to tee up Carolyn Buppert.
will you be able to speak in the afternoon?

MS. WILLIAMS: No, I can't. I'm actually
on my way to Indianapolis.

MS. EMRICH: I figure it will take five
minutes to transition.

CHAIRWOMAN KEELS: Okay. Do you want to
come up while we -- we're going to have to get
Carolyn on the phone while you talk, if you don't
mind.
MS. WILLIAMS: Okay.

CHAIRWOMAN KEELS: Sorry about that.

MS. WILLIAMS: No, no problem. I understand.

CHAIRWOMAN KEELS: We've got lots of conversation going on.

MS. WILLIAMS: This will just take me a minute.

CHAIRWOMAN KEELS: Okay. Chris Williams is here on behalf of OAAPN.

Good morning, Chris.

MS. WILLIAMS: Good morning.

Good morning, everybody.

MEMBER BOLTON: Good morning.

MS. WILLIAMS: I know most of you, not all of you, glad to meet you.

I'm on the Board of the Ohio Association of Advanced Practice Nurses, and I've been coming intermittently to Board meetings, and I know there are a lot of people on the Board that certainly know my face and give me welcome looks when I show up.

I'm -- I actually am the person who went to the Board, six or seven years ago, to ask the Board of Nursing to implement an AA -- no -- APRN Advisory Committee, and we went with OSANA, ONA, and
OAAPN, and it was the first time in history those three groups linked arms. We approached the Board, we petitioned them.

And the suggestion for an APRN Advisory Committee comes from the National Council of State Boards of Nursing. We didn't make this up, we didn't dream about it, we didn't think about it. That is your -- that's the trade association for Boards of Nursing, it comes from them.

So after a couple of months of deliberation, we met with the Board again and they told us that no, they were not going to have an APRN Advisory Committee, although they had other advisory committees and they did not give us an answer, but they did say that if we wanted one, we would have to pass legislation.

So I wanted to tell you that legislation is a very expensive process, it took a number of years, but we did get it in House Bill 216 because for us it was very important. There was only one seat on the Board held by an APRN, with 16,000 APRNs or more in the State of Ohio, that really the issues that we face day-to-day are not understood in general, certainly by LPNs and sometimes not by our fellow RNs, although we are RNs also.
So we felt it was very important in order to move ahead in Ohio professionally, this was the first step so that we weren't always on the back end, begging to be heard, begging to be able to speak, begging to show you what we know and share documents. So you came from that beginning.

The role of the Board is -- of the Committee is not to represent the Board of Nursing. The role of where you are, except for the person representing the Board, Erin, is to represent the APRNs.

I just want to remind you of your role, because when you become a member of a sort of quasi administrative committee or body, it's easy to sort of forget who you're representing. And that's who you're representing, the issues that we face in practice. And I think that some of you do it very well; others, I'm not so sure to be honest with you. So I just want to remind you of that.

The other thing I want to remind you is that good outcomes have to come from good process, and good process means you collaborate with those who represent the APRNs in the State of Ohio and with other professionals.

I mean collaborating with Margaret Graham
and the group at OSU is of benefit to all of us. I
listened to Margaret speak, and I come back and I
leave renewed, I've learned something.

That's a collaborative process.

Not just meeting with OONE or -- a
collaborative process, if you want to talk about
consensus, if you want to talk about exchange of
ideas, then foster an exchange of ideas. Bring these
groups together. We have a lot to say about this.

How would this look, how would that look, does this
work here, is it your purview or the Board's purview
to regulate specialty practice.

And I'll remind you of something else.

I'm an old person. I am. I was going to say old
lady, but I'll just say old person. I've been
practicing for over 40 years. I remember when family
medicine was attacked by internal medicine and
specialty practice and I remember it well, and the
reason I remember it so well is I am in family
practice and I'm still working, but my husband was in
family medicine, and it was quite something, and a
lot of the things that were said then are said now
when it comes to APRNs.

And I will tell you that the executives
and the directors of these health facilities look at
us like we're crazy. You're what? You can't do what? The Board said what? More and more we hear the move towards PAs, so I just -- and APRNs are light years above in terms of taking care of people and understanding and being compassionate. So there's my reminder.

So I talked to you about coming to consensus and working together as a group and that's what I would define as leadership. The leadership to bring together these different ideas and to help us hear each other.

And I know you have a call. Thank you very much.

MEMBER ZAMUDIO: Thanks, Chris.
MEMBER BOLTON: Thanks, Chris.
MS. WILLIAMS: Thank you.
CHAIRWOMAN KEELS: Next up we are going to dial in Carolyn Buppert. You have her extensive CV in front of you. Carolyn is an Adult Primary Care NP, certified back in 1985.

Carolyn?

MS. BUPPERT: Hi. Can you hear me?
CHAIRWOMAN KEELS: Good morning. You're a little bit low.

MS. EMRICH: Let's turn the volume up
here a little bit.

CHAIRWOMAN KEELS: That's better.

MS. BUPPERT: How's that?

MS. EMRICH: That's better.

CHAIRWOMAN KEELS: That's better.

MS. EMRICH: Carolyn, hello. This is Lisa Emrich.

MS. BUPPERT: Hi, Lisa.

MS. EMRICH: Hi. And I'm going to introduce you to our Chair, Erin Keels.

MS. BUPPERT: Hi, Erin.

CHAIRWOMAN KEELS: Hi. Good morning.

Thank you so much for joining us. We really appreciate your time. I was just calling out your extensive CV to the Committee, they have that in front of them, and was noting that you are an Adult Primary Care Certified Nurse Practitioner since 1985, but also --

MS. BUPPERT: I was.

CHAIRWOMAN KEELS: -- a lawyer who specializes in legal issues related to the administration of and delivery of healthcare. Your clients include hospitals, medical practices, nursing homes, agencies, individual healthcare practitioners, and you have an extensive listing of presentations
and publications related to APRN practice issues; so your expertise is invaluable.

And at the request of the Committee some months ago, we asked -- we were hoping that we would be able to borrow some of your time to get your perspectives and opinions on scope of practice issues.

I know that Lisa has been in contact with you and has brought you up-to-speed on the conversations our APRN Advisory Committee has been having around scope of practice and particularly where, you know, one scope may end-ish, such as say primary care and where it becomes the domain of only acute care certification, but also recognizing that the populations overlap each other in many areas.

And the other challenge we're having is how do we sort of define clinical experience and education as it relates to APRN practice and scope of practice, so we'd be very interested to hear your opinions.

MS. BUPPERT: Okay. So, first, a little bit of a disclaimer. I practiced as a nurse practitioner for 16 years, including while going to law school, but I let that certification go in 2015 because I didn't -- I don't want to keep up the
clinical requirements, so I let it go.

And the other part of the disclaimer is that I -- I know you all have lawyers, and I don't want to be accused of practicing law in Ohio without a license, so what I'm going to say is more of a policy rather than legal opinion because I don't think you would protest, but, because of the controversial nature of this topic, I don't want people, who might disagree with me, accusing me of practicing law in Ohio,

So, given that, we'll proceed and these are policy consultation recommendations, I guess, or opinions.

So I come to this because I am frequently called or e-mailed by nurse practitioners who have one of three issues.

One would be they'll say should I take this job. They are commonly, say, a family nurse practitioner, newly graduated, are being recruited by a GI or other specialty practice and the job requires not only office visit evaluations but some time in the hospital. And they are not acute care certified. So they ask should I take this job.

And I say well, it doesn't matter what I think, I think you should contact your Board of
Nursing. And they often will say well, they didn't
call me back or I did get a response but it was
vague, so I don't know what to do with that.

One nurse practitioner did get four
documents e-mailed from the Board of Nursing which
was helpful. They included the NCSBN algorithm and
the Consensus Model statement and so on.

But anyway, I don't -- I don't give them
advice and it doesn't matter what I think. I mean I
do know what I think, but I don't tell those people
whether to take a job or not.

The second batch is they'll ask, well, my
employer has -- I'm an Adult Nurse Practitioner, my
employer wants to open a Saturday walk-in clinic and
they want to be able to serve children, and they want
me to cover this clinic. Am I on safe ground there?

And again, my opinion would be no, but I
tell them to contact the Board of Nursing about that.

And then the third batch would be the
Family Nurse Practitioners who are being sort of
forced to see patients with major mental illness for
psychiatric treatment, and the reason being there
aren't any psychiatric providers in that area to take
care of these people.

The third being -- that's really a
worrisome situation but, again, you know, I don't
give them advice. I tell them to contact the Board
of Nursing which, of course, brings it back to you
all.

So my worries are that if something goes
wrong in any of these situations and a patient or a
parent sues, the first thing that the plaintiff's
attorney will focus on are the qualifications of the
nurse practitioner. If it's a savvy plaintiff's
attorney, I think the chances of that are high. I
don't know of any cases right now where this has
happened, but I would like to prevent such a
situation.

So you want the nurse practitioner to be
able to defend by saying I'm qualified to do this by
nature of X, Y, and Z, which hopefully are the
standard certifications and/or, in addition to that,
I have this and that, and this and that, so -- okay,
that's one concern.

Another concern is those who are doing
the hiring, whether it be a private practice
physician group or a hospital, they don't know how
nurse practitioners are educated and they tend to
often think one size fits all, and so it's really on
the nurse practitioner, himself or herself, to
safeguard his or her own career and practice.

And the nurse practitioner, I think, needs a little something to help them not only make their decision, but to also show to their employer to offer some guidance.

So I am a proponent of the NCSBN Algorithm, the Decision-Making Algorithm, which applies to not only procedures but roles, and I think it would be helpful for Boards of Nursing to offer that as a tool.

One thing the nurse practitioners are going to want to know is, if their practice is challenged, what standard is the Board of Nursing going to use in determining whether they are outside scope of practice or not.

And given that the NCSBN already has this tool, it seems to me to be a reasonable thing to offer nurse practitioners and say, well, I'm not going to go through every nurse practitioner's job situation and give them an opinion on whether to take the job or not, but if you can get through this algorithm with yes answers all the way to the end, after the first one which is "Is there any legal prohibition of this," the answer should be no, but all the other questions the answers should be yes.
If you can get to the end of this algorithm with yes answers, then you probably can feel somewhat comforted; and if you can't, I wouldn't take the position or perform that role.

So -- so that's sort of my general stance on this issue and I'll just leave it at that if you want to comment.

CHAIRWOMAN KEELS: Thank you.

I'm not sure that we've reviewed that algorithm here, and I like that suggestion, and I think we can definitely pull that up and see how and if it meshes with what we're trying to do here. Maybe that would be helpful.

Anybody else have some questions yet?

Sherri.

MEMBER SIEVERS: Hi. Sherri Sievers. I'm an FNP representing practice.

So do you ever refer folks to their -- to the papers that were put out by their certifying body?

I know -- I'm an FNP, and I work at Cincinnati Children's, and I'm in a position where I'm hiring, and I often will use the white paper from PNCB that was put out about age, because we run into that. We have many patients who continue at
Children's through the lifespan, right, your cystic fibrosis.

So they removed those hard-and-fast ages and it's really about can you say you're the expert.

Are you referring patients or consulting with conditions that are outside your expertise, you know, if a CF patient, who is an adult, developed heart failure or something. And so, we often use those white papers.

Do you refer folks to their own certifying-body documents such as those?

MS. BUPPERT: Yeah, well, that's part of the algorithm. One of the questions in the algorithm is, is the role or practice consistent with, you know, professional organization statements, so yeah.

MEMBER SIEVERS: Okay.

MS. BUPPERT: Yeah, take a look at the algorithm. It covers things like are you prepared to accept responsibility for, you know, the outcomes; what does the professional organization say; are there resources within the organization that are going to help you with this and so on.

I'm quite impressed with the algorithm, so, I mean, not that it -- I mean I don't know, you're the ones who will need to implement it, you
know, if someone comes with a complaint.

And I know I was asking sort of Lisa what she -- what the standard would be now if someone came -- say this complaint came to the Wyoming Board of Nursing and it was the example I gave about an Adult Nurse Practitioner being assigned, by an employer, to work a clinic, a sole-provider clinic, and the person was required to see a child, and the patient's parent found out about the nurse practitioner's preparation and complained to the Board of Nursing.

So the Board of Nursing in Wyoming did discipline the nurse practitioner for that, I think it was minor discipline, but then the Board of Nursing went on an educational mission to inform the employers, the hospitals, they shouldn't be asking that kind of a -- they shouldn't be putting the nurse practitioner in that position.

CHAIRWOMAN KEELS: Brian.

MEMBER GARRETT: Hello. My name is Brian Garrett. I'm a CRNA representing CRNAs.

I just have a question about your experience from '85 to '93. I have one question and, based on that answer, I'll have a couple of follow-up questions.
What did you do as a Nurse Practitioner in the Department of Anesthesiology at John Hopkins?

MS. BUPPERT: I did pre-op medical evaluations.

MEMBER GARRETT: Okay. Did you -- so your training on anesthetic pharmacology or how it might interact with that patient, did that come from your education as a nurse practitioner or did that come from employer training and --

MS. BUPPERT: I didn't do anything with the anesthesia. This was just a medical evaluation of the surgical patient. So we took a history, did a physical --

MEMBER GARRETT: Just the H&Ps, okay.

MS. BUPPERT: -- and recommended sometimes that the person go back to their internist.

MEMBER GARRETT: Okay.

MS. BUPPERT: And then the anesthesiologist would come through and go over that, so I didn't do anything with medication at all.

MEMBER GARRETT: Okay.

MS. BUPPERT: I mean other than occasionally I'd prescribe a Reglan or something, that's it.

MEMBER GARRETT: Gotcha, okay. Thank you
very much.

CHAIRWOMAN KEELS: Pete.

MEMBER DIPIAZZA: Hi, Carolyn. This is Pete DiPiazza. How are you?

MS. BUPPERT: Hi.

MEMBER DIPIAZZA: I have a quick question about your thoughts around clinical experience prior to an APRN getting their certification.

Do you know of other licensed professionals where -- well, where pre-certification experience comes into play after they get their license or certification to practice in their state after?

MS. BUPPERT: Are you asking me if I think an ICU nurse, that becomes a Nurse Practitioner, is okay to practice as an Acute Care Nurse Practitioner?

MEMBER DIPIAZZA: Well, no. I guess what I'm wondering is if there is anything out there, any precedent out there where if someone's individual experience, prior to their formal education, weighs in on license by a state agency or anything like that.

MS. BUPPERT: No.

MEMBER DIPIAZZA: No?
MS. BUPPERT: No, I don't, uh-uh.

MEMBER DIPIAZZA: Okay.

CHAIRWOMAN KEELS: Sherri.

MEMBER SIEVERS: So I pulled up the algorithm and I have a couple of questions. So I don't see where it specifically says that this is for advanced practice; is that correct? So it's nursing, it's general.

MS. BUPPERT: Right.

MEMBER SIEVERS: Okay. And then where it says "Is there documented evidence of a nurse's current competence (knowledge, skills, abilities, and judgments) to safely perform the activity, intervention or role," would that be where you would think -- is that interpreted by you to be clinical practice? That's one of our issues that we have been discussing, where does clinical fit into that.

MS. BUPPERT: I interpreted that to mean well, if you're certified in acute care, that would be one thing. I mean basically that or if you have some sort of -- you've done some sort of residency or, you know, I mean it's an open-ended question, but I thought it would include certification and other things.

MEMBER DIPIAZZA: I would think, like,
successful proctoring has been met.

    MS. BUPPERT: Yeah.

    MEMBER SIEVERS: Right. It doesn't specifically says clinical practice, but it says skills and abilities which I would think would probably be interpreted that way.

    MS. BUPPERT: I think given the questions and any specific answers, reasonable people might disagree on, you know, whether you can get a yes or not. Reasonable people could disagree, but at least it's posing the questions.

    And I think that some of the nurse practitioners might self-select and not take on some of these jobs if they had to go through this algorithm, and it gives a structure at least.

    MEMBER SIEVERS: Thank you.

    CHAIRWOMAN KEELS: Any other questions?

    So as we think -- we've had a request to put some clarity around the terms "formal education" and "clinical experience." Those exist in our current statutes. I guess, what would your recommendation around that be?

    MS. BUPPERT: In designing formal -- what was it? In defining? I'm sorry, what was the term?

    CHAIRWOMAN KEELS: Putting clarity around
the terms "formal education" and "clinical experience" as it relates to APRN scope of practice within the population focus.

MS. BUPPERT: Well, I would have to focus -- I mean the hard part is clinical experience. "Formal education," you know, I interpret that to mean degree. I suppose you could -- a degree program where a person, you know, is evaluated on the basis of grade.

You know, is "formal education" taking a CME class? Well, I don't know. That, to me, is tricky because you sit there, but has anybody actually tested whether you have got the information down or not?

So, I mean, I -- I don't -- I've not given a lot of thought to defining those terms and I'm not sure that I would be the right person to opine on that.

CHAIRWOMAN KEELS: Okay, great. Thank you.

Do you have any questions?

MS. EMRICH: No.

CHAIRWOMAN KEELS: Anybody else have any questions around the Committee?

Okay. Well, it looks like we're out of
-- I can't believe it, but we're actually out of questions. That almost never happens.

    MS. BUPPERT: Okay.

    CHAIRWOMAN KEELS: All right. Thank you so much for joining us. We really appreciate your time.

    MS. BUPPERT: My pleasure.

    MS. EMRICH: Carolyn, thank you very much. I appreciate it.

    MS. BUPPERT: Uh-huh.

    MS. EMRICH: Bye-bye.

    MS. BUPPERT: Bye-bye.

    MEMBER GARRETT: I have a comment about clinical experience. Don't throw things at me yet until I'm done.

    So as a CRNA working on the outside looking in, also having been involved in education, I also do education for practitioner students and my wife is a nurse practitioner.

    So when I first saw the clinical experience piece in the Ohio Revised Code, I knew it very well through OSANA, I was livid. I was like how can they do that, you know, because they didn't have their training and all this, right? So I was over here, first. Well, they didn't have it in their
training, so they can't do it, right?

    So I started listening to my wife. My
wife manages Nurse Practitioners at a local hospital,
a big hospital, it has a red "O", you know, and I
started listening to her talk about the clinical
experience part and the issues that go into that.

    And then, you know, there's no possible
way if you've been a nurse practitioner for 20 or 30
years, there's all these new specialties popping up,
there's new procedures and drugs and all those
things.

    So I started going away from "They don't
have education and training so how can they do that,"
to I started moving towards it, right?

    And then I started thinking about
anesthesia practice and I started to think about all
the new procedures.

    I'm actually asked to train attending and
primary care physicians on procedures, and I know
there's procedures, you know, there's population foci
on procedures such as intubating and, you know,
they'll tell me, "I didn't get any of this in my
residency," so I have to sign them off. Now, our
Medical Director comes in and just makes a slash and
writes his names. So they're getting that as their
practice evolves and I've heard about the family medicine intervention specialist.

So, on the outside looking in, being not a nurse practitioner but being around it, I have changed my opinion from, "Hey, they didn't get it in their training, so they shouldn't be able to do it," to "Healthcare has evolved and healthcare is different." And I see your other specialties, I see your other medical professionals do it, we have to do it in our own. I've watched our education standards for anesthesia education change over the years.

And also, you know, for example if you get OB training as a CRNA, but then you don't do it for 20 years and you go back; well, your hospital is not going to let you walk into an OB unit. They're going to make sure you have clinical experience, training, whatever that looks like, which is what we're trying to do.

So I like what she said with this Decision-Making Model because at least it's some kind of guidance for people, because I was reading through it a minute ago and I said wow, that's kind of like the decision-making we have to make, one, ourselves as practitioners, but also the hospital has to make.

So, I don't know, that's my outside
looking in. I'm the new person to the group, but I just want to give you my thoughts and experience.

CHAIRWOMAN KEELS: I actually don't think you're far away from where we've actually been.

MEMBER GARRETT: Yeah.

CHAIRWOMAN KEELS: I think -- I mean we've had turnover, but at our last Committee meetings I think we all agreed that your formal Master's degree program is your formal education for entry into practice, but that your job changes over time, the scope evolves over time.

The example that one of our former members gave was asthma care which was once considered a very acute illness that should be managed by acute certified people perhaps, but now it's a well-established chronic condition. It's well in the wheelhouse of primary care certified providers.

So I think that's what I'm thinking about this education and clinical expertise is it builds upon your expertise as you transition from novice to expert, or from one job to another job, but still within your population focus.

So, by example, I wasn't here last time but there was some questions or comments around the
NPN role and we are certified to take care of patients up to the age of 2. If you query most NNPs, they will say uh-uh, I'm not trained to do that.

It's in everything. It's in the NONPF competencies, it's in the NANN position statement, it's in our NCC certification standards guidebook, but many of us did not train in well baby care beyond the newborn period. Many of us did not do a practicum in that, but it's within my certification, it's within my scope.

If I wanted to leave what I'm doing right now and go take a job in a neonatal follow-up clinic or even a well baby care area to see patients up to 2, I would need more education and training within my population focus so that I could develop competency and expertise to do that job. I think that's what we're saying.

MEMBER GARRETT: Just like an asthma attack under anesthesia is called a bronchospasm, that's the most acute. A nurse practitioner wouldn't walk in and take care of that in my population which is anesthesia --

MEMBER DIPIAZZA: Right --

MEMBER GARRETT: -- and I wouldn't try to go to --
CHAIRWOMAN KEELS: Yeah.
MEMBER GARRETT: -- an outpatient facility and manage that same asthma attack.
CHAIRWOMAN KEELS: So I think we are splitting hairs and I think an FAQ might be helpful to sort of put maybe some guidance around the guidance document.
Sherri.
MEMBER SIEVERS: I think it depends on what we put in there.
CHAIRWOMAN KEELS: Yeah.
MEMBER SIEVERS: I think, again, going back to the references that our certifying bodies have put in place.
CHAIRWOMAN KEELS: Yes.
MEMBER SIEVERS: I know a lot of them have great white papers.
And I think that's a very good observation that you made, Brian, because the difference between anesthesiology and primary care, we get 600 hours. 600 goes like that, right? And it was in a wide variety of settings. You might have only had 60, 120, 240 in different areas.
Where, anesthesia, you probably had way more than that and it was all in anesthesia or all in
neonatology, right?

So it's very different when you're trying
to capture and to not include some sort of clinical
practice beyond that entry level would really be a
miss by this group because you just can't do it.

Even acute care, depending on the
variation of what they got, some of what I'm hearing
the acute care folks for their primary care
experience were going to camp for the week and
observing camp, kids at camp. So it looks very
different and you have to continue that once they get
in a job.

CHAIRWOMAN KEELS: I think you hit on a
key element. Within the Interpretive Guideline we've
got recommendation to reference back to --

MEMBER SIEVERS: Yes.

CHAIRWOMAN KEELS: -- those statements
because those will evolve over time --

MEMBER SIEVERS: Right.

CHAIRWOMAN KEELS: -- as the scopes
evolve, as the roles evolve, as the population needs
evolve.

MEMBER MINIARD: A little question for
clarity. I know we're not really talking about the
Interpretive Guidelines, but we keep talking about
it.

CHAIRWOMAN KEELS: But we keep talking about it.

MEMBER MINIARD: It's not on the agenda for today, but I just want to make a quick comment about something you said about the national-certifying white papers.

Isn't that -- didn't you say, at the last meeting, that those Interpretive Guidelines were kind of based on those white papers from the national-certification statements?

MS. EMRICH: Correct. And let me back up. The -- we didn't re-distribute the draft or a redraft it.

MEMBER MINIARD: Right.

MS. EMRICH: That's what we meant by not being on the --

CHAIRWOMAN KEELS: We can still talk about it.

MS. EMRICH: Yeah, we can still talk about it. So the graphs or charts on the draft IGs were -- those parameters were taken directly from the individual certifying organization.

MEMBER MINIARD: Right, right, that's what I thought.
MEMBER SIEVERS: Which are great resources.

CHAIRWOMAN KEELS: Yeah.

MEMBER SIEVERS: I send them to folks all the time. They ask me and I say read this. If you can answer that you fit into this, then --

CHAIRWOMAN KEELS: And those are your living documents.

MEMBER SIEVERS: Sometimes the answer is no and sometimes it's yes.

CHAIRWOMAN KEELS: Yeah.

Michelle.

MEMBER ZAMUDIO: So when I was thinking back on what Carolyn mentioned with these decision-making tools, it just kind of struck me that those are very generalized to either nursing or to all APRNs. This is only for CNPs.

CHAIRWOMAN KEELS: Right.

MEMBER ZAMUDIO: So, as the midwife representative, there's nothing in here for me.

CHAIRWOMAN KEELS: Yeah.

MEMBER ZAMUDIO: So would it perhaps be better to have either something that's more global and addresses us referencing white papers and referencing our national guidelines, or to just use
our current decision-making tool which is on the
Board of Nursing website which does address all of
these things?

CHAIRWOMAN KEELS: So that was a
recommendation. There was a concern and a
recommendation and, you know, going back to all of
the past discussions over the last two years has been
really around NPs which is why we decided to make an
IG for NP only at this moment because the Board
receives the most questions on NP practice and that's
where there seems to be the most questions.

But you raise a good point. And if the
NCSBN algorithm could be used, I mean there's
probably no reason why we can't have a link on the
Board website for all APRNs to take a look at that.

MEMBER ZAMUDIO: Well, I'd have to look
at it, first, to see if it's really addressing
nursing. It may not fit our needs.

But to have something similar, rather
than make it specific and restrictive for one group
of those four nursing specialties as defined in our
ORC, why not make a global one if we're talking about
that scope of practice.

CHAIRWOMAN KEELS: So -- I'm sorry. I
didn't see your hand up, Jody.
MEMBER MINIARD: That's okay.

CHAIRWOMAN KEELS: So one of the reasons
we wouldn't be able to make a global Interpretive
Guideline is because each of the four roles has their
own statutory language, so it would be challenging,
other than to use like the NCSBN, a very generic sort
of model which I'm sure that -- I mean it's publicly
published and available for all to use. We could
probably draw attention to it.

Jody, I'm sorry.

MEMBER MINIARD: That's okay.

So I think there is a very global one
already currently on the Ohio Board of Nursing, and I
agree that the NCSBN one is very global as well, but
I think the whole purpose of this was -- and you
correct me if I'm wrong but this is my interpretation
of it -- was to give better -- in an attempt to
clarify some things about what we've been talking
about for the last two years which is focused around
primary care versus acute care and population-focused
certification.

So I think we can't lose sight that we
all have different population certifications. That's
the way that our Nurse Practitioner Model has been
formed across the country, and it is what it is, so
we have to practice within that.

And I think the goal of this -- however, I think it fell short a little bit, in my own personal opinion, was to give clarity to all nurse practitioners practicing in the State as to what really their population is because, unfortunately, as an educator, which is who I represent here, I can tell you that a lot of graduating NPs don't understand what their scope of practice is.

There are a lot of questions that come after graduation that I keep in contact with multiple students who have graduated and are taking jobs, and all population focused, mostly family and acute care, and most of the questions I get from students and they don't know.

And I think it's also important -- there's been a lot of conversation today, both from public comments and around the table, about this limiting people.

There's nothing limiting in an Interpretive Guideline unless you place the limits there yourself or an employer places the limit there themselves because this is all stuff that we already know when we graduate as a Nurse Practitioner.

And I don't think anyone is saying that
there isn't something valuable in clinical expertise
or clinical practice that you gain, but I think it's
important to remember that that clinical expertise
does not therefore eliminate the fact or allow you to
practice outside of your population focus.

So a Family Nurse Practitioner -- I think
this is what you were alluding to with Carolyn but
I'm not sure she really felt like she could give an
answer without overstepping herself a little bit, is
kind of the feeling I got.

So, like, you're a Family Nurse
Practitioner and you're working in a hospital and
you're taking care of cardiac patients which is all
fine, but that moment when that patient becomes
unstable or has an acute coronary syndrome are you --
because you're there, should you be taking care of
the acute coronary syndrome?

And maybe you have in the past and maybe
it's something you have clinical experience in,
either before your graduate education or after, does
that mean you are therefore capable of practicing,
that it's within your scope?

And I think that we can't lose sight of
those little things. And it is gray and I think it's
going to be hard to come up with something that's
very specific.

But I do think that we have to be careful as a group, which I think Chris alluded to. I don't know if she's here anymore, she was going to Indy.

I know, as for myself, that most of us at the table are here to represent everyone and not one individual group. However, we're all going to have different opinions about it.

But I just don't want to lose focus of Interpretive Guidelines versus law. I don't think anyone at this table wants to enact more laws over NP practice, I don't think that's the goal of anyone, but I don't want to lose the scope of Interpretive Guidelines just to gave clarity to what it means to actually practice within your scope

MEMBER ZAMUDIO: I can address that.

When I mentioned the limitations of the restrictions, just as a new person coming in because I wasn't here when we initially had the Interpretive Guidelines, one was the grandfathering which we've talked about; two was any of the continuing education; three was the Bachelor's.

And then I went back to the Ohio Revised Code, and I keep going back to this specific passage of 4723-8-01 paragraph (F), and it says the practice
of nursing as an APRN in your definition means
"providing to individuals and groups nursing care
that requires knowledge and skill obtained from
advanced formal education, training and clinical
experience."

And Erin is the only one I've heard
saying the word "training."

So when we struggle with those three
areas, it says, you know, this care is described in
4723.43.

My concern when I say "limitations" is,
one, the definition of "critical care" wasn't
accepted by this Committee, at least at the 1-hour
and 10-minute mark that I looked at, and I watched
the entire tape. So that was a limitation so we
needed to work on the definition.

Two was the word "training." So we talk
about our certification being our knowledge and then
we talk about our clinical experience, but there's
training in there. That could be our residencies,
our conferences, our whatever. That's training. And
that's in the law already.

MEMBER MINIARD: Right.
MEMBER ZAMUDIO: So those were the --
when I said "restriction" --
MEMBER MINIARD: Right.

MEMBER ZAMUDIO: -- I think if we don't mention those, we are amiss.

MEMBER MINIARD: But I don't think anyone is debating that, what is stated in the law. What I'm saying is that all of those things come into play and are important in practice as an APRN, 100-percent for sure, but certification only allows for entry-level practice.

And as we all know, I mean, I've been practicing for 15 years in the same specialty, that you don't get good at what you're doing until you've been doing it for a while, right? I mean the first year or two, you're still learning how to do your job.

But we can't lose -- I think the whole purpose, this conversation that I've only been part of for a year as an insider, but as an outsider I've been part of -- 2016/2015 when it started, working at an institution in the city where it was sort of the epicenter of the whole debate, so I just don't want to lose sight.

I don't think anyone's training and clinical expertise matter, but they only matter when you're working within your scope. And I think that
that's what this whole purpose and conversation should be focused on, not on acute versus primary care.

MEMBER ZAMUDIO: Right.

MEMBER MINIARD: Let's just focus on standard of practice. Are you getting clinical expertise, are you getting training within your population focus.

MEMBER ZAMUDIO: I think we do all agree on that, but my concerns were those aren't written down.

CHAIRWOMAN KEELS: Sherri.

MEMBER SIEVERS: Two quick things. I think we're saying the same thing.

MEMBER MINIARD: Right.

MEMBER SIEVERS: I think we really are. When I think about the three examples that she gave, so the FNP, GI specialty, time in the hospital, I think what I hear you saying is you really have to understand what it is they're being asked to do because I would push back to her and say if their time in the hospital is evaluating patients for things that they might do in the outpatient setting like, you know, rounding to help the nursing team or the general --
MEMBER BOLTON: H&Ps.

MEMBER SIEVERS: -- our people round and help the hospital medicine folks understand what a cleanout looks like, and she's certainly not managing acute but she's doing what she does in the outpatient and it happens to be in the inpatient setting which is totally appropriate for what she's doing.

MEMBER MINIARD: It is.

MEMBER SIEVERS: So the other person forced to see major mental illness, I think it's tough because -- I was more confused by this, I will just say that as the newbie.

MEMBER MINIARD: I kind of was too.

MEMBER SIEVERS: I was like holy cow, and I think the thing I struggled with is the continuum of health with the patient because where does major medical, is it right here below where I can take care --

MEMBER MINIARD: Is it orange or red.

MEMBER SIEVERS: -- or is that here?

What is the definition?

So I think having things that, to what you were saying, make us too focused and too narrow were not helpful. This would stem a lot more questions in my opinion.
So I think it's just being broad enough where we can help people ask themselves those questions.

I tell my folks "If you're on the stand, could you say absolutely this is how I am prepared to take care of this patient considering what is in the rule and what I'm legally protected to do."

CHAIRWOMAN KEELS: I think you're spot on.

MEMBER SIEVERS: Yeah.

CHAIRWOMAN KEELS: And all of those comments were received about the graphs and, you know, we'll tweak it, and if it still seems like it makes more questions than answers --

MEMBER SIEVERS: It would be nice to vet it through some people --

CHAIRWOMAN KEELS: Yes.

MEMBER SIEVERS: Like if I showed it to a student and said --

CHAIRWOMAN KEELS: It's publicly posted.

MEMBER MINIARD: I've showed it to my students.

CHAIRWOMAN KEELS: Vet away.

MEMBER SIEVERS: I think the overlap is good. It's the continuum of care or the critical
illness continuum is very hard.

CHAIRWOMAN KEELS: So I think we're still wrestling with what are those scope of practice parameters to say that education, training, clinical expertise within that population.

Pam, you had your hand up.

MEMBER BOLTON: I hear absolutely both of your sides, and I think from an employer standpoint the difficult piece in this is making sure that that new or relatively new person coming out, understands their scope when they're in that setting, and I don't like using that, you know, to know that that -- that they're in the appropriate scope. And that's what's really hard.

And what do you do as an employer? Do you hire an FNP? Do you hire an Acute Care? How do you differentiate that? Because the bottom line is you have a patient in front of you that needs help, and I don't think anybody is going to walk away from that and that's the difficult piece.

My other comment, and I haven't had time to kind of digest the NCSBN algorithm, the one thing that I want to hear from the Committee if you feel the same way, the one thing that is a little concerning to me is in a couple of these questions
they have "setting," "practice setting," and I feel
like that is counter to the Consensus Model, and so
as we evaluate that I would just ask that we consider
that.

CHAIRWOMAN KEELS: That's a good point --
MEMBER ZAMUDIO: Great point.
MEMBER MINIARD: It's a very good point.
CHAIRWOMAN KEELS: -- because we have
been trying very hard to say it's about the patient's
needs and severity of illness, not the setting.
MEMBER BOLTON: Yes.
MEMBER DIPIAZZA: Right.
MEMBER BOLTON: Age.
CHAIRWOMAN KEELS: That has caused many
more questions.
MEMBER SIEVERS: Which, going back to
referring people back to their certifying bodies, I
think would take care of that.
MEMBER MINIARD: One just completely
sidetone. I've heard the term thrown around a lot,
and I just want to be very clear that we're really
not talking about credentialing. We're really
talking about privileging, okay?
MEMBER DIPIAZZA: Right.
MEMBER MINIARD: Credentialing is not the
same thing as privileging.

So we're not really talking about a credentialing committee, credentialing that that person is who they say they are, they really do hold the certification, they really do have a license, they check the national database that there's nothing pending against them.

We're talking about privileging where the group then allows this individual to perform certain tasks and care for certain types of patients in the hospital.

MEMBER SIEVERS: Yes, you're right.

MEMBER BOLTON: Medical staff.

MEMBER MINIARD: Right. Completely two different things.

CHAIRWOMAN KEELS: That's a really good point.

MEMBER ZAMUDIO: Right. And that's what I liked about the OSU, I forget who the author was of this, but on the OSU suggestions it said clinical scope of practice may be further delineated by the employing organization. I took that to mean their DOPs. Right? That's their delineation of their privileges. So it could be more restrictive, it can't expand on your scope, but it could be that
individual person being privileged to do that particular function.

MEMBER MINIARD: And so maybe it makes sense to -- I don't work on a credentialing committee, I'm not part of privileging, I'm an educator, so it's not something that I do on a regular basis but, you know, it seems there needs to be more, as Dr. Graham referred to, more education on the privileging part of the credentialing committees as to -- and again if it comes out to be something, it could be sort of a guide, the Interpretive Guidelines from the OBN.

CHAIRWOMAN KEELS: Yeah.

And to that point you're spot on, you're spot on, because we get lots of questions from employers as well. And through our meetings with OHA and OONE, we've been able to have some really good conversations, it's been very robust and there's been a lot of understanding and collaboration there.

And I think there's opportunity to continue to work with employers on their levels of understanding that then would transmit to the privileging process to ensure all organizations are up-to-speed.

I also think there's an opportunity to
continue to work with the educator side as well so
that we do have graduates who understand their scope.

I appreciate that OSU is doing a great
job with their students, but that may not apply to
everyone, so think about what are ways that that can
happen as well.

MEMBER BOLTON: The other piece, there
are organizations that do not medical staff
privilege, outpatient advanced practice, and so I've
seen acute care in the primary care setting, so we
want to consider that as well.

CHAIRWOMAN KEELS: Yeah, I'm not sure how
to reach that, so that would be a good question back
to OHA, yeah.

MEMBER ZAMUDIO: So when you said there
was some concerns expressed over the graphs, et
cetera, that you would -- that we could tweak it, et
cetera, is there a work group or someone that is
working on these?

My concern is, having been here for a
bit, getting things done in three meetings or four
meetings over a year -- so she's pointing at you,
Lisa. So someone else -- rather than them put it out
and us debate it and redo it and us debate it and
then redo it, could it be more collegial when we're
developing those?

Can the OAAPN, can people in clinical
practice help with constructing that, maybe, so we
don't have to keep just giving the suggestion and
more work for you to go back and do it again and we
talk about it again?

CHAIRWOMAN KEELS: Well, I believe since
it's a Board product, it needs to be emanated by the
Board.

MEMBER ZAMUDIO: But it could be
collaborative with input, right?

CHAIRWOMAN KEELS: Oh, we've been getting
lots of input, yeah, and we will be meeting with OPN
and, you know, we met with OHA and OONE and we're
getting input from the individuals. It's posted
online.

Is there something further you want to
address with that?

MS. EMRICH: No. I mean that's why we
did not re-distribute it because we're getting so
much input.

MEMBER ZAMUDIO: Okay.

MS. EMRICH: And so we really wanted to
give, you know, us, staff, simply because we had an
extra Board meeting in between the short time period
between last meeting and this meeting and we got additional input, we chose not to keep sending out little tweaks.

MEMBER ZAMUDIO: Right, right.

MS. EMRICH: Just to send out one good document. That seems to be --

MEMBER ZAMUDIO: Is that what we'll discuss this afternoon then?

CHAIRWOMAN KEELS: Well, we're kind of discussing it all through the meeting. We're not going to go over it line by line again. You've been given it so you can take a look and provide feedback to Lisa and her staff.

MS. EMRICH: And the goal is, you know, to have a significant draft re-disseminated, you know, our goal is in August and to give plenty of time for input from the people before this Committee convenes again in October, so.

MEMBER ZAMUDIO: Got it.

MS. EMRICH: And at that time --

CHAIRWOMAN KEELS: Brian --

MS. EMRICH: I'm sorry.

At that time, once it's disseminated, if there's, you know, anyone can proffer any revision back to us that they mark it up, you know, whatever
is believed to be appropriate by any individual and we'll look at those.

CHAIRWOMAN KEELS: But we have been working on this for two years.

MEMBER ZAMUDIO: Right.

CHAIRWOMAN KEELS: In the meantime, the Board continues to receive oodles of questions every month from APRNs who are asking scope of practice questions, so I would hope that we can finally come to a decision and get something posted that can be very helpful back to APRNs and other organizations.

MEMBER GARRETT: I know some of this has been discussed before, but why don't we just call it "Guidelines"? Why does the word "Interpretive" have to be in there?

MEMBER ZAMUDIO: I don't know.

MEMBER GARRETT: Because when I listen to everybody talk, the word -- they have to work with the words "Interpretive Guideline" and the word "Interpretive" is the problem. Why couldn't it just be "Guidelines with FAQs"? It could still do the same thing. As soon as you put the word "Interpretive," it applies that some kind of magic power came down and interpreted this. It implies maybe --
MEMBER MINIARD: Authority.

MEMBER GARRETT: Authority or law, right?

We're just trying to give them guidelines, right?

Can we just call it "Guidelines and FAQs"?

MS. EMRICH: Well, not from the Board of Nursing.

MEMBER GARRETT: Okay.

MS. EMRICH: Because the Board of Nursing is charged with enforcing the Ohio Nurse Practice Act.

MEMBER GARRETT: So we have to use the word "Interpretive."

MS. EMRICH: "Interpretive" is -- well, the law -- any guideline -- in the guideline -- the Board has adopted other Interpretive Guidelines before for RN practice. We just have not needed, in the past, to do one for APRN practice.

MEMBER GARRETT: Right.

MS. EMRICH: And so the whole idea is that it's assisting with the application of enforceable law --

MEMBER GARRETT: Sure.

MS. EMRICH: -- and rules to very specific practices.

In this particular case it was determined
by this Committee that an Interpretive Guideline for
individual CNP scope of practice was needed and so
that's why, and it's called "Interpretive Guidelines"
because that's what's been adopted by the Board.

MEMBER GARRETT: Okay.

CHAIRWOMAN KEELS: So we chose -- to
remind everybody, we chose that route instead of
going back through the legislative process --

MEMBER GARRETT: Right.

CHAIRWOMAN KEELS: -- and opening up the
Nurse Practice Act and changing the law to further
define clinical expertise, training, and education.

People felt --

MEMBER GARRETT: I was trying to find a
way to soften the optics of the words "Interpretive
Guidelines."

CHAIRWOMAN KEELS: Yeah, yeah. Because
people felt and this Committee felt to take it that
way would be more restrictive and more unwieldy than
simply trying to clarify what's in rule and law.

MS. EMRICH: Correct.

And just to clarify too, for purposes of
this Committee, it really wouldn't necessarily take a
law change. It's really just an administrative rule
change is what could be done. And the Board could
certainly go that route if it chose to, or with
recommendation from this Committee as well, because
an administrative rule could be changed through the
rulemaking process but that's not a direction that
this Committee, that I've heard from this Committee
that they want to go at this point.

CHAIRWOMAN KEELS: At this point, yeah.
Sherri.

MEMBER SIEVERS: Is it also a
possibility, I heard you say -- I listened to the
recording of the last meeting to get caught up, that
you asked do we want to include this. I believe that
was your question.

MS. EMRICH: Get rid of the chart.

MEMBER SIEVERS: Right. So is that still
something this group could consider and could we --
is it -- are we now in the position where we have to
implement an Interpretive Guideline if we decided to
have something that was a reference to either this or
some other documents? Do we have to -- do we have to
go that route? That is my question.

Because I think it's a slippery slope
once you -- even though it's an Interpretive
Guideline, I think this is what you're getting at, it
could be interpreted, even though it's not in rule in
legislation -- in litigation it's going to be looked at. So I think we --

MEMBER GARRETT: The optics.

MEMBER SIEVERS: -- have to be very careful we don't hurt the very same people that we're trying to help, right?

MS. EMRICH: When this Committee began discussing some type of guidance document, this really started out as just a Word document like a white paper almost.

MEMBER SIEVERS: Right.

MS. EMRICH: And then it was thought that was getting a little too lengthy, that it needed to just be a quick reference, so that's why the charts included just a two-page IG. So it could go back to just a document in and of itself.

MEMBER SIEVERS: Simple.

CHAIRWOMAN KEELS: I think the bottom line is we have to come up with something to help people answer those questions --

MEMBER SIEVERS: Right.

CHAIRWOMAN KEELS: -- and to keep them within their scope. Everybody -- nobody wants to harm a patient and nobody has.

MEMBER SIEVERS: Right.
CHAIRWOMAN KEELS: But also nobody wants to step outside their scope, you know, and have corrective action for that and that's where a lot of those questions are coming. Can I do this? Can I do that? What about this? What about that? And we need -- there needs to be something. I think, through the hundreds of questions that are received, there's a need.

And if there's a better way other than rulemaking or the Interpretive Guideline, I think this Committee is open to it, but I don't know that we've found some other method that could be helpful at this point.

So, Pete had his hand up.

MEMBER DIPIAZZA: I just wanted to make a comment because this is -- Jody and I, this is our second year, and I know this has been going on for some time and what I would love see this Committee do is start wrapping this up --

MEMBER MINIARD: Up.

MEMBER DIPIAZZA: -- because we have rules pending to advance Advanced Practice in the State of Ohio. I think it would be really hard for people to support those rules or that pending legislation when we, as a group, can't even decide
what the heck we're doing, and I think that's really
unfortunate because it's coming down to more of egos
and what can we do and what can't we do, and we
really are here to protect the public --

MEMBER MINIARD: Right.

MEMBER DIPIAZZA: -- and advance our
profession. And I just -- it's nuts. So I hope, as
new Committee Members, we can move this forward --

MEMBER MINIARD: Yes.

MEMBER DIPIAZZA: -- and then move on to
more pressing issues for Advanced Practice.

MEMBER ZAMUDIO: So just to Brian's
comment about the title. I agree, when I was looking
through the information that was given to us, I
noticed the Consensus Model uses the term
"Decision-Making Tool" when it was referencing scope.

Can we not either stick with that or
label this specifically "CNP"? Because, as a nurse
midwife or someone in another specialty is going to
look at that, it doesn't say just for CNPs. So if
we're going to give an Interpretive Guideline for a
specific group, can we change the title?

CHAIRWOMAN KEELS: I thought it did.

MEMBER ZAMUDIO: At the very top it will
have to saying something specific about that or my
recommendation would be to use the Decision-Making Tool, because -- you referenced an employer. If you called and said look, I'm going to hire this person, can they do this? "Look at our Decision-Making Tool."

MEMBER SIEVERS: This one or the Ohio one? Which one are you --

MEMBER ZAMUDIO: The Ohio.

MEMBER SIEVERS: The Ohio.

MEMBER GARRETT: Just call it something and go with it.

MEMBER SIEVERS: Right.

CHAIRWOMAN KEELS: So the Decision-Making Tool that exists is around tasks.

MEMBER ZAMUDIO: Right.

CHAIRWOMAN KEELS: And what we're trying to do is around scope and managing patients.

MEMBER ZAMUDIO: So do we tweak it a little bit?

CHAIRWOMAN KEELS: I don't know that -- I don't -- I don't know the answer to that question but I believe, and I don't have that guideline in front of me, that it is labeled for CNPs only and it tries to clarify that this is not new rules, just simply trying to clarify existing rule and law. And maybe
it's not at the top. Maybe we can go ahead and put it up at the top.

MS. EMRICH: Make it more prominent.

CHAIRWOMAN KEELS: Put it in really big capital letters or something like that.

MEMBER ZAMUDIO: Just so it's clear who it applies to.

MEMBER MINIARD: I don't think it was on the chart, but it wasn't on the other --

MEMBER ZAMUDIO: Right.

MEMBER MINIARD: Yeah.

MEMBER ZAMUDIO: It's the title, it's like the second line, it just says "Interpretive Guidelines." So depending on how it's phrased and just to be clear for everyone.

CHAIRWOMAN KEELS: The intent of it, sure, absolutely.

Yes, Sherri.

MEMBER SIEVERS: Maybe we could come up with something like this but it's just very generic. "Is it within the Ohio law and rule?"

And then we reference those numbers. "Is it within your scope of practice?"

Kind of like a tool and then have the resources for the certifying bodies. So like a
series of questions that if they work through every
single one of those --

MEMBER MINIARD: But that's the problem,
that's what this is trying to solve is that second
question, "Is it within your scope of practice?"

That's the problem is that's what this
Committee has been arguing about for two years is the
Board continues to receive numerous questions about
what is scope of practice and what is within their
scope of practice. So that's the whole purpose of
this was not a decision-making tool on how to be an
APRN or CNP, it was where does your scope start and
end in a very gray area.

MEMBER SIEVERS: Right.

But like I said, sending them -- what I
send my folks for the PNCB is the white paper, it has
all the areas, it talks about what the -- if they
read through that and I send them that and they go
"Oh, yeah, I see what you mean that really would not
be something I would want to do."

CHAIRWOMAN KEELS: And we definitely plan
to include those lines.

MEMBER SIEVERS: If they have a question,
they read through that and then --

MEMBER MINIARD: And I think the purpose
of this, however, is exactly -- because that's what
they used to create this to make it simpler so they
wouldn't have to read through a big document was the
purpose of this. I'm not saying that is a perfect
thing, because I had a lot of --

CHAIRWOMAN KEELS: Yeah.

MEMBER MINIARD: -- issues with it at our
last meeting.

CHAIRWOMAN KEELS: There's probably a way
to clean it up.

MEMBER MINIARD: So I'm just saying that
I think it's needed not because I like it and I think
it's the best thing ever, but because I think there
is still a lot of questions, outside of this room, as
to what falls within the scope, and simply referring
them back to their certifying bodies' white papers is
not sufficient from -- it should be, but it's not --
and there's continuing to be question after question
after question.

So I think it's good to have something
very simple, whatever you want to call that, FAQs,
Interpretive Guidelines.

MEMBER SIEVERS: I just don't know that
we'll capture every clinical setting.

CHAIRWOMAN KEELS: I don't think we can.
I think we --

MS. EMRICH: It's not setting-specific.

CHAIRWOMAN KEELS: -- have to all acknowledge there --

MS. EMRICH: It's not setting-specific.

CHAIRWOMAN KEELS: -- will continue to be gray. We can't possibly anticipate every clinical or patient scenario but help just provide some guidance to make the best decision that the person or the organization can. And whatever those questions and answers are is what we need to find, you know, those needles in the haystack.

Pete, did you have a question?

MEMBER DIPIAZZA: No.

CHAIRWOMAN KEELS: Lisa?

MS. EMRICH: No.

CHAIRWOMAN KEELS: Anybody else have their hand up?

Thank you. This was a great discussion. For those of you who are just joining us, thanks for just jumping right in. It's apparent that you guys have been staying current and updated on where we are and what we're trying to accomplish, so thank you for that.

Next up we have General Information and
Updates. First, after the "a," is Legislative Report to the Board which is Mr. Dilling who is over there deep in thought.

MR. DILLING: Yeah, very interesting discussion.

So you have my May Legislative Report. For you all, I think you're all interested in House Bill 177 and House Bill 224. We have all kinds of people who normally come in and talk to you and give you real specifics about them.

I would just say generally that both the Bills are being heard currently in the House Health Committee and have had proponent and opponent testimony.

A sub-bill will be introduced this week for the CRNA Bill. And listening to both sides, they seem to be coming to some common areas of agreement. But how that looks in the sub-bill and, you know, how much agreement that is, you know, I think there's still potentially a ways to go, but people are smiling at one another, that's a good sign.

CHAIRWOMAN KEELS: A good thing.

MR. DILLING: I think they've gotten away from a formalized protocol within an institution and, you know, fall back on the privileging and
what's being done normally in every hospital today,
right, really, and there's no reason to change the
way that happens.

So I think there are some time frames
that are being attempted to be put around that
peri-anesthesia practice and then the clinical
support functions which may or may not be further
defined. You know, I think that that's -- we'll see
what happens, you know, in that regard. I think
there has been some movement in the bill that have
been introduced, quite frankly, so we shall see.
That looks encouraging.

House Bill 177, after listening to the
opponent testimony, there are a lot of questions that
were raised. I thought both sides did a good job in
presenting their testimony and I think that there
will be interested party meetings and we'll see what
can be worked out. I don't know where you go in
terms of the middle ground. I'm not there on the
inside. As with 216, it's mostly the associations
talking with one another. You know, you'll hear
things here, but I don't know what that tells you as
to is this all-in, get rid of the Written Standard
Care Arrangement, or is there some possible middle
ground.
Certainly the physicians, both nationally and here in Ohio, echo the refrain of team-based care and somebody has got to be in charge of the team, right? There's always a captain. And who do you think wants to be the captain? Everybody wants to be the captain, right? Who is going to vote in the captain? It's going to be an institution? Well, it's not all institutional practice.

It's hard to define, you know, globally some of these practice questions, you know, that come into play here when you're talking about these different scope issues as well. That's what makes it tough and that's why there's a political process.

Where it is open, again I think you see at least a lot of arguments being put out on the table and people focusing a little bit more as to, you know, what the next step is going to be.

As for the other things in that memo, if you have some questions of how that applies to you all or to us, I'd be happy to answer them. I just don't know how interested you really are in military licensing and temporary licensure.

MEMBER ZAMUDIO: Sorry, actually, I do have a question about the military license as a retired military officer.
MR. DILLING: Great. I don't mean to --
that's not a comment on it.

MEMBER ZAMUDIO: No, no.

So I did have a question, when I was
reading through it, it specifically addressed people
who would be moving to Ohio and in order to expedite
those licensures so they can provide care for that
military population.

It did say the words "active duty." Has
there been any consideration to the people moving to
Ohio to practice who would be retiring here? They
will no longer be on active duty as of the date they
arrive, but they still have to go through a lot of
the same processes.

MR. DILLING: That's a good question.
The bill for both the military and the spouses were,
you know, focused on the active military because I
think that's the most concern for the branches right
now, okay, they want to keep people moving and moving
forward.

You hear a little bit about people don't
want to overbuy or whatever and they feel like if
they ask for too much that's it going to be, you
know, I don't know, how much can you -- how can you
ask for too much with the military today? I don't
know. Pretty much you put a military stamp on it.

MEMBER ZAMUDIO: Right. I was just curious as to --

MR. DILLING: At least it's heard several times.

MEMBER ZAMUDIO: Right. I was just curious if there was discussion about that, because it was striking to me that it was only the active duty, when the veterans, the retired folks would have, for the identical reasons, would appreciate those courtesies.

MR. DILLING: There have been side questions -- direct questions about reservists and people in different statuses, and I believe one of the statuses was added onto it, but again there's a lot of hemming and hawing when they're answering those questions. It's still got a ways to go and I think that is on people's minds.

I think the bottom line from the Board's perspective is the system that's been set up already through, you know, coming up the expedited licensure, it's working. All these people who check off temporary license and, you know, military, military spouses, they're getting licensed in a day.

MEMBER ZAMUDIO: Nice.
MR. DILLING: Now, the kind of hidden
secret here is that the way that it's drafted up is
dependent upon getting in your background check and
that means supplying your background check.

Actually, I have tried to tell people you
are fighting against yourself here. You are going to
put an additional burden on some people by doing it
this way because the way we set up our rules we do
not require that background check upfront.

We require that you start that process
and it's going to finish up within the six months
when you get your full license, but we are giving
great faith and credit to the other states in terms
of them keeping an eye on that part of the situation;
and under the statute and under our current rules
that would evaporate immediately if we found out you
did have something active, the temporary nature of
that license, so that's the public's protection
there.

And greater minds than mine saying this
is what they want, this is what the General wants in
Washington, D.C.? Okay, I'm not all that concerned
about it for two reasons:

One, we're going to have to report back
statistics. And some day if, in fact, it does work
out that way for some people and they start calling,
then somebody is going to say oh, maybe he was right,
you know, but also I think that we could probably
maneuver our rules in such a way, even though
somebody could make an argument about it, no one is
going to make an argument about it if we go in
through the rule process and say hey, this is the way
it works and will you just let us do this.

The third option, too, is the way
eLicense, which we're really a beneficiary of in
allowing it to be done so quickly, I don't see that
the statute gets rid of the current temporary and
then -- it creates almost a separate six-year
temporary license. It's sound like jumbo shrimp,
it's a little bit of an oxymoron, "six-year temporary
license."

That's what's really being created here
under the military, so that's for, in large part,
let's keep Wright-Patterson Air Force Base and let's
keep the military here in Ohio and keep us
competitive.

MEMBER ZAMUDIO: Okay. Thank you.

MR. DILLING: We don't want to rain on
that parade.

CHAIRWOMAN KEELS: Thanks, Tom.
Certainly we've really appreciated hearing from OSANA and OAAPN on the status of their bills.

Do you happen to know when the next rounds of testimony are?

MR. DILLING: Yeah. Actually there's an all-in, anybody who wants to testify tomorrow for House Bill 177, the APRN bill, and then I think they have an Interested Party Meeting afterwards so getting maybe some more details.

And then the CRNA bill will have that sub-bill introduced which will, you know, then people can more focus their thoughts and what happens, you know, following that, again perhaps somebody will come up and tell you a little bit more specific on that or we'll just wait and see what happens.

This is mid to late June. The Budget Bill is getting closer and closer. They tend to pass that Budget Bill and kind of go away for a couple months, everybody enjoys the summer, go on vacation, whatever, so that usually is a time where people, you know, clear up things like that. I think they want to try to be in a position where at least they captured common ground.

CHAIRWOMAN KEELS: Great. Thank you.

Anything else?
All right. Thank you.

MR. DILLING: Thank you.

MEMBER ZAMUDIO: Thanks, Tom.

CHAIRWOMAN KEELS: Okay. Next up, a brief public service announcement on relicensure.

MS. EMRICH: Yes.

RN and APRN renewal will begin on July the 1st, beginning at 6:00 a.m. If you sign in a little bit before that, it may be possible that it may occur a little bit before 6:00, but officially we're saying 6:00 a.m.

A reminder that all current APRN licenses and RN licenses expire after October the 31st of 2019. The late fee will go into effect on September the 16th.

We are highly recommending that all RNs and APRNs renew early in the cycle.

I looked back on -- I'm involved with licensure now, very heavily, and we've been doing a lot of work in preparation, testing the system and making tweaks to the online applications and so forth, and I was looking -- we were looking back at data from the 2017 renewal.

The data graph goes from July 1st and it's sort of up and down and up and down. Then it
gets to about September 14th, 15th, and there's a sharp spike up, up, up, and then a sharp spike down as of the 16th and then it's flat, very low and flat until October the 31st, which, to avoid any volume problems, I would highly recommend staying away from September 14th, 15th, and certainly to renew prior to that date to avoid the 50-dollar late fee.

CE. Again, Registered Nurses are required to have completed 24 hours of continuing education, one of which is required to be Category A, prior to October the 31st, on or before that. So when you're renewing your RN license, you have to say I have or will, by October the 31st, complete 24 hours of CE.

APRNs are not required to complete CE on or before October the 31st. The reason being this is the first renewal of the APRN license for all APRNs in the State of Ohio.

With House Bill 216, you transitioned from a Certificate of Authority to an APRN license so, therefore, this is the first renewal of the license and no CE is required upon first renewal of the license so there is no absolutely no CE required of APRNs for purposes of the license renewal.

They are required, obviously, to maintain
their CE needed to maintain your national certification.

CHAIRWOMAN KEELS: Michelle.

MEMBER ZAMUDIO: Only because I know I'm going to get this question. With renewal, the late fee beginning on 9/16, is that after midnight on the 15th, until midnight on the 16th, or is it --

MS. EMRICH: As of midnight September 15th.

MEMBER ZAMUDIO: Got it.

MS. EMRICH: When that day ends, if it's not a completed renewal application, as of switching over to 2016, you get a late fee.

MEMBER ZAMUDIO: Okay. Got it.

MEMBER MINIARD: September 16th.

MS. EMRICH: September 16th, I meant, sorry.

MEMBER DIPIAZZA: At 12:01.

CHAIRWOMAN KEELS: Yes.

MS. EMRICH: At 12:00:01.

MEMBER ZAMUDIO: That spike is probably going to be right at 11:00 p.m.

MS. EMRICH: So what's key is, and we're working with the system administrators on this, your renewal application cannot just be started on
September -- it has to be completed. You would be surprised, you'd be surprised. We are recommending that you renew early.

We're sending out reminder e-mails already from the Board. You should have all gotten a reminder e-mail about that; three, you should have at this point.

The other thing we're doing is through the system we're able to generate a series of e-mails, so let's say renewal begins on July 1st, well, later in the summer, all those who have not yet renewed will get an e-mail saying "Reminder, you need to renew." And then, as time goes on, hopefully those e-mails will be sent out to fewer people.

Now, as an aside, because we are expecting 220,000 nurses to renew over the course of those few months and the volume of e-mails, it's conceivable that you might renew on one day and be perfectly fine, you're renewed, but the next day you'll get an e-mail that says, "Reminder, you need to renew." And the reason for that is because we're having -- because of the volume the system has to generate those over a series of days.

So if you -- if that happens, just please look back at the public verification website, look
back into your portal, you will see that your license has been renewed and that it expires in, you know, 2021; so that's what you should see. So please just be aware of that. We're trying to be very proactive and get the information out there.

I also ask that you help us to refer persons to the Continuing Education FAQs. They are published on the Board's website. They are updated to include dates for this current renewal period for both the separate RN and then the APRN FAQs. So, thank you.

CHAIRWOMAN KEELS: Any other questions about relicensure? The most wonderful time of the year. Great.

So then next up is a sample or summary of APRN practice questions. These are in your packet for your review.

MS. EMRICH: These are ones that came in since your last meeting, so this is a sample of those. So I always -- we always provide, between meetings, what's happened.

CHAIRWOMAN KEELS: Some of them are, you know, like where do I find something, but some of them are also around scope of practice, can I do this, is this within my scope, so it sort of
underscores the need for something to help people answer these questions in the least-restrictive way possible but still consistent with current rule and law.

Comments or questions about that?

MEMBER MINIARD: It just validates why we're doing what we're doing. Some of these questions about -- I mean some of them about where do you find things and what about collaborating physicians, I mean those, I think, are all reasonable questions, but many of these questions are about scope of practice.

CHAIRWOMAN KEELS: Michelle.

MEMBER ZAMUDIO: I thought the interesting one on No. 3, when I was reading through these, it said "Does the collaborating physician need to co-sign each chart that's reviewed, per the Nursing Board requirements?"

So I went back and looked at the requirements and it does say the APRN must keep a record of them, but the physician doesn't have to co-sign that chart, right, we just have to keep a record of those.

CHAIRWOMAN KEELS: Many times that falls back to the individual hospital --
MEMBER ZAMUDIO: Right.

CHAIRWOMAN KEELS: -- or organization's bylaws for either just authentication of the attending physician or billing requirements or such.

MEMBER ZAMUDIO: But not the Board of Nursing requirements, right? We just have to keep that, that we've done our due diligence.

CHAIRWOMAN KEELS: Right.

Great.

Do you want to say anything about the Board website? I know it's going to be updated.

MS. EMRICH: Sure. The Board --

MEMBER MINIARD: Good. It's hard to find anything on there.

MS. EMRICH: The Board has contracted with Web Design and they're currently working on a new website. I don't know when it will go live.

But the goal is that when a person goes on the website, they know what they're looking for, it's obviously for specific information, so the goal is that they will get to where they need to be in one to two clicks or two to three clicks. Three clicks, I think, is the maximum they were wanting. Hopefully in two. So that's the goal.

And there is a plan for there to be sort
of transitional information on the current website, when you go there, to say a new one is coming and so forth. So that will be expected down the road a little bit.

MEMBER ZAMUDIO: That's good.

MS. EMRICH: It's very much needed, we know.

CHAIRWOMAN KEELS: Okay. So now we've come to lunch, yay. So we will break for lunch until 1:00. We will start, at 1:00 sharp, the Interested Party Meeting on the 4th floor.

MS. EMRICH: It's the old board meeting room where you can enter it from the 4th floor hallway. There will be a door there and it will say "Interested Party Meeting."

May I --

CHAIRWOMAN KEELS: Of course.

MS. EMRICH: -- just for logistics?

Okay, thank you.

So the Interested Party Meeting is for anyone who would like to attend. It's actually being convened by our Chief General Counsel who will be going over all of the draft revised rules that will be considered by the Board or would be going to public hearing later this year, usually in November,
so this is an opportunity to provide input to those.

   I put the complete rule packet memorandum
in your materials, all 167 pages of it, but that's
just how it looks, so.

   As Erin mentioned, that begins at
1:00 p.m., so please just go directly to the 4th
floor meeting room.

   And then I don't know how long that
meeting will last. They've given an hour for it. So
if the meeting is done in 30 minutes, which I'm not
sure, it just depends on how many persons are there
and how many comments are received, it will be up to
Erin as far as when to reconvene -- this Committee
will reconvene.

   CHAIRWOMAN KEELS: I assume we would
prefer to start sooner than later, so when that is
done then we will come back up here and get
restarted. Okay, great. See you guys after a little
bit.

   (At 12:20 p.m. a lunch recess was taken
until 2:00 p.m.)

   -- --

   CHAIRWOMAN KEELS: Welcome back. Hope
you all had a nice lunch.

   Next up on our agenda is to review the
proposed rules on detoxification.

For the members of the Committee, we have this in our packet. We have it labeled "Five-Year Rule Review." If you turn to --

MS. EMRICH: Page 10.

CHAIRWOMAN KEELS: -- page 10 is where the definitions start.

So the history behind this is that the -- all of the boards, the Nursing Board and the Medical Board, are required to develop detoxification rules. We have to have similar rules. The Board of Medicine has drafted their rules. We intend, unless there's any other comment or concerns or input, to change the word "Physician" to "Advanced Practice Registered Nurse" essentially.

So you've had this, hopefully you've had a chance to review this. Like I said, on page 10 and 11 are essentially definitions.

MS. EMRICH: Page 12 is the definition of withdrawal detox and ambulatory detox.

CHAIRWOMAN KEELS: Yes.

MS. EMRICH: That's the change.

CHAIRWOMAN KEELS: And that's got a line under it so that must mean that it's new.

MS. EMRICH: Uh-huh.
CHAIRWOMAN KEELS: So take a look at that and see if you have any questions around that. Questions? Concerns? And my understanding, from the Board retreat, was that in correctional facilities they were going to draft their own rules.

MS. EMRICH: I think so.

CHAIRWOMAN KEELS: That would be separate from this, that's why it's called out in these definitions.

Okay. So on page 13, standards and procedures for withdrawing management -- for withdrawal management for drug or alcohol addiction, you have a chance to look through that.

MEMBER ZAMUDIO: Erin?

CHAIRWOMAN KEELS: Yes, ma'am.

MEMBER ZAMUDIO: On page 13 where it talks about "The ASAM Criteria, Third Edition," do we want to tie ourselves into which edition of the book or guideline?

CHAIRWOMAN KEELS: Can you tell me exactly where that is?

MEMBER ZAMUDIO: It's at the bottom of page 13. Underlined is the website and above that it says "Third Edition."

You know, I always wonder about being really specific with these criteria.

MEMBER ZAMUDIO: I know.

CHAIRWOMAN KEELS: They're updated every five years and, you're right, some of them will be reviewed and updated ahead of that.

MEMBER GARRETT: Maybe say "most recent."

CHAIRWOMAN KEELS: Yeah, you know what, we'll put an asterisk on that and send that back to Holly as a comment. Most-current copy, most-current edition. Good question.

MEMBER DIPIAZZA: I don't -- I think the rule might have changed, but can CNSs obtain DEAX, the DATA Waiver?

MS. EMRICH: Correct. The federal law changed that. The federal law, that became effective October the 24th of 2018, included all types of APRNs, CNSs, for a period of time, I think it's five or six years, but I know for CNMs they do not yet have a track ready to get the waiver, but federal law allows it.

CHAIRWOMAN KEELS: So the rule or the statute is in place, but the process wasn't implemented yet.
MS. EMRICH: Yeah, by the feds.
MR. McCLAIN: I can speak on that.
CHAIRWOMAN KEELS: Can we have Jesse?
MS. EMRICH: No.
CHAIRWOMAN KEELS: Wait until the public comments.
MR. McCLAIN: That's fine.
CHAIRWOMAN KEELS: Page 14, evaluations.
For those in the audience, I just want to make it clear these are posted for comment and any comment can be received by the Board, okay?
MS. EMRICH: Anything on these? I don't know that these are actually -- these were in the Interested Party materials that Holly sent out, so any comments regarding these, they should be sent to Holly, and the sooner the better.
CHAIRWOMAN KEELS: Sooner rather than later.
MEMBER SIEVERS: She said July 24th.
MS. EMRICH: Yeah.
CHAIRWOMAN KEELS: July 24th to Holly.
MS. EMRICH: That's right before the Board's July meeting, and then she will file these with JCARR after that.
MEMBER MINIARD: End of August you said?
MS. EMRICH: Uh-huh.

CHAIRWOMAN KEELS: Any other comments or questions?

Okay, all right. So again, any comments, concerns, or input should be directed to Holly Fischer before July 24th.

MS. EMRICH: This Committee itself has to make its own collective recommendation and comments.

CHAIRWOMAN KEELS: Okay. So this Committee needs to make a recommendation --

MS. EMRICH: A collective --

CHAIRWOMAN KEELS: -- a collective recommendation whether to accept these or to accept with revision.

MS. EMRICH: Or just to give a comment.

CHAIRWOMAN KEELS: So aside from the comment on referring to the most-current version of references, any further comment, concern, questions?

By consensus, does this Committee recommend that the Board move forward with these rules?

MEMBER ZAMUDIO: Yes.

MEMBER SIEVERS: Yes. That would be identical with APRN?

CHAIRWOMAN KEELS: Advanced Practice
Registered Nurse, yes.

MEMBER SIEVERS: Okay, great.

CHAIRWOMAN KEELS: Do I need a vote?

MS. EMRICH: Consensus is fine.

CHAIRWOMAN KEELS: Okay. We'll make that recommendation to the Board. Thank you.

Okay. Well, we haven't talked about them yet, but next on the agenda is a brief discussion on the Draft Interpretive Guidelines and an update from the meeting we had from OHA and OONE.

So, in my earlier discussion, I summarized that the Interpretive Guideline, the goal of it is to help clarify existing statute and rule to help address some of the questions that the Board receives around scope of practice.

It pulls all of the rules and laws that exist right now into one document; it makes a disclaimer that it is not a new rule or law, it's not enforceable, but the rules and laws are obviously; it is directed at only Nurse Practitioners at this moment because that is where the need seems to be.

We also, Lisa and her team -- I say "we" very loosely because Lisa and her team do a yeomen's job pulling these together -- we were hoping to use the CMS definition of "critical care" as sort of the
point of which primary care scope of practice ends and it becomes the scope of practice for the acute care certified practitioner, and it really speaks to that critical nature of the patient and that multi-system organ failure, imminent death, you know, acute dysfunction of body systems.

And so there's a concern that it may confuse people who are billing for services, and so we don't want to cause any more confusion than already exists. We hope there may be another point of reference, perhaps there's a World Health Organization definition we can't seem to find, but we know we saw it once before.

MEMBER ZAMUDIO: I found it.

CHAIRWOMAN KEELS: Do you have it?

MEMBER ZAMUDIO: Well, I looked through the World Health Organization information ad nauseam the other night and I did find "Critical care is designed to meet the needs of the patient facing immediate life-threatening conditions" -- I'm sorry -- "it's the critically-ill, unstable patient, to meet the needs of this patient facing immediately life-threatening conditions such as that their survival is in absolute jeopardy," and that sounded right to me.
MEMBER DIPIAZZA: It's in there, it's just --

MEMBER MINIARD: Buried.

CHAIRWOMAN KEELS: Okay. Well, if you want to pull that out and send it to Lisa.

MS. EMRICH: Do you have a citation for that?

MEMBER ZAMUDIO: I do not, but I thought we don't need a citation, do we, if we decide that's the definition? I'm just saying.

CHAIRWOMAN KEELS: Well, we need a citation because it needs to be evidence-based and, again, we're not putting new definitions around anything; we're just using it as a point of reference.

MEMBER ZAMUDIO: Okay.

CHAIRWOMAN KEELS: But if you can pull that up and send it.

MEMBER ZAMUDIO: Watch, I won't be able to find it again. And it also is on a site, though, that was referencing the World Health Organization, so I will look for that again.

But that certainly resonated with me that that's what we're trying to say, right? It's that immediate jeopardy of life.
CHAIRWOMAN KEELS: Yeah, immediate jeopardy, yeah.

Let's see, the other thing, you know, the graphs. We've talked about the graphs. We've gotten input on the graphs. We're going to take the input on the hard lines and the severity of health, you know, wellness to severity of illness and try to make some tweaks to see what people think.

If it continues to be too confusing, we don't have to use it. We just thought it would be nice to have a visual, but we'll see what happens with that.

Provide links back to national certification exams and your national professional organizations, any policies or white papers that they have on scope of practice, to help sort of send people back to look at those.

MEMBER ZAMUDIO: Erin, at the end of the definition, a line that's concerning to me where it says "Although this care usually occurs within an ICU, it is not limited to that location." Do we even want to mention setting because we keep going back and forth?

CHAIRWOMAN KEELS: I know. I think I still like talking about a point of reference, but I
understand your concern.

MEMBER ZAMUDIO: So maybe not the word "usually" then. Maybe "can." Like something to say that it can occur outside of an ICU is the point we're trying to make.

MEMBER DIPIAZZA: That's what they're saying is that it can.

MEMBER ZAMUDIO: Right, but it's worded such that it sounds like it should be in the ICU instead of outside.

CHAIRWOMAN KEELS: Okay.

MEMBER ZAMUDIO: So I think if we can rephrase that to say that it may occur in an ICU but it's not limited to that location. I think that would solve a lot of people's angst.

CHAIRWOMAN KEELS: Maybe, yeah.

So yeah. And then we, as I mentioned earlier, met with OHA and OONE, sort of brought them up-to-speed, really gave them a similar summary to what I provided earlier today.

We walked through the Interpretive Guideline, answered some of the very same questions, showed them the graphs, answered all of the same questions.

It was kind of a great -- it was a great
meeting and I saw some aha moments, so I thought that was really good.

And their feedback was, you know, this would be helpful for employers as well as individual APRNs; and consider FAQs because we're limited in what we can define because of rules, but an FAQ can help explain things maybe a little better than an Interpretive Guideline could, so maybe using them together might be more helpful. We'll see.

MEMBER GARRETT: I would call this the "Ohio CNP Practice Clarification Document," and then just have some info, have some FAQs. Then it looks like the optics are softer, it looks like we're trying to help people understand, instead of, you know, I don't know.

MEMBER SIEVERS: I think it depends on what the FAQs say.

CHAIRWOMAN KEELS: Yeah.

MEMBER SIEVERS: It could go either way, right?

CHAIRWOMAN KEELS: Sure.

MEMBER GARRETT: Well, the reason I said that is we keep saying it's Interpretive Guidelines but it's really clarification. I've heard several people refer to "clarification." What we are really
meaning is this, right, a clarification?

CHAIRWOMAN KEELS: Yeah, I'm not sure.

I'll have to defer to Lisa on how limited we are through Board processes.

MEMBER GARRETT: Gotcha.

MS. EMRICH: An FAQ, in and of itself, I mean we have different types of FAQs. It's the same principle as doing an article in "Momentum." It's the -- it's informative. It's less formal than an Interpretive Guideline.

MEMBER GARRETT: Yeah.

MS. EMRICH: An Interpretive Guideline is actually adopted or approved by the Board of Nursing very formally --

MEMBER GARRETT: Yeah.

MS. EMRICH: -- and then it's open for review and revision every two years to make sure it's up-to-date and it's still needed; so I think it depends upon the level of formality that you have.

Regardless, you know, an Interpretive Guideline, should we continue with the development of an Interpretive Guideline, once it gets to the point where this Committee says it's good to go, it then has to be approved or looked at by the Attorney General's office to make sure they're in agreement
with it, and then it would go and be looked at by the
Board itself.

You know, an FAQ, it's less formal but we
couldn't say something that's different than what
statute or rule requires. I think the similarity
would be looking at the CE FAQ is a perfect example
of an FAQ that's out there. It's reviewed internally
by legal staff, as well, but it's published.

CHAIRWOMAN KEELS: And, you know, one of
the thoughts I had was the memorandum --

MEMBER MINIARD: "Momentum."

CHAIRWOMAN KEELS: -- the "Momentum"
article was trying to help clarify some of this, but
it seemed like it --

MEMBER MINIARD: It made it --

CHAIRWOMAN KEELS: -- it caused a lot
more concerns, although maybe it just simply started
the conversation, and then people were able to work
through that and clarify things. So I'd like to
avoid something that would be --

MEMBER GARRETT: Yeah.

CHAIRWOMAN KEELS: -- more inflammatory.

We really do want to help people
understand so that we can, you know, make everything
greater, that's all.
MEMBER GARRETT: Optics through advertising.

MEMBER ZAMUDIO: I agree 100-percent with what Brian is saying. I know that you're saying there's -- if this Interpretive Guideline would be very formal and has a process, do we need to have this Interpretive Guideline?

Can we term it -- you kept saying the word "informative." Can we call it "Informative Guideline"? It's still going to serve the same function, right, it just wouldn't tie us to the more formal "Interpretive Guideline."

CHAIRWOMAN KEELS: I mean it still has to refer back to current rule and law --

MEMBER ZAMUDIO: Yes, absolutely.

CHAIRWOMAN KEELS: -- no matter what we call it.

MEMBER ZAMUDIO: Right. But putting it together all in that one place, like you said, would be good.

MEMBER SIEVERS: It could just be like the FAQ for continuing education. Could it just be an FAQ?

MS. EMRICH: We could do an FAQ. I would have to, you know, we could certainly develop an FAQ
for review and see how --

MEMBER SIEVERS: With factual things, right? I mean --

MS. EMRICH: It would be application of statute and rule to very specific -- it would be almost like taking our responses to practice questions, through this time, and sort of making that more formal.

MEMBER GARRETT: I think the end-user would really like that.

MEMBER ZAMUDIO: I agree.

CHAIRWOMAN KEELS: You know, National Council of State Boards of Nursing already have examples, you know, questions that have been asked and answered by NCSBN that we could use as case examples.

You know, one of my bullet points, you know, I think we definitely want to have a little bit more language around clinical experience and education within the scope, to help develop an expertise and maintain competency.

MEMBER SIEVERS: And by -- oh, sorry.

CHAIRWOMAN KEELS: Yes, ma'am.

MEMBER SIEVERS: By "FAQ" not really -- I don't mean what Carolyn Buppert said about, like,
people give her examples of scenarios and weigh in, right?

General questions about what guides my practice, and then have the statutes and the law and the rule there. Similar to the algorithm kind of questions. Does that make sense? Not like scenario-based FAQs because then you get into the weeds.

CHAIRWOMAN KEELS: It can simply refer to the NCSBN.

The one thing that I'm a little bit worried about is we've been working on this for almost a year, right? And again, we're delaying our duty back to help the licensees and the organizations the longer we draw this out. We want it to be understandable, easy to use, answer the bulk of the question.

We're never going to be able to answer all of the nuanced scenarios. There will always be some gray where it has to fall back to good clinical judgment and, you know, based within your scope.

So I think we can entertain it. I don't know how long it would take to sort of completely redo what Lisa and her staff have done.

Again, I think almost -- well, I don't
know if an FAQ would need to go through the Attorney
General's Office or not.

MS. EMRICH: We would rely upon our Chief
Legal Counsel first --

CHAIRWOMAN KEELS: Okay.

MS. EMRICH: -- and then go from there.

CHAIRWOMAN KEELS: Yeah. It's worry
about delaying if we kind of, every couple meetings,
we come back and sort of say "Oh, let's redo, let's
do something different. Sort of trash this idea and
move on to this idea." So I'm just trying to be, you
know, cognizant of the time that it's taking us.

MEMBER SIEVERS: I think you could almost
put this into a question and make this be the
answers, like, what would be some of the questions
that you get. When you get the questions to the
Board and then you respond, you probably use a lot of
this.

MS. EMRICH: I use -- we use those every
day.

MEMBER SIEVERS: Right. So what would
their question be: "How do I know what I'm allowed
to do?" So this might be Answer No. 1: "You need to
follow this, this, and this."

Answer No. 2 is this answer.
"How do I know what my certifying body says?"

"Here's what your certifying body says. Here's the links to that."

That's like the questions and answers. This is the answers to those questions.

MS. EMRICH: Yeah, except just from a practical standpoint, the way the document is done, it basically gives the individual looking at it the hub itself and it's basically making it their responsibility to go out and find the spokes of the wheel, meaning their national certification information, so.

MEMBER SIEVERS: Right.

MEMBER ZAMUDIO: I think we said earlier it could reference those white papers or whatever.

So if it was an FAQ, taking out that -- changing the definition that's in there, striking the part about "may occur in an ICU," leaving this here, it would be specific to an FAQ specific to CNPs so other people wouldn't misinterpret that to be "Oh, you're an NP instead of an CNM," so, you know, we could put that on there, and then to be sure we included education, training, and clinical experience, like, to match the statute.
CHAIRWOMAN KEELS: I'll take those recommendations.

Jody.

MEMBER MINIARD: I don't mean to be difficult, I feel like I'm being difficult.

MEMBER ZAMUDIO: It's robust.

MEMBER MINIARD: A robust conversation.

I truly, truly feel, after only sitting at this table for a year, that we are well beyond the need of an FAQ.

We need something that's more formalized because this discussion has been going on way too long, it's been taking many different avenues, it's been misinterpreted by almost everyone who's had an opinion about this, and myself not being -- I'm including myself in that, it's been sort of misinterpreted.

And I just feel like for us, as a profession of Advanced Practice Nurses, I just feel like we're beyond just a simple thing that they're going to pull up a FAQ. I think there needs to be something more formalized that people could go to.

There's still going to be gray, it's not going to be perfect, but I think it would help to settle things better than a simple white paper, Word
document.

CHAIRWOMAN KEELS: Lisa.

MS. EMRICH: I'm going to just raise this simply because in the discussions back and forth and all, I've heard that additional rules are not wanted --

MEMBER MINIARD: Correct.

MS. EMRICH: -- clearly. Okay. I just want -- rules are not necessarily a bad thing if you're the persons involved in the drafting of those rules, if it truly will help to further define and explain. Just -- I just want you to think about that. That's all, that's all. We'll leave it there.

CHAIRWOMAN KEELS: Pete's turn.

MEMBER DIPIAZZA: I just wanted to reiterate what Jody said because I feel like FAQs diminish the importance behind our conversation, and we've spent a lot of time and a lot of effort and we owe it to the Advanced Practice to kind of put this to rest.

CHAIRWOMAN KEELS: Thank you.

Sherri.

MEMBER SIEVERS: Yes, and only if it helps. If it makes things muddier, then it doesn't help if they come away more confused.
Do you have an idea of what it looks like for you? I'm trying to envision what -- if you could design something, what would that look like for you? Like, what would help, what do you think would make it clear?

MEMBER MINIARD: So I -- that's a difficult question because I think the work that Lisa and her team has done throughout all of this to come up with, you know, eight people sitting around a table just talking about it and then to come up with what they did, I think was an excellent start.

Did I find it somewhat confusing when I first looked at it? Yes, I had the same comments you did the last time we met about what are these -- what's this continuum on this side from yellow to -- from green to red and what does that really mean. That's confusing, but I think it was broad enough where it leaves room for gray.

So I would have to defer, you know, that's not my area of expertise by any stretch of the imagination to come up with an Interpretive Guideline or write rules and statute, but I do think we need something that's more formalized in a way than when you get on the Board's website and you pull up a FAQ that just has various questions that are very vague.
We've been asking those questions and so has our fellow nurse practitioners across the State since -- for years, for two or three years, and we haven't -- I think we need something that's more formalized that really gives APRNs, particularly CNPs because that's what we're talking about, a more definitive answer in a way. And then if there are questions that come aside from that, then those can be answered in the FAQ.

But I think there has to be -- I'm not talking about writing rules or statutes, I appreciate Lisa's opinion, but I get a little nervous about that. I don't want any more rules or statutes that govern our practice from the Board's perspective. That's not my role here to try to pursue that.

But I think that I would love to see the revision that comes back from Lisa's group because I think what they presented to us the first time was an excellent start from just nothing, I mean just two years of back-and-forth conversation about it.

MEMBER SIEVERS: I just wondered. And I think if we do -- if the revision is made with the recommendations, I think we're probably --

MEMBER MINIARD: Closer.

MEMBER SIEVERS: -- close to agreement
with the critical care definition, adding in the
clinical practice. I think that's the big things
right now.

MEMBER ZAMUDIO: And the word "training."
MEMBER GARRETT: You said earlier,
something between Interpretive Guideline and FAQ. I
think FAQ is a little too informal. I think
Interpretive Guideline locks us into some processes,
right? Am I interpreting that correctly?

Is there something in between where you
can take the work you've done so we don't lock us in
the process, but it's still informative to the
membership? I'm the freshman here, so I'm just
asking. Is there somewhere in between?

My interpretation is you put the words
"Interpretive Guidelines" and it is really formal,
it's got to go through stuff, right, and it makes it
more cumbersome and difficult. FAQs is a little too
informal. Is there an option --

MEMBER ZAMUDIO: What are the options?
MEMBER GARRETT: -- where you can take
what you've done --

MS. EMRICH: The document, regardless, is
going to say the same thing.

MEMBER GARRETT: Right, right.
MEMBER MINIARD: That was my comment. Why does it matter what we call it. If it's not rule or statute, it's not rule or statute.

MS. EMRICH: I think it comes down to the Board's usual procedure and it comes down to what --

MEMBER MINIARD: Right.

MS. EMRICH: -- the Board's policy and what it looks to what it would call it.

CHAIRWOMAN KEELS: Pete had his hand up.

MEMBER DIPIAZZA: You know, I think we're focusing too much on just the one graph that Lisa has done and we have to keep in mind, I like the graph but it also has to be taken into consideration with other things like the reference to the national bodies, my comfort level, you know, we have this spectrum, right, of, I don't know, it's green to bright deep red, right?

MS. EMRICH: I can get rid of the colors.

MEMBER DIPIAZZA: No, no, but when you speak of scope of practice, I mean I could be in new acute care, and what you, 20 years in, might consider yellow, I might consider burning red, right? I mean I think that's what was trying to be depicted was take into consideration that spectrum and just don't focus on only the graph.
MEMBER MINIARD: Right.

MEMBER DIPIAZZA: The graph is just a piece of the puzzle.

MEMBER SIEVERS: But I think you hit it on the head because it's going to be -- there's not going to be one interpretation so then it's still being --

MEMBER DIPIAZZA: It's not meant to serve as one interpretation --

MEMBER SIEVERS: Okay.

MEMBER DIPIAZZA: -- for all, though.

MEMBER MINIARD: It's meant for you to use it however it works for you.

MEMBER ZAMUDIO: But, to be clear, it can also be used in quite the opposite way. This can be used by your facility, this can be used by the Board, this can be used in other ways; so although it's not just simply a guide for our practice, I think it does limit individual clinical decision-making.

And again, by including training and clinical experience, that would give us a little room in there to say my clinical experience is different than yours or his.

MEMBER DIPIAZZA: That's what we're talking about.
MEMBER ZAMUDIO: No, no, but she's saying it's just for us to decide our own scope of practice. I'm cautioning that this document will be used for other purposes as well.

MEMBER DIPIAZZA: You could use any rule today for --

MEMBER ZAMUDIO: But this specific one. MEMBER DIPIAZZA: -- an inappropriate purpose, though.

MEMBER ZAMUDIO: Right. But this one, because it's such a hot-button issue and we have so many questions, this can be turned around certainly from an employer, et cetera, position and be used, I don't want to use the word "against," but it's against.

MEMBER SIEVERS: And it could be used in a negative way. I go back to Carolyn's example and the person who was being forced to see a patient. She maybe raised her own concerns about the psychiatric patient, I forget what the example exactly was, but she wasn't comfortable. The employer could say "Oh, no, no, that patient is way down here. See, it's in your scope, you're good."

So if it's not clear it could be good or bad. I'm just raising that it might add more
confusion and not be as helpful.

MEMBER ZAMUDIO: Right.

CHAIRWOMAN KEELS: So I'm going to remind everybody to raise your hands. We're starting to get into that robust conversation part again which is fine, it's great.

I'll remind you that those levels were taken directly from the certification guidebooks as much as possible. But you're right, there's a gradation of severity of illness or condition.

So, we provided a lot of feedback, I'd like to see what the next draft looks like. We will -- if we do think it's too confusing and we don't want to create more confusion --

MS. EMRICH: We can make the graphs look differently possibly too, depending.

CHAIRWOMAN KEELS: It's meant to be a helpful tool.

MS. EMRICH: Same content but maybe configured differently.

CHAIRWOMAN KEELS: A helpful tool.

MEMBER ZAMUDIO: Can we formally state our recommendations then? So if someone is looking at it, like, Lisa would know, like, what were the recommendations, can we just kind of either poll each
person or state what our recommendations are? That would give the groundwork, I think, to a document that reflects kind of what everybody is thinking.

CHAIRWOMAN KEELS: So we have recommendations from the last Committee meeting.

MEMBER ZAMUDIO: But this one, from this Committee meeting.

CHAIRWOMAN KEELS: I see Lisa with her pen, so go ahead, Michelle.

MEMBER ZAMUDIO: Okay. So I would -- I'm sorry but I just have to say just to put on record, I would like to add training and clinical experience which would bring it in line with statute, under where it says education and certification.

The definition of critical care to match ones similar to what I found or -- but not a billing one, oh, my goodness, I do a lot of our billing and that would be a nightmare.

To change the word "usually" to the word "they" in the second paragraph under "Although this care may occur in the ICU."

And to add, of course, like the use of the recommendations from last time about those few APRNs who still have a Bachelor's degree.

CHAIRWOMAN KEELS: The grandfathering.
MEMBER ZAMUDIO: Yeah, the
grandfathering.

CHAIRWOMAN KEELS: Yes.

MEMBER ZAMUDIO: And with the
grandfathering, also people who are already in that
job, whether they had a Bachelor's or not, like, what
if -- we're saying grandfathering, are we talking
about grandfathering just those with only a
Bachelor's or are we grandfathering those people
currently functioning in a role?

MS. EMRICH: When the statute refers to
grandfathered APRNs, there's only two. There's CNPs
who received their Certificate of Authority on or
before 2001 --

MEMBER ZAMUDIO: Okay.

MS. EMRICH: -- who hold national
certification but do not hold a graduate degree. So
those are your certified, baccalaureate-prepared
CNPs. They don't have a graduate degree.

The other type are CNSs who received
their initial Certificate of Authority on or before
-- before 2001, who have a graduate degree but don't
hold any type of national certification.

MEMBER ZAMUDIO: Okay. So by putting
clinical experience in there, in my mind that's going
to grandfather -- to use a different -- I can't come up with another word. Is that a protection issue for those people who, like, I read some of these articles saying it would be egregious to take someone out of a 25-year job position and say you need to go back to school.

CHAIRWOMAN KEELS: The Board is not saying that.

MEMBER ZAMUDIO: Okay. So by putting clinical experience, we would state that to other people.

CHAIRWOMAN KEELS: No, we would make that separate. We would call out grandfathering and what that means.

MEMBER ZAMUDIO: Got it. Thank you. That's perfect.

CHAIRWOMAN KEELS: Because there are the two roles that have had grandfathering. The clinical experience is, in my mind, what you do within your scope as a novice to expert, right?

MEMBER ZAMUDIO: Yes, absolutely.

CHAIRWOMAN KEELS: To Pete's point, you know, a novice new grad has very, very different clinical experience than someone who has been practicing that for 10 or more years, right?
MEMBER ZAMUDIO: Right.

CHAIRWOMAN KEELS: So --

MEMBER ZAMUDIO: That's great.

CHAIRWOMAN KEELS: And that does define what you do. It should, right?

MEMBER ZAMUDIO: Right.

CHAIRWOMAN KEELS: Okay. Sherri, do you have comments?

MEMBER SIEVERS: I don't think anything in addition to what you covered in those two areas. Just adding in, like we talked about, make sure the reference list is complete with the resources.

CHAIRWOMAN KEELS: Okay.

MS. EMRICH: Last time I was told. I will doublecheck those.

MEMBER SIEVERS: Yeah.

CHAIRWOMAN KEELS: Pete, anything further?

MEMBER DIPIAZZA: No.

CHAIRWOMAN KEELS: Brian, anything further?

MEMBER GARRETT: No.

CHAIRWOMAN KEELS: Jody?

MEMBER MINIARD: No.

CHAIRWOMAN KEELS: Pam?
MEMBER BOLTON: And you said clinical practice within your scope, right?

CHAIRWOMAN KEELS: (Nods.)

MEMBER BOLTON: Okay. I just wondered on that.

MS. EMRICH: If I can clarify, and I may need Michelle to -- this is -- I think Dr. Graham, when she was talking earlier, started down this but we never -- I don't think she was ever directly asked the question and that is, when you're talking about training and clinical education, are you referring to, you know, I'm a family nurse practitioner and I want to learn how to do a certain procedure which certainly you can, colposcopies or punch biopsies, those kinds of, you know, I don't think that's at question.

MEMBER MINIARD: No.

MS. EMRICH: I think certainly that's not at question at all.

But will any amount, say you're an individual, you've been through a graduate program and you've qualified to take the Women's Health Nurse Practitioner Exam and you're out there as a Nurse Practitioner, will any amount of training and clinical experience, outside of a graduate program,
prepare you to manage acute psychiatric patients?

    MEMBER MINIARD: No.

    MS. EMRICH: Okay. That's a significant difference.

    MEMBER MINIARD: Yes.

    MEMBER SIEVERS: Yes.

    MEMBER ZAMUDIO: Right.

    MEMBER BOLTON: Yes.

    MS. EMRICH: I just want to make sure we're all on the same page here because the latter is truly what we have been focusing that you cannot do.

    MEMBER MINIARD: So it's training and education within your population --

    MS. EMRICH: Exactly.

    MEMBER MINIARD: -- focus.

    MEMBER ZAMUDIO: Right.

    MEMBER SIEVERS: Right.

    MS. EMRICH: Exactly.

    MEMBER MINIARD: So an FNP or an Acute Care NP can't go practice primary care because they did it for a year or they've been doing it for five years and, all of a sudden, they should be able to do it, you know, because it's outside their population focus.

    MEMBER SIEVERS: Babies are in my scope
as an FNP, but I shouldn't be a Neonatal Nurse Practitioner.

CHAIRWOMAN KEELS: You're not managing an extreme pre-term infant --

MEMBER SIEVERS: Exactly.

CHAIRWOMAN KEELS: -- on an oscillator.

MEMBER ZAMUDIO: Right.

MEMBER SIEVERS: Because it's a separate specific certification for that.

CHAIRWOMAN KEELS: And it's management of the patient. We're also getting to the management of the patient, not consultation. You, as a cardiology FNP, may go into the ICU and consult on your patient on a chronic --

MEMBER SIEVERS: But you shouldn't be writing orders for complicated drips and --

CHAIRWOMAN KEELS: Managing the care.

MEMBER SIEVERS: Right.

MEMBER ZAMUDIO: That's a great distinction.

MS. EMRICH: So I think that's significant.

CHAIRWOMAN KEELS: And maybe we can somehow clarify that.

MS. EMRICH: So I'm happy that that's all
of our thoughts.

MEMBER MINIARD: That will be a whole 'nother conversation.

MS. EMRICH: I just want to make sure that is clear.

MEMBER BOLTON: Thank you for that clarification.

CHAIRWOMAN KEELS: Okay. Okay.

So now we have public comment. I have two more. Anybody else going to -- you need to sign in.

MS. WILLIAMS: I already filled out one this morning.

CHAIRWOMAN KEELS: Does she have to --

MS. EMRICH: No.

CHAIRWOMAN KEELS: I'm going to put you back in the pile.

MS. EMRICH: She can restate who she is representing.

CHAIRWOMAN KEELS: So, first up, I have Jessica Davis who is representing OAAPN.

MS. DAVIS: Good afternoon.

By way of a brief introduction, my name is Jessica Davis, and I'm a partner at Brennan, Manna & Diamond.
I specialize in the defense of medical malpractice claims, those brought against Advanced Practice Nurses, physicians, hospitals employing those folks, skilled nursing facilities employing those folks, and home healthcare agencies, just to name a few.

I've done so for the last 17 years. I spent a few years representing patients, and then I switched, and the vast of my majority career has been on the defense side of things.

I've been asked, by the OAAPN, to talk about Ohio's law as it relates to medical malpractice in the context of the standard of care, and I thought it might be beneficial for all of you to hear about what we do in the litigation world relative to the standard of care.

The standard of care in a medical malpractice action in the State of Ohio is what is reasonable, careful, and prudent for that practitioner to do under the same or similar circumstances.

What's reasonable, careful, and prudent under those same or similar circumstances is always established by expert testimony.

So a certification, education, training
and experience, that will not be enough to establish
the standard of care. An independent expert must
come in and offer testimony on the topic. I'm sure
many of you are very familiar with the process.

When a jury is considering whether the
standard of care has been met by an individual
practitioner, the jury is considering the education,
training, and clinical experience of that
practitioner.

By no mistake that same language, I've
heard you discuss all day today, is found in Ohio's
laws. It mirrors the statute.

In defending these claims over the last
15-plus years, I will tell you that we consider the
details of every aspect of that qualification.

The clinician's education, and when I say
"all details," we talk about where those clinicians
attended for their education, how long they went
through the process, if they had to repeat any
courses. All of that is covered.

Similarly with training, all those
details are considered. Where the training occurred,
the length of the training, whether the training was
repeated, whether a clinician had to take a year off,
what they saw and experienced in that training for
example, the length of the training, the orientation, the preceptorship or the lack thereof of preceptorship, the proctor, who was the proctor, how long the proctorship lasted. All of that is considered.

And of course similarly, I'm sure it's no surprise, experience is considered.

So many of the questions that are presented to practitioners in a medical malpractice case are: Has that practitioner seen this ailment before, how many times, how often has it been treated by that individual; how many times is it in the consultive role versus the management role, for example, the individual's role in treating that.

So, for example, I've been sitting through depositions over the course of the last three months. Every single clinician has been asked how many babies they've delivered, how many shoulder dystocias they saw, not just in their training but their clinical experience, their nursing school experience; so all of those bases are covered in a medical malpractice claim.

And then, of course, we talk about CMEs, conferences that the clinician may have attended, presentations, lectures. In fact, I just had a
physician be asked to provide the data that was given
to him during a lecture that he attended, over the
course of a weekend, relative to acute care for a
fetus in lifesaving efforts.

And so, we're always looking at that
entire scope and it's as important when we talk about
education and training as it is in clinical
experience.

Specifically, that brings to my mind this
concept of certification.

What I can tell you as a medical
malpractice attorney is that certification will not
be the deciding factor in determining whether a
clinician is qualified to practice in that area.

Indeed the question is always asked:
"Are you Board certified in" insert the particular
area of specialty. However, it's a question and then
it stems more from there.

Did you pass on the first attempt? Did
you pass your written exam on the first attempt?
Your oral, how many times did you it take? How long
in between the different settings -- sittings, excuse
me -- for your various areas of certification? It's
not simply a question of certified or not.

The inquiry never stops there and it will
not protect a clinician or establish the
qualification in a specific area because you have to
remember that overall marking umbrella, excuse me, of
what the standard of care is.

So a certification isn't going to stop
the inquiry and it's not going to isolate the
practitioners. It's not going to -- excuse me.

Rather, this Committee, in my opinion,
should consider what detailed guidelines will do in
providing context for your clinicians.

And I would respectfully suggest to you,

as you're looking at this, you consider what type of
fodder you're providing for patients' counsel to use
against the clinicians. That won't always be the
case, sometimes it will create a very bright line
that I could advocate for on behalf of your
practitioners, but it will undoubtedly create fodder
as well.

Let me give you --

CHAIRWOMAN KEELS: I'm sorry, you'll have
to stop. Thank you so much. Your five minutes is
up. Thank you.

Does anybody have any questions?

Yes, Michelle.

MEMBER ZAMUDIO: What were you going to
say as an example for us?

MS. DAVIS: Sure.

So the first example that comes to mind is the ACOG guidelines, for example. So clinicians that deliver babies are always asked about ACOG and whether ACOG sets the standard of care, and the answer to that question is no, it doesn't set the standard of care. It provides a guideline by which that clinician then uses their independent education, training, and experience in that particular setting, that same or similar circumstances to answer that question.

Hospital policies and procedures are a similar example of that.

MEMBER ZAMUDIO: So a guideline, similar to the ACOG Technical Bulletins or Practice Bulletins including some type of not just a regular disclaimer but then including "This is not meant to be a legal guideline, this is for clinical guidance," et cetera, et cetera, is that a recommendation that we put something like that in here?

MS. DAVIS: Absolutely. It's a best practice. It's never a substitute for clinical judgment and experience; using your experience, education, and training.
CHAIRWOMAN KEELS: Any other questions?
Great. Thank you so much.

MS. DAVIS: Thank you.

CHAIRWOMAN KEELS: We appreciate your
time.

MEMBER MINIARD: Thank you.

MEMBER BOLTON: Thank you.

CHAIRWOMAN KEELS: Okay. Next up we have
Maria Kiesling.

MS. KIESLING: "Marcia."

CHAIRWOMAN KEELS: Oh, "Marcia." I'm
sorry. Hi, Marcia.

MS. KIESLING: It was probably my
handwriting.

CHAIRWOMAN KEELS: She is with Aultman
Hospital in Canton.

MS. KIESLING: I am a practicing Family
Nurse Practitioner. I work four days a week actually
seeing patients. Another day of the week I have an
administrative role. I'm the Lead Nurse Practitioner
for our organization, actually APP, I have PAs as
well, but I also am Chair of our Allied Credentialing
and Privileging Committee at Aultman Hospital.

And I know we're unique. There are a lot
of hospitals out there that do it, but we have our
own Allied Health, so we credential our CNAs, all our
APRNS, our PAs. We actually have physical therapists
we're credentialing, an optometrist, so, you know,
it's a broad range. Anything that's not a doctor, we
credential.

And I just want to -- I've been here
before and I know there's new members now and I know
most of you understand it, but if you're in the
outpatient world sometimes you don't have to go
through the actual privileging and credentialing
process; it's pretty stringent.

So we all sit up here and talk about what
we're allowed to do as FNPs and what we're allowed to
do as Acute Care but, in the end, you're doing it in
a facility hopefully that's credentialing and
privileging you and, you know, we have very strict
guidelines through JCAHO and our medical staff
office. It's peer-reviewed, it's confidential, and
we take it very seriously.

So yes, you are credentialed as far as
checking all those boxes, do you have your DEA, we
did your background check, we did everything we
needed to do that way, but then you're also checking
the box of what procedures do you want to do on our
hospital premises.
And those of us on the committee don't just check the box saying go do what you want to do. We look at your education, we look at your background and we decide, "Hey, yeah, go ahead, but you've got three months of supervision" and we check that box and you can do nothing unless that doctor is standing right beside you.

And you can only be proctored by a physician, not a nurse practitioner or a PA. We do not allow our APPs to proctor even paps. In the outpatient world, you're being proctored to do a pap, it has to be with a physician.

So we take that very seriously and I think most of the institutions in the State of Ohio do as well. I know there's some outliers, there always will be, unfortunately, but I think that's a legislative issue. I think that should be dealt with on the legislative part of the realm with the Joint Commission and how is everybody credentialed and privileged throughout the State so we are equal because right now, you're right, we aren't completely equal.

Do you have a question, Pam?

MEMBER BOLTON: No. I'm sorry.

MS. KIESLING: So, you know, like I said,
process, procedure, we follow it very seriously and
there are many times we have APPs come by asking for
privileges and we'll say no. We look at your
education, we look at your background, you came from
another facility and you haven't done this procedure
in five years, no, you have to go out and proctor it
and bring me the documents to make sure it's done
correctly and we're staying safe and we're keeping
the patients safe. So there is a very strict process
that I think most of the people in the State of Ohio
follow.

CHAIRWOMAN KEELS: Questions for Marcia?

MS. KIESLING: Thank you.

CHAIRWOMAN KEELS: Thank you. We
appreciate your time.

MS. KIESLING: You're welcome.

CHAIRWOMAN KEELS: Chris Williams with

OAAPN.

MS. WILLIAMS: Thank you.

I just want to say I was surprised to
hear, at the end of the discussion, about acute care.
It's just a constant "square peg, round hole," you
guys. You've been here three years doing this, it's
time to let it go. It doesn't fit. You just heard
about liability. It doesn't fit there either.
Acute care, from my perspective and what I've read, is not a population, so once you start talking like that, I know exactly where the conversation is going and what's going to show up next and I think it's sad that that was shoved in at the very end of the day.

I think you need to look really hard at that and I think you need to let it go. This is not good process. There's not going to be good outcomes here. This is not in the purview, from my perspective and OAAPN's perspective, of the Board of Nursing. It's licensure.

Everyone gets in trouble. A bad practitioner, physician or otherwise, will eventually be caught or at least we hope they're caught. And when they are, this is a vigorous, rigorous Board of Nursing. I don't think they mess around and I think they go after bad practitioners as quick as they can so people meet their final outcome pretty quickly here.

So I would ask you to reconsider whether it's time to let this go. Nothing fits here. I know it's on some people's agenda. I know it's on some national agenda. I know it happened in Wyoming and it's happened in a couple other states. And the
reason why you have so many questions and so many
people showing up here is we think it's wrong, and
it's wrong for practice, and it's wrong for patients,
and it's wrong for healthcare.

CHAIRWOMAN KEELS: So, Chris, I have a
question for you.

MS. WILLIAMS: I'm sorry, pardon?
CHAIRWOMAN KEELS: If you don't mind.
MS. WILLIAMS: No.
CHAIRWOMAN KEELS: So there are distinct
certifications exams in acute care and primary care
for adults and for pediatrics, right, so do you not
consider those distinct populations?
MS. WILLIAMS: No, I don't. I don't. I
think that's a continuum. Just like life is on
continuum, healthcare is on a continuum. And if
someone is here and someone is there, can you tell
the difference? Probably yes. Yes, you can.

A well-child 3-year-old is not someone
who has been in the ICU for a month and is on
lifesaving machines. I hate going to ICUs. I'm
primary care, needless to say. Yes, that's easy, but
anything in between is a mixture of everything.

And I don't think -- the reason why
there's so much trouble with this is because you
can't draw the line and you shouldn't draw the line and medicine doesn't do it. Medicine didn't do it to family medicine. The profession regulated itself. The Board of Medicine didn't regulate family medicine. And they went through these struggles.

So I think this is one profession or one APRN type and I think it's a turf struggle or a job struggle. There's economics involved here. I don't have it mapped out, I'm not an economist, but somewhere there is always economics.

So I think you should let it go. I think it's "square peg, round hole," really.

CHAIRWOMAN KEELS: So I think our challenge has been that we get so many questions --

MS. WILLIAMS: Right.

CHAIRWOMAN KEELS: -- from NPs on where -- and I agree I think the prudent person would acknowledge where I'm a primary care certified person and this is critical care management --

MS. WILLIAMS: Right.

CHAIRWOMAN KEELS: -- and I shouldn't be doing this.

MS. WILLIAMS: Right.

CHAIRWOMAN KEELS: Unfortunately we're still getting questions. So I'm still -- we're
struggling on --

MS. WILLIAMS: How do you answer those?

CHAIRWOMAN KEELS: -- how to provide the answers to those.

MS. WILLIAMS: I'm going to give you a perfect guide, a perfect guide, and that's OAAPN's legal answers. They have come from the years we spent researching every statute, every rule, to give the right answer and quote the right statute and rule. We have legal expertise now. When I read the answers, I think they're so right on, they're so succinct and they take it back to that individual.

They quote where it comes from. It's right here, it's here and here. And if you fit in here, here, and here, then you should be okay, or however they say it. And it's not heavy-duty legalese. It's very understandable. I think they do a great job and I think they're a guide for answering anything in terms of practice. It's better than it's ever been.

CHAIRWOMAN KEELS: Lisa, you had your hand up.

MS. WILLIAMS: And that was not an ad.

MS. EMRICH: You talked about the Board's actions when something bad occurs. I think the Board
is always concerned and always wants to make sure
information is available to all of its licensees --

MS. WILLIAMS: Yes.

MS. EMRICH: -- so to forewarn as to what
may cause disciplinary action.

So if information needs to be provided
regarding national certifications and what those
mean, I think that's important to provide
because, you know, it's not a catch-ya kind of
situation. It has to be --

MS. WILLIAMS: But I think what you've
also heard, though, is it's not just the national
certification.

So if you're a family medicine doc and,
when you first entered, you did deliveries, let's say
10 years of deliveries and then you didn't like
getting up in the middle of night so you quit for 15,
20 years. You cannot -- well, if you do you're a
fool -- walk out your door and start delivering
babies again.

If you get before a Court, I'm sure you
would be in big trouble, big trouble. When was the
last time you did this? How many have you done in
the -- I mean, that's where it stops and it's too bad
it stops there after there's been a problem.
But regulating, getting specific and regulating it beforehand, that's where I think you meet trouble. It's going to happen. And I think the legal discussion about what's asked for in court, it's the standard of care, did you meet it and are you competent.

CHAIRWOMAN KEELS: I think that sort of circles back to the discussion we had on clinical experience and formal education as you build upon your levels of expertise within your population.

Michelle, did you have your hand up or was it Jody?

MEMBER ZAMUDIO: Actually I did not this time.

CHAIRWOMAN KEELS: I'm sorry.

MEMBER MINIARD: You said exactly what I was going to say.

CHAIRWOMAN KEELS: I'm sorry. Did anybody else have their hands up for Chris?

MS. WILLIAMS: Okay. Thanks.

CHAIRWOMAN KEELS: Thanks so much.

MS. WILLIAMS: Thanks for allowing this input.

CHAIRWOMAN KEELS: Sure, absolutely.

I see Jesse. Are you coming down here to
talk?

MR. McCLEIN: Yeah, I just want to

address the CNS thing.

CHAIRWOMAN KEELS: Okay. Oh, yeah, yeah,

I know that you are -- have been involved in the --

MS. EMRICH: MAT.

MR. McCLEIN: In the waiver.

CHAIRWOMAN KEELS: Yes, please and thank

you.

MR. McCLEIN: So I am a CNS, I have my

waiver, so you can take the waiver program. You

cannot, on SAMSHA's website, click a button to allow

a CNS or a CNM to apply for that X DEA waiver.

CHAIRWOMAN KEELS: It's at the SAMSHA

level.

MR. McCLEIN: It's at the SAMSHA level.

CHAIRWOMAN KEELS: Okay.

MR. McCLEIN: The problem with SAMSHA is

it falls under the Executive Branch which is Trump's

branch, okay?

So I've been working with Senator Portman

and his team on trying to update SAMSHA's website.

The problem is that Portman has no pull under there

because he's the legislative Branch.

So when they reached out to SAMSHA, they
said, well, we have to give a report in two years on
how well the program is working, so that's the answer
we have, so I mean --

CHAIROWMAN KEELS: Which won't be working
very well if --

MR. McClain: Well, it could be next
month, it could be in 22 months, because in 24 months
from October of '18 they have to give a report. So
honestly like every day or every other day, because I
have it saved on our Favorites, I always go in to see
if they updated it.

Now, when I met with Senator Portman's
Aide about this, like, we walked through the website
together and I showed him, like, I can click the NP
and go to the next level, and I showed him that, but
then there's two attestation statements that I have
to attest that I'm NP with a collaborator. Well, I'm
not, you know, so I don't want to continue that
process even though he's like, well, you function
similar, just continue that process.

I'm like listen, there's already enough
scrutiny with this, with waivers and all this stuff,
like, I don't want to, even though my intentions may
be good, I am not clicking that button, they need to
update their first page.
So I think that's where the problem is.

So, I mean, I'm glad the rule is going to change because it could be tomorrow that their website is updated.

CHAIRWOMAN KEELS:  Okay. Thank you very much. It all came back to me now.

MR. McCLAIN:  Okay.

CHAIRWOMAN KEELS:  Appreciate it. Thank you.

Okay. That brings us to the end of the meeting, I think.

MS. EMRICH:  Yup, 3:01.

CHAIRWOMAN KEELS:  We don't have any other requests and so I heard a couple requests for our next meeting. I'm pulling up my agenda.

We'll take the Interpretive Guideline input on both the graph as well as the document, and Lisa and her team will work on it, and as soon as they can get it out to everyone to review, it will be posted for comment and then we'll talk about it at our next meeting which is in September.

MS. EMRICH:  October.

CHAIRWOMAN KEELS:  October. October meeting.

MEMBER MINIARD:  October 28.
CHAIRWOMAN KEELS: October 28?

MEMBER MINIARD: I'm pretty sure.

CHAIRWOMAN KEELS: Okay.

MEMBER MINIARD: Is that correct?

CHAIRWOMAN KEELS: I don't know.

MEMBER MINIARD: It's what's on my calendar.

MS. EMRICH: October the 28th.

MEMBER MINIARD: Yay.

CHAIRWOMAN KEELS: Were those the only requests I heard really around the IG?

MEMBER MINIARD: Is OAAPN speaking?

CHAIRWOMAN KEELS: Yes, yes. President Greaves will be here and she will be speaking, yes. And hopefully we'll have some updates on the CNRA as well as the Standard Care Arrangement Bills.

MEMBER MINIARD: Okay.

CHAIRWOMAN KEELS: And we should have some feedback on the detox rules if there was any feedback at all.

Okay. Then we are adjourned.

(Thereupon, the proceedings concluded at 3:05 p.m.)
CERTIFICATE

I do hereby certify that the foregoing is a true and correct transcript of the proceedings taken by me in this matter on Monday, June 17, 2019, and carefully compared with my original stenographic notes.

Carolyn M. Burke, Registered Professional Reporter, and Notary Public in and for the State of Ohio.

My commission expires July 17, 2023.