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Advisory Committee on Advanced Practice Registered Nursing

Meeting Minutes
January 29, 2018

Members Attending: Erin Keels, Chair; Latina Brooks; James Furstein; Candy Rinehart; Kristine A. Scordo; Sandra Wright-Esber; Michelle Zamudio

Members Absent: Christopher Kalinyak

Staff Attending: Betsy Houchen; Lisa Emrich; Anita DiPasquale; Holly Fischer (Present for Rules discussion); Tom Dilling; Chantelle Sunderman

Guests Attending: Keeley Harding, APRN; Jodi Ulloa, OSU School of Nursing; Judy Audas, OSANA; Christine Williams, OAAPN; Sarah Kincaid, OSU-NP Council; Lori Nicholas, Premier Health; Lori Chovanak, ONA

Call to Order and Welcome
Erin Keels, Chair, called the meeting to order at 10:00 a.m. and welcomed members and guests.

Review and Approve October 2017 Meeting Minutes
Kristine Scordo moved to approve the minutes as written and Michelle Zamudio seconded. The Committee unanimously approved the minutes.

Acute Pain Rule
Lisa Emrich reported Rule 4723-9-10, OAC, was effective January 1, 2018. Related materials are posted on the Board website and were provided to the Committee. Chair Erin Keels asked the Committee members if they were hearing from APRNs with questions on acute pain rule prescribing and if the members thought APRNs were clear about the rule. No Committee members stated they were hearing questions.

Administrative Rules

Medication Assisted Treatment
Holly Fischer stated the law requires the Nursing and Medical Boards to work together to adopt consistent Medication Assisted Treatment (MAT) rules. She asked Committee members to review draft concepts/discussion points from the Medical Board she received just prior to the Committee meeting.

H. Fischer explained the rule would include both detoxification and treatment, however the discussion points only address treatment. The treatment rule would apply to office-based treatment and exclude facilities already regulated by federal and state laws, such as correctional facilities, hospitals, or treatment providers regulated or certified by the federal government. The discussion points specify requirements such as examinations, screens, OARRs checks,

treatment planning, coordination with other providers, psychosocial plans, etc. There would be prescribing limitations and special considerations regarding types of drugs prescribed. The use of certain drugs, such as Subutex for treatment would be excluded. H. Fischer stated that detoxification would be addressed, but perhaps in a separate rule. After talking with Dr. Hurst, Medical Director of the Ohio Department of Mental Health and Addiction Services, she believes the detoxification rules could apply to correctional facilities and jails because detoxification is currently occurring in those settings. H. Fischer noted that only Clinical Nurse Specialists (CNSs) were included in the Medical Board's discussion points as "qualified behavioral health care providers" for coordination of services. The Committee recommended that CNPs be included.

H. Fischer stated she anticipates an expedited timeframe for the rulemaking process in 2018, and asked that the Committee review the discussion points and provide recommendations and concerns to her as soon as possible. She noted that the Nursing Board members have not yet discussed the rules or reviewed the discussion points being reviewed by the Committee today.

Chair E. Keels clarified that the Nursing Board would draft rules that mirror the Medical Board rules. She asked if the Committee would have an opportunity to review the rules before they are filed so the Committee has time to review for the rule language to be congruent and acceptable for both the Nursing and Medical Boards. H. Fischer suggested the Committee could schedule an additional meeting in May to review the draft MAT rules and chronic pain rules. She stated the Medical Board plans to review MAT rule proposals in February and the Nursing Board would review them either at the March Board meeting or Board Retreat in April. She anticipates the interested party meeting will be held in May and invited all members of the Committee to attend, and the Public Rules Hearing could be held at the July 2018 Board meeting. H. Fischer responded that if members see something off base in these discussion points or if they are aware of research, best practices, or pertinent information to please send it to her. H. Fischer noted that some topics are statutorily required, as included in Section 4723.51, ORC.

Chair E. Keels asked about CARA 2016 that authorizes CNPs to be MAT prescribers. Staff reported that legislation to amend federal law to include CNSs was introduced, but NCSBN is not optimistic about its passage.

M. Zamudio stated that nursing specialty associations may have comments and H. Fischer requested Committee members to ask those groups to contact her with information, questions, protocols or guidelines. She stated members could individually contact her with comments, but she cautioned the Committee members that according to the Open Meetings Act, members should not discuss the rules via emailing each other. T. Dilling stated the Committee could track information provided to the Board through the Board website and social media and emails.

Sandra Wright-Esber stated she believes the acute pain rules reflect a lack of understanding about APRN practice but she is pleased to start early in the process to have these discussions and regarding the MAT rules, work closely with the Board so APRNs have their voice heard. She noted the issue of prescribing opioids is mainly a physician issue, not an APRN issue. Candy Rinehart stated in her experience, it seems outside entities are defining APRN practice without understanding APRN practice so she sees the value of this Committee and gathering information from others.

Chair E. Keels stated the Committee has an opportunity for input with these rules and asked if the Committee members would agree to schedule a meeting in May. A meeting was scheduled for May 14, 2018.

Chronic Pain Rule

H. Fischer stated GCOAT is discussing rules to address prescribing for chronic pain. The Committee was provided the 2013 GCOAT Guideline for chronic pain prescribing. She stated prior to prescribing, the rule could require consideration of non-opioid and non-medication modalities. After seven days of a 50 mg Morphine Equivalent Dose (MED) daily dose, the prescriber would consider referring the patient to a pain management specialist. After seven days of 80 mg MED daily dose, the prescriber must obtain a urine drug screen, consult with a pain management specialist, and consider consulting with an addiction medicine specialist or psychiatric specialist. H. Fischer asked the Committee to review the materials and contact her with information, protocols, questions, or concerns.

M. Zamudio and L. Brooks stated a concern regarding referrals to specialists because there is limited or a lack of reimbursement or insurance coverage and it is difficult for patients to get to appointments. They asked about having consumer and insurance company representatives involved. Tom Dilling stated there were numerous discussions and testimony concerning cost, access, and the convenience for the patient during past GCOAT meetings.

S. Wright-Esber stated that the Guideline seems to mirror the CDC guidelines and her hospital is implementing the CDC guidelines. She believes the Committee should be more involved in the early conversations in drafting the chronic pain rule to present narratives and opinions, and to provide clear language. H. Fischer asked if S. Wright-Esber would participate in meetings or conference calls if that was a possibility; she stated she would be willing to participate.

Chair E. Keels asked about the impact of medical marijuana and the treatment of chronic pain. H. Fischer stated she is a member of the Marijuana Regulatory Guidelines Committee established by the National Council of State Boards of Nursing (NCSBN) and indicated the NCSBN Committee has found inconsistent research on the effectiveness of medical marijuana for treatment of chronic pain.

S. Wright-Esber stated she had several points for Board consideration. She stated APRNs are prescribing in many areas and types of practices, such as primary care, specialty care, and rural areas. Also, CNSs need to be included. L. Brooks stated that prescribing for patients who are currently are being treated for chronic pain would also need to be addressed in the chronic pain rule. M. Zamudio asked about using the term "prescribing APRN" rather than "nurse" to eliminate possible confusion. S. Wright-Esber stated she learned at a conference that in the Netherlands there are no overdoses and there are clinics and assistance available.

Chair E. Keels thanked Board staff for informing the Committee and associations about the MAT and the chronic pain rules so there is an awareness of what is being developed. She suggested the Committee further review and discuss the draft rules for chronic pain prescribing at the May 14, 2018 meeting.

CNPs Acute and Primary Care Practice

Chair E. Keels summarized the materials provided to the Committee. She reported that the Board met with OONE/OHA who then surveyed their members about the practice of CNPs in hospitals. The Committee was provided the survey results. In addition, Committee members received the National Organization of Nurse Practitioner Faculties (NONPF) document showing acute and primary care competencies. Chair E. Keels stated the Committee is to advise and make a recommendation to the Board and highlighted the options as to continue to follow the Consensus Model or identify alternatives to the Consensus Model. She stated the Consensus

Model outlines four roles within a population focus for which CNPs are certified for entry into APRN practice.

C. Rinehart stated she wanted to begin by discussing competencies saying she believes graduation from an APRN education program shows that APRNs have the needed competencies, and she agreed that competency is determined through national certification examinations.

S. Wright-Esber stated she believes the term "acute" must be defined because Ohio law says APRNs can care for acute conditions without defining it. She does not believe the Committee should start by discussing the two options because that is an all or nothing approach and she believes the question is how Ohio is interpreting the Consensus Model. She questioned the appropriateness of the Board regulating whether CNP practice is acute or primary care because she believes a CNP's competency and certification is relative only at entry level. She does not believe the Board should license an APRN and then regulate APRN practice which limits the APRN's ability to manage patients requiring either acute or primary care. She stated the Consensus Model is a guide and not law and application of it is not required.

K. Scordo disagreed with the need to define "acute." She stated the Consensus Model clearly delineates the population of a role through national certification. She agrees there can be overlap in the hospital setting, however she asked how could a primary care CNP have a collaborative arrangement with an intensivist. There was discussion regarding acute conditions and acute care. S. Wright-Esber stated she did not believe it would be appropriate for a primary care CNP to have a collaborating arrangement with an intensivist.

M. Zamudio read from the Consensus Model language about specialty areas saying the Board is not to regulate specialty areas. Director Houchen stated that the Board does not regulate APRN specialties because specialties are obtained after national certification and licensure. Director Houchen stated she believes that the term specialty as used in the Consensus Model is confusing, and it should not be applied to national certification and population foci. She asked the Committee members to discuss what the Committee's suggestions would be for an alternative model other than the Consensus Model.

L. Brooks stated that a primary care CNP could manage and treat an acutely ill patient within the hospital because the setting itself is not the determining factor for the population. The Committee discussed populations of patients that require care within the hospital setting and their conditions, which range from patients who can be managed by primary care CNPs to patients with conditions that should be managed by acute care CNPs.

S. Wright-Esber stated that this might be the time to raise a concern that a Committee member advertised her acute care graduate program on a social media website, and she believes the social media advertisement is a conflict of interest for the Committee member. K. Scordo responded that S. Wright-Esber was referring to a post that K. Scordo wrote because she was receiving emails asking where APRNs could return to school.

S. Wright-Esber said she was concerned about alternative motives since K. Scordo is a Committee member. K. Scordo clarified that there are no alternative motives and stated she was sorry it was interpreted that way. K. Scordo stated she called the Ohio Ethics Commission and the Ohio Ethics Commission advised her they did not view it as a conflict of interest.

S. Wright-Esber stated she is asking the Board to look into it. Chair E. Keels clarified that the conflict of interest inquiry is at the individual level, not the Committee level. Director Houchen

stated K. Scordo was advised to contact the Ohio Ethics Commission and that ethics training was provided at the last Committee meeting so all members would be aware that they should review their work and professional positions in relation to potential conflicts and contact the Ethics Commission. S. Wright-Esber stated she wanted it on the record that she did not disclose the member's name, that the member disclosed it herself. K. Scordo responded that she volunteered the information because she has nothing to hide.

C. Rinehart suggested that the Committee look at how issues regarding CNP practice started and asked if it started because APRNs are not taking good care of people and then the issue transformed into the Board regulating where APRNs work. She stated she believes the OONE review shows that APRNs are doing well, so what is the Board hoping to achieve. Director Houchen said the Board is to protect the public and to apply the law and rules. This began when the Board was asked a question about the law and the Board responded.

S. Wright-Esber asked what acute care means because there are gray areas. L. Brooks stated that many hospitals will not hire primary care CNPs and we need to be clear about language regarding populations. L. Emrich asked that if hospital training or post-graduate training is used, whether it is standardized. K. Scrodo stated that training and education provided by hospitals is not standardized. M. Zamudio stated she thinks Board is trying to determine what ARPN credentials should be and she believes post-graduate training or education should determine it. She stated that training could provide the APRN with an expanded scope of practice.

Chair E. Keels said the Board is not addressing credentialing, rather it is requiring that APRNs work within their population foci. She stated the hospital is to hire and credential based on the national certification and population focus, which determines the scope of practice.

S. Wright-Esber stated this started when the Board published an anonymous article in *Momentum*. L. Emrich responded the article was a Board article in a Board publication. T. Dilling noted the Committee previously discussed the history of the article, background, and purpose in detail.

K. Scordo spoke against the idea of not following the Consensus Model because it would make Ohio licensure and practice inconsistent when the purpose of the Consensus Model is to unify states and the regulation of APRNs. T. Dilling stated multiple organizations and associations developed the Consensus Model and NCSBN asked that state boards of nursing follow it. Over the years, practice has changed but the basic requirements of core education, national certification and population focus in the Consensus Model have not changed.

S. Wright-Esber stated that APRN practice has not changed and asked what are the next steps and expectation of the Board? She stated she thinks the Board has already made a decision and she disagrees with where the Board is taking this. She stated that acute illness language is used in current law. T. Dilling stated that in 2013 acute illness language was added through HB 303 at the request of the APRN association who informed the Board that it needed to be added due to reimbursement issues, not to expand the scope of practice.

Chair E. Keels agreed that the acute illness language may be confusing, but it can be clarified. She summarized saying the discussion began by identifying two choices. She stated this Committee is to advise the Board of the next steps, and she does not think the Committee is there yet, but she may be hearing agreement about some parts of the issue.

C. Rinehart asked if there was feedback from institutions and what are they were doing. Chair E. Keels stated that the Board will continue the dialogue OONE/OHA. She stated the discussion

would continue at the May 14, 2018 meeting and asked that members bring guiding definitions and concepts for discussion, review past discussions and materials including the Consensus Model, and bring their recommendations.

The Committee reviewed the *Emergency NP Specialty Certification Candidate Handbook,* noting that this certification is for a primary care CNP who wishes to specialize in the provision of primary care in the emergency department. There was discussion about NCSBN re-visiting the Consensus Model for clarification. It was noted that the NCSBN APRN Roundtable is scheduled for April 11, 2018. Committee members were directed to the NCSBN website to obtain addition information if they are interested in attending.

APRN Practice Question/Response: HCG for Weight Loss

L. Emrich stated the Board received a question about APRNs prescribing Human Chorionic Gonadotropin (HCG) for the purpose of weight loss. She explained that prior to implementation of the Exclusionary Formulary, the CPG revised the Formulary to specify that an APRN "may not prescribe" HCG for weight loss. With the implementation of HB 216, the Board adopted an Exclusionary Formulary and prescribing HCG for weight loss is not currently excluded. Recently the Board received a request again with a 1972 article as supportive evidence. L. Emrich explained that the question would be considered by the CPG, and asked the Committee if they would like to make a recommendation. The Committee stated it is a standard of practice issue and that APRNs should not prescribe HCG for weight loss because it is not evidence based practice, but agreed by general consensus not to recommend that prescribing of HCG for weight loss be added to the Exclusionary Formulary.

General Information

Director Houchen reported that 91% of APRNs completed the COA renewal/APRN license issuance process. The renewal and licensure season proceeded smoothly except an erroneous auto-generated email message was sent on January 1, 2018. She thanked the APRNs who alerted the Board, so Board staff had the opportunity to quickly provide correct information.

Uploading collaborating physician information and continuing education (CE) for APRN license renewal were discussed. APRNs will need to comply with the CE requirement for licensure renewal in 2021 using CE obtained between November 1, 2019 and October 31, 2021. The 2017 RN and APRN Workforce Reports are posted on the Board website. K. Scordo asked if future APRN reports could include the number and type of APRN national certifications. L. Emrich informed the Committee members about a *Freakonomics* podcast.

James Furstein asked the Committee to consider requiring one hour of CE to address the opioid crisis and be counted as part of the current 24 hour CE requirement for RN renewal. The Committee agreed by general consensus and the recommendation will be presented to the Advisory Group on Continuing Education for their consideration.

Legislative Updates

T. Dilling provided an update on HB 191, the CRNA bill. Surgeons testifying as proponents of the bill provided testimony stating a preference not to have liability as the CRNA's supervising physician, although the surgeon may be the only physician present when the CRNA is administering anesthesia. J. Furstein discussed the differences in CRNA practice between states.

Future Meetings

Meetings are scheduled for May 14, 2018; June 11, 2018; and October 1, 2018. There was additional discussion about the May meeting. C. Rinehart asked if APRNs will be reported to the Board based on their practice. Chair E. Keels stated that there could be a complaint that would be reviewed and investigated. S. Wright-Esber asked about grandfathering and Chair E. Keels stated that could be part of the recommendations brought to the next meeting.

Public Comments

Christine Williams, OAAPN, provided comments about the CRNA bill testimony regarding supervising physicians and CRNAs providing anesthesia and pre- and post-anesthesia care. She stated the Committee should be cautious in its discussions because people are interpreting the Consensus Model differently and she did not hear enough agreement by the Committee to pursue regulation based on population foci.

Adjournment

The meeting adjourned at 1:32 p.m.