



Advisory Committee on Advanced Practice Registered Nursing

Meeting Minutes May 14, 2018

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

Members Absent: None

Board Members Attending: Lisa Klenke

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

Guests Attending: Jamie Bourn, Center for Symptom Relief; Jennifer Hannum, Center for Symptom Relief; Delica Butler, Center for Symptom Relief; Karin Grant; Peter DiPiazza, OhioHealth; Christina Roberts, OhioHealth; Christine Williams, OAAPN; Tiffany Bukoffsky, ONA; Michelle Chase, Ohio State University Wexner Medical Center; Christina McGee, Ohio State University; Michele Staton, Byers, Minton & Associates; Jesse McClain, OAAPN; Jessica McCullough; Stephanie Gilligan, OHA; Erin Snyder, OAAPN; Kimberly Anderson, State of Ohio Medical Board; Willa Ebersole, Pappas and Associates; Bruce Garrett.

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 January 2018 Meeting Minutes

Kristine Scordo moved to approve the minutes as written, and Sandra Wright-Esber seconded. The Committee unanimously approved the minutes.

CNP Acute and Primary Care Practice

Erin Keels, Chair, introduced Ann O'Sullivan, PhD, FAAN, CPNP, who spoke with the Advisory Committee via audio-conferencing to discuss the Consensus Model. Chair Keels noted that Dr. O'Sullivan, as Chair of the NCSBN APRN Advisory Committee, collaborated with APRNs, APRN educators, accrediting bodies, etc. for the development and implementation of the Consensus Model through the work of the national APRN Consensus Work Group. In 2016, Dr. O'Sullivan served as chair of the Pennsylvania State Board of Nursing's advanced practice registered nurses committee, and has been a proponent of full practice authority legislation. She is recognized as a leading proponent of APRN practice and has written and lectured extensively. Dr. O'Sullivan has been a clinician educator since 1987, and presently practices at The Children's Hospital of Philadelphia.

Dr. O'Sullivan stated that she reviewed the Advisory Committee materials and minutes. She stated her first recommendation would be to recognize the different populations because it is

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

She stated that at the 2017 NCSBN APRN Roundtable, it was noted that lawsuits are increasing, and in malpractice lawsuits, all individuals listed under collaborative practice agreements are considered potentially liable. Her concern is that liability insurance providers may not cover a claim if CNPs are delivering care to critical/complex patients when they are prepared as a primary care CNP, including a Family Nurse Practitioner, Pediatric Primary Care Nurse Practitioner, or Adult-Gerontology Primary Care Nurse Practitioner. Insurance will not protect APRNs if they are practicing outside of their population scope, and if an APRN practices in a manner not consistently used throughout the country, the insurer may determine the practice is not within the national norm.

K. Scordo added that a recent presentation provided by the Nurse Service Organization stated that 5% of all malpractice cases are related to APRN scope of practice such as primary care CNPs practicing critical/acute care or taking on complex psychiatric patients. Christopher Kalinyak stated he is concerned about APRNs and PAs providing inappropriate psych/mental health care without having the appropriate certification.

Latina Brooks stated that one difficulty she has in understanding scope of practice relates to asthma management. With improvements to asthma treatment over the years, primary care practitioners now manage asthmatic patients. A primary care CNP would need to learn how to manage an asthmatic patient, but this disease may not have been included in the CNP's graduate program curriculum. Similarly, other conditions currently treated in primary care were treated in the hospital five years ago. It seems it would be very difficult to regulate this. Dr. O'Sullivan stated that curriculums change over time. For example, specialty providers managed asthma in the past, but now it is the primary care provider that manages asthma and it is now taught in the FNP curriculum.

Dr. O'Sullivan stated that CE taken by APRNs should be congruent with their national certification population and that many years ago, APRN graduates were told they could change their scope of practice by returning to school, obtaining on-the-job training, or completing specific CE, but that is no longer the case. The development and publishing of the Consensus Model clarified this at a national level. She said she was one of the few academicians on the committee that developed the Consensus Model with other members such as accreditors, certifying agencies, and state boards of nursing. All agreed, as stated in the Consensus Model, that neither on-the-job training nor CE could be trusted to protect the CNP in the future with respect to the parameters of their authorized practice. A FNP who previously had experience as a RN in ICU before becoming a FNP and desired to manage critical/unstable patients would

need to obtain national certification with an acute care population focus. While this may be a difficult concept to understand, and regardless of whether people agree with it, it is the national norm.

Michelle Zamudio stated that at her facility FNP's practice in the labor and delivery department, and she believes, as a member of the credentialing committee, the FNP's are well prepared to practice there. She wants to be careful that the population certification does not restrict the APRN from practicing in other areas and believes that the Board Decision Making Model helps the APRN to determine this. L. Brooks agreed and stated the APRN Decision Making Model is especially useful in the overlapping areas of practice, at the hiring process, and in practice. S. Wright-Esber said she encourages APRNs to use the Decision Making Model and she believes the Decision Making Model is all that is needed rather than adopting rules.

S. Wright-Esber stated that she disagreed that APRN provider liability should be a focus of discussion because it is not related to whether the Board should adopt rules clarifying scope of practice. She stated that Ohio law clearly states that CNPs may manage acute illnesses. She stated that the Consensus Model is not law, is no longer current, and should not be considered by the Board in adopting scope of practice rules. She stated that the *Momentum* article reflected an interpretation that is not protecting APRNs. She also disagreed with Dr. O'Sullivan's statement that CE should be congruent with the CNP's certification, stating there are primary care patients who may become acute. For example, S. Wright-Esber stated she believes she is competent to handle a child who presents with an acute abdomen and to refer the patient to the correct provider. Dr. O'Sullivan stated that she does not believe an acute abdomen is the basis of this overall discussion and she would expect an APRN to address an acute abdomen and then refer the patient to the appropriate provider. The Consensus Model states that primary care APRNs are to direct patients to the correct level of care.

S. Wright-Esber asked if the acute care CNP must stop providing patient care when an acute care patient stabilizes and leaves ICU. Dr. O'Sullivan stated the CNP scope of practice in a population is not setting specific. The Consensus Model pertains to the level of care the patient requires, not where the patient is located. For example, a primary care CNP may see patients in ICU, but if the patient is unstable, critical/complex, a primary care CNP is not prepared to care for the patient. S. Wright-Esber stated that based on that explanation, an acute care CNP would have to stop caring for patients who leave the critical care setting. Dr. O'Sullivan said Ms. Wright-Esber's statement is incorrect, and stated that the acute care CNP would prepare the patient for discharge and refer the patient to a primary care provider.

Lisa Emrich stated that Dr. O'Sullivan's statement is consistent how the Board has addressed this issue; the patient's level of medical management need is the focus, not an incident or a health situation that occasionally occurs. For example, the FNP practicing in labor and delivery would not manage an obstetrical patient presenting with a fetal demise and disseminating intravascular coagulation. M. Zamudio agreed and said each APRN has to know when a situation is beyond their scope of practice, however, anything can happen at anytime and the APRN must respond.

Candy Rinehart told Dr. O'Sullivan that the acute care versus primary care issue came up suddenly in 2016 and was presented as a patient safety concern. This is the first time the Advisory Committee has heard any information about a liability concern. She stated that the primary focus of the Advisory Committee is to ensure patients have care and she does not want to start a turf war. M. Zamudio stated that she and others do not practice in fear of a lawsuit, but practice what is safe and best for the patient. She stated that additional discussions regarding the Consensus Model should only be through the lens of patient safety and not legalities.

S. Wright-Esber stated L. Brooks made a good point regarding management of the asthmatic patient. The Board cannot address gaps in education. The question is whether the Board should adopt the entire Consensus Model with this incorrect interpretation of the scope of practice for acute care and primary care certified CNPs. Education of APRNs is ongoing and that should allow an APRN to care for multiple patients in multiple scenarios with different diagnoses. She said the Board should use the Decision Making Model as a guide and avoid adopting scope of practice rules.

Dr. O'Sullivan responded that this discussion reflects a philosophical difference, and she is trying to convey that to protect patients in Ohio, the Advisory Committee should consider thinking in terms of reality and not remain grounded in philosophical differences. She stated she believes since this is difficult, it is not likely for the Committee to reach 100% consensus. She then excused herself from the call due to former commitment.

Chair E. Keels stated that Ohio has many FNPs and too few acute care APRNs, and as a result there are APRNs who are practicing inconsistently with their national certification population competencies. She stated she understands the Consensus Model is not law, but it is a national standard to be considered. She believes there is confusion between the terms acute care and critical care, though she believes that everyone agrees there is fluidity of care between managing levels of care, but there is no bright line. The FNP may be practicing in labor and delivery but would not manage the care of a 28-week gestation premature infant. Also, a primary care CNP may recognize a child has an acute abdomen and initiate treatment, but the primary care CNP would not continue to manage the child's condition, they would refer the patient to the appropriate level of provider.

S. Wright-Esber stated that if the Board regulates APRN practice based on acute care versus primary care certification there would be limits to the practice of APRNs. Scope of practice is learned through all the APRN does; the Board's regulation should be at the entry level and not involved in the APRN scope of practice that develops after the entry level. Chair E. Keels asked S. Wright-Esber what she is specifically advocating. Is it for the Board to regulate only the role of CNP, CNS, CNM and CRNA, and not the population focus? If so, that is not possible. Current law for APRN practice in Ohio requires continued national certification. S. Wright-Esber responded that she is opposed to the Board stepping in and trying to regulate all things. The Board cannot be involved in that level of practice detail.

Chair E. Keels stated that CNPs do not get certified as a "general" CNP. The CNP national certification is for role and a population. She asked the Advisory Committee members if the CNP with national certification in primary care should be able take CE and then be qualified to manage critically ill unstable patients? Advisory Committee members stated that hospital credentialing committees look at the CNP's national certification and competencies.

Lisa Klenke reminded the Committee that the Consensus Model speaks to what is already in Ohio law. The 2016 *Momentum* article was written to clarify questions that the Board was receiving; the article cited and applied current law that predates the Consensus Model. She said that because this is existing law, the Board is not seeking to change or add to the law unless there is a specific need to do so. However, the Committee's discussion is creating confusion as to what is the core issue because the current dialogue and arguments have pulled the discussion away from the original question of whether the content of Consensus Model addresses the needs in practice today.

Chair E. Keels and L. Emrich summarized the discussions from the April 23, 2018, meeting with OHA/OONE. They reported that OONE members stated there are an inadequate number of acute care graduate programs to meet the demand for acute care CNPs; hospitals want to hire acute care CNPs, but there are not enough to meet demand. There was also discussion that the educational model for APRNs is not the same as PAs. Staff referenced an article provided to the Advisory Committee members. OHA/OONE recommended clarifying definitions of "acute care" and having additional guidance documents from the Board to use with the Consensus Model.

Chair E. Keels stated that the OHA/OONE members at the meeting stated that if the same *Momentum* article were published today, there would be fewer concerns because hospitals have a better understanding of the law and realize that the Consensus Model is consistent with law. OHA/OONE members described the *Momentum* article as a "wake up call" that created an opportunity for dialogue with their APRN leadership. Chair E. Keels stated that her experience has been that years ago, hospitals were not clear as to what APRNs could do within their scope of practice. She believes it would be helpful to provide clarification of terms to assist hospitals in their credentialing process, clarification that APRN scope of practice must be consistent with the competencies of national certification and the population focus, and the NONPF competencies.

S. Wright-Esber stated that she disagrees because the concerns are about definitions and not the NONPF competencies. M. Zamudio and S. Wright-Esber stated that the APRN Decision Making Model is sufficient and additional rules are not needed. L. Emrich stated that the Decision Making Model is provided by the Board to assist APRNs to determine whether they may perform a specific activity or procedure; it was not designed as a tool for APRNs to use to determine their scope of practice.

Chair E. Keels stated she believes the Committee is closer to consensus. C. Rinehart stated the concerns began with the Board stating in the *Momentum* article that it was going to take action against anyone who was not practicing in their appropriate place. She stated that hospitals let staff go and stopped hiring. She believes the Board should have taken more appropriate methods to address its practice concerns, such as looking at the APRN workforce, going to the universities and accreditors to discuss that more acute care APRNs are needed, rather than putting out an article telling everyone the Board would take action against them.

L. Klenke said the Board has many things it would look at if there is a question about practice, including the law and rules, national guidelines, records and information, and what the APRN is privileged or credentialed to do within the hospital; this review would be done only in response to a complaint. The Board would determine whether the complaint was valid after a review of the facts. She stated she believes the more significant issue occurs when a new graduate takes an APRN position for which they have not been educated and may not be qualified to accept. The *Momentum* article responded to legitimate questions that nurses presented to the Board.

L. Klenke stated that smaller hospitals have FNPs who are being used within the hospital system. She stated the key is for the Advisory Committee to understand the basic law that is currently in place. It is her opinion that FNP education may not be the right model, but is the closest generalist model there is, and smaller hospitals need CNPs who can provide care to both children and adults.

S. Wright-Esber stated she would provide care to trauma patients when needed and referenced L. Klenke's comment about smaller hospitals using FNPs. S. Wright-Esber stated that as a small rural hospital, she believes L. Klenke's hospital would credential a FNP to address traumatic conditions in the emergency department. L. Klenke responded that FNPs at her

hospital would respond in emergency situations as needed, which is permitted by law, but her hospital would not credential FNPs to provide trauma care because FNPs are not qualified to provide trauma care.

Chair E. Keels stated that a year ago the Committee was charged with making a recommendation to the Board. The options are whether or not to follow the Consensus Model. If we choose not to follow the Consensus Model, there would be a significant number of regulatory decisions that need to be determined. S. Wright-Esber stated that there should be a third option, such as to recommend the adoption of the Consensus Model without adopting any rules. She stated that she is clear as to the Board's position, and she is in agreement with adopting the Consensus Model, but she does not agree with adopting rules to clarify APRN scope of practice.

L. Brooks and L. Emrich discussed the Emergency Department Nurse Practitioner (EDNP) certification that may be completed by a FNP. L. Emrich explained that a FNP is a specific population focus and may practice in emergency departments to provide primary care in the treatment of presenting injuries and illnesses such as lacerations, fevers, etc. The EDNP certification assists the FNP to further "subspecialize" or focus their primary care practice to those types of presenting conditions. L. Brooks stated that as a FNP, she provides that type of care without the EDNP certification. L. Emrich agreed and stated the Board does not require certification for the APRN to subspecialize within their national certification population focus. The Consensus Model states that boards of nursing do not regulate this additional specialization within their national certification. However, the FNP with EDNP certification remains a FNP who does not hold an acute care national certification population focus; this FNP would not be qualified to medically manage a patient presenting to the ED with multi-trauma, flailed chest, amputation, etc.

Christine Williams, OAAPN, attending the meeting in the gallery and asked whether the Advisory Committee had considered OAAPN's document that was submitted by Attorney Jeana Singleton. L. Emrich responded that Ms. Singleton emailed the information yesterday (Sunday), and the email stated that OAAPN representatives would bring the document to today's meeting for members of the Advisory Committee. OAAPN President Jesse McClain, attending the meeting in the gallery, stated he had copies of the document and then distributed them for the Advisory Committee's review. C. Williams informed the Committee that it should be actively eliciting comments and has not done so. Chair E. Keels disagreed, stating the Advisory Committee meeting dates have been published and OAAPN responded by distributing its document today. C. Williams stated the OAAPN document was in response to the Board April 12, 2018 Memorandum, which was not made public until May 9, 2018. Director Houchen clarified that the April 12, 2018 Memorandum was written for the April 18-19, 2018 Board Retreat, and it was made public and posted on the Board website on April 16, 2018. It was provided to the Advisory Committee to keep the members of the Advisory Committee informed of the Board review and discussion.

K. Scordo stated that the OAAPN document was lengthy and suggested the Advisory Committee needed more time to review it. It was noted that the members received the document at about 2:30 p.m. The meeting was scheduled to end at 2:00 p.m., but the members agreed to stay until 3:00 p.m. to try to agree on a recommendation. K. Scordo stated she believed more time was needed to review the document.

From the gallery, OAAPN President Jesse McClain addressed the Advisory Committee stating that the Committee needed to address the document to be fair to OAAPN and the APRNs of

Ohio. The Advisory Committee clarified that the members were not refusing to review the document, but rather wanted more time to review it to have a better discussion.

S. Wright-Esber raised a concern about delaying a recommendation until the June meeting, stating that new members may be appointed to the Committee who may not be informed on the topic. Director Houchen stated that turnover in members is the nature of Committees and Boards and noted that similarly, Board of Nursing members change as issues are being discussed and before decisions are made.

M. Zamudio stated she wanted the Advisory Committee to make a recommendation at this meeting. She moved that the Committee disregard the document from OAAPN, and recognize the Consensus Model and BON guidance, and that the BOB adopt no further rules in clarifying current law.

Chair E. Keels stated that M. Zamudio's motion included multiple motions and suggested that the Committee should consider the first part of the motion, whether the Committee should consider the OAAPN document at this meeting. M. Zamudio agreed to this, and K. Scordo seconded the motion. There were two votes in favor of the motion; the motion failed.

M. Zamudio moved that the Committee recommend recognizing the Consensus Model, including full practice authority, utilization of the Decision Making Model and that no further regulatory action is needed. K. Scordo seconded the motion. Director Houchen clarified that the motion recommends a continuation of the Board's current interpretation of APRN scope of practice. From the gallery OAAPN President McClain called out "bingo, bingo" in agreement. S. Wright-Esber reminded the Committee of the AGO opinion, which states that the Board has the option of adopting rules to clarify scope of practice.

Chair E. Keels stated that for the Advisory Committee to consider the OAAPN document, the Committee would need to table making a recommendation until the June 11 Advisory Committee meeting and asked M. Zamudio and K. Scordo if they would withdraw the motion and second. They agreed.

After discussion, the motion was withdrawn and the Advisory Committee agreed to continue the discussion and make a recommendation at the June 11, 2018 Advisory Committee meeting. Chair Erin Keels reminded members that it would be the Advisory Committee's opportunity to provide a recommendation, or no recommendation, to the Board prior to the July Board meeting,

OARRS Update: Buprenorphine

L. Emrich provided information from Ohio Automated Rx Reporting System (OARRS). If buprenorphine is prescribed for purposes of Medication Assisted Treatment (MAT), it is excluded from the calculation of the morphine equivalent dose (MED) dosage.

Review Proposed NTSB Resolution

Director Houchen reviewed the information about the National Transportation Safety Board (NTSB) recommendations for all states to implement. She explained the recommendations and that the proposed Resolution would complete implementation of both NTSB recommendations. She stated the Board requested that the Advisory Committee review and provide comments regarding the proposed Resolution. Committee members had no questions, comments, or suggestions. Director Houchen stated it would be taken to the Board for adoption.

Legislative Updates

Tom Dilling provided an update on HB 191, the CRNA bill and HB 111, and the anticipated timeline for the bills. He reported that there is language about rapid sequence intubation in bills addressing physician assistants.

T. Dilling asked C. Rinehart to address OAAPN's plan to propose a bill to discontinue the standard care arrangement. C. Rinehart stated OAAPN found a sponsor, Senator Hoagland, and anticipates the bill will be introduced this week.

T. Dilling stated that the Board receives questions whether the Board requires a doctoral degree for APRN national certification and he clarified that APRN licensure requirements do not require a doctoral degree.

Administrative Rules/Interested Party Meeting

Holly Fischer presented draft language related to Rules 4723-9-10 and 4723-9-12, OAC, related to the treatment of chronic/sub-acute pain with opioid analgesics; a draft rule for MAT; proposed revisions to Rules 4723-23-03 and 4723-23-10, OAC, dialysis technicians; and Rule 4723-1-03, OAC, regarding forms/applications. She provided the anticipated timeline for the rule filings and public hearings.

Medical Board Attorney Kim Anderson was present as an interested party and responded to questions about the Medical Board draft rules. The Board is working closely with the Medical Board in drafting of the chronic/sub-acute pain rules and MAT rules.

Comments included:

- In both MAT and chronic/sub-acute pain rules, globally changing "nurse" to APRN when indicated
- In the chronic/sub-acute pain rules, remove "who is a hospice patient"
- In the MAT rule:
 - Recognize the new Addiction Specialist certification for APRNs
 - Discussion regarding use of the word "consult" vs. "confer" vs. "collaborate" in the MAT Rule; H. Fischer discussed that "collaborate" may be confusing due as this carries a distinct legal meaning with respect to APRN collaborative arrangements; C. Williams stated she would prefer that the Nursing Board and Medical Board language be identical. Kim Anderson, Medical Board, indicated she would discuss with Medical Board using word "confer."
 - Consensus among the APRN Committee that for APRNs providing MAT, 8 hours of CE for renewal in addiction/substance abuse be required, which may count towards the hours required for national certification;
 - Discussion regarding buprenorphine dosing quantities/duration; K. Anderson, Medical Board indicated she would bring the comments to the Medical Board.

H. Fischer asked that members of the public who have any comments or questions regarding the Medical Board proposed MAT rules submit those directly to Sallie Debolt, State Medical Board. She clarified that at this point, the Medical Board is focusing on treatment rule language and detoxification language would be addressed at a later time. She indicated that it the Board's version of the MAT treatment portion of the rule would be the subject of rule filings after the Medical Board's rule language was filed.

Future Meetings: Meetings for 2018 are scheduled for June 11 and October 1.

Adjournment: The meeting adjourned at 2:47 p.m.