

BEFORE THE OHIO BOARD OF NURSING

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MEETING OF THE ADVISORY COMMITTEE ON
ADVANCED PRACTICE REGISTERED NURSING

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MEETING

of the Advisory Committee on Advanced Practice Registered Nursing, at the Ohio Board of Nursing, 17 South High Street, Room 660, Columbus, Ohio, called at 10:00 a.m. on Monday, October 1, 2018.

Advanced Practice Registered Nursing Advisory Committee:

- Erin Keels, Chair
- Peter DiPiazza, RN, APRN-CNP, Committee Member
- James Furstein, RN, APRN-CRNA, APRN-CNP, Committee Member
- Christopher Kalinyak, RN, APRN-CNP, Committee Member
- Jody Miniard, RN, APRN-CNP, Committee Member
- Kristine A. Scordo, RN, APRN-CNP, Committee Member
- Sandra Wright-Esber, RN, APRN-CNP, Committee Member
- Ann Marie Konkoly, RN, APRN-CNM, Committee Member

Staff:

- Lisa Emrich, MSN, RN
- Anita DiPasquale, JD
- Chantelle Sunderman, BA

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1 Monday Morning Session,
 2 October 1, 2018.

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4 CHAIR KEELS: So we will go ahead and get
 5 started. Good morning, everyone. Thank you for
 6 being here. My name is Erin Keels. I am a Certified
 7 Nurse Practitioner from Columbus, Ohio and the Chair
 8 of the Advisory Committee on Advanced Practice
 9 Registered Nursing, and we will take a few minutes to
 10 have the members of the committee introduce
 11 themselves.

12 MS. EMRICH: Lisa Emrich, Board Staff.

13 COMMITTEE MEMBER DiPIAZZA: Pete
 14 DiPiazza. I represent the APRNs in Primary Care.

15 COMMITTEE MEMBER SCORDO: Kris Scordo,
 16 Acute Care, COCHA.

17 COMMITTEE MEMBER KALINYAK: Chris
 18 Kalinyak, APRN in practice.

19 COMMITTEE MEMBER KONKOLY: Ann Konkoly,
 20 I'm a Certified Nurse Midwife and representing
 21 midwives.

22 COMMITTEE MEMBER WRIGHT-ESBER: Sandy
 23 Wright-Esber, a Certified Nurse Practitioner. I'm
 24 representing employers.

25 COMMITTEE MEMBER MINIARD: Jody Miniard.

1 I'm a Certified Nurse Practitioner, and I'm here
2 representing faculty/education.

3 COMMITTEE MEMBER FURSTEIN: Jamie
4 Furstein. I'm a Nurse Practitioner, also a Nurse
5 Anesthetist.

6 MS. DiPASQUALE: I'm Anita DiPasquale,
7 also Board Staff.

8 CHAIR KEELS: And I failed to mention
9 that I'm the Board Member appointed to this
10 Committee. I want to take a minute and read the
11 charge of the Committee, that the Committee shall
12 advise the Board regarding the practice and
13 regulation of Advanced Practice Registered Nurses and
14 they make recommendations to the Committee on
15 prescriptive governance.

16 I'd like to note that we have a court
17 reporter for the purpose of the official meeting
18 minutes. I would like to invite everyone who wishes
19 to speak towards the end of this meeting to please
20 sign in. And if there is time at the end of the
21 meeting, somewhere around 1:30 or so, we will be able
22 to have time for public comments.

23 I'd also like to call everyone's
24 attention to the public participation guidelines for
25 conduct during the meeting. The Committee meetings

1 are not set up as an open forum, so that's why we
2 make some time at the end of the meeting for public
3 comments.

4 I'll also ask the members of the
5 Committee to please raise your hand when you wish to
6 to speak. And I'd like again to welcome everybody
7 here that's here live and in person, as well as those
8 who are joining us virtually. This meeting is being
9 taped through a third party.

10 Okay. So the first order of business is,
11 number one, I'd like to welcome our new member Ann
12 Connelly (sic).

13 COMMITTEE MEMBER KONKOLY: Thank you.

14 COMMITTEE MEMBER SCORDO: Connelly or
15 Konkoly?

16 COMMITTEE MEMBER KONKOLY: Konkoly.

17 CHAIR KEELS: Konkoly, so sorry.

18 COMMITTEE MEMBER KONKOLY: That's okay.

19 CHAIR KEELS: Already messed it up.

20 And the first thing is the review of the
21 minutes. In your packet, you have not only the
22 meeting minutes, the members of the Committee but
23 also a letter on behalf of OAAPN about some of the
24 meeting minutes, as well as the response from Holly
25 Fischer, legal counsel for the Board.

1 MS. EMRICH: Was that distributed? Is
2 anyone here for OAAPN? Oh, Jesse, hi, do you have
3 the letter you'd like to distribute? You can --

4 (Inaudible.)

5 MS. EMRICH: To members of the Committee?
6 Okay. Thank you so much. I'll give the court
7 reporter a copy.

8 CHAIR KEELS: For the minutes, OAAPN has
9 distributed the letter that has been provided to the
10 Board.

11 Yes, Sandy.

12 COMMITTEE MEMBER WRIGHT-ESBER: Can I
13 make another request? We didn't get the packet of
14 information for this meeting except a week ago, and
15 I'm requesting again that we could have it at least
16 two weeks in advance because most of us work full
17 time and these are issues that impact the entire
18 state and should be taken seriously and read
19 carefully. So I am again asking that we have at
20 least two or three weeks in advance to have these
21 documents.

22 CHAIR KEELS: Okay. Duly noted.

23 COMMITTEE MEMBER WRIGHT-ESBER: Thank
24 you.

25 CHAIR KEELS: I'll give everybody a

1 minute to read through this.

2 (Pause.)

3 (Inaudible.)

4 COMMITTEE MEMBER SCORDO: I just wanted
5 to know if I heard if it's a response from the Board
6 or not....

7 MS. EMRICH: Right. Since the Board was
8 provided a response from our chief legal counsel
9 that -- with respect to the minutes themselves, they
10 are draft minutes and it is the Advisory Committee's
11 opportunity to review and make any corrections as
12 needed. The minutes, according to Ohio law, are not
13 necessarily a verbatim copy of the conversation but
14 are a summary of the business held and that's it.

15 COMMITTEE MEMBER SCORDO: Okay, thank
16 you.

17 CHAIR KEELS: Maybe a few minutes.
18 Chris, are you done?

19 COMMITTEE MEMBER KALINYAK: Yes.

20 CHAIR KEELS: With that in mind, are
21 there any changes to the minutes?

22 Yes, Sandy.

23 COMMITTEE MEMBER WRIGHT-ESBER: I would
24 like to move that the request that the Ohio Board
25 of -- or OAA can make -- I'm sure they did their due

1 diligence in knowing what their President said, so we
2 can change the minutes to reflect that.

3 CHAIR KEELS: Sandy, I think you have to
4 make the specific request.

5 COMMITTEE MEMBER WRIGHT-ESBER: So I am
6 requesting that from this letter from Jeana
7 Singleton, that the OAAPN request to -- with the
8 comments of Mr. McClain be updated to reflect what's
9 in these -- Do you need me to read them specifically?
10 I will.

11 CHAIR KEELS: I think you need to read
12 them specifically for the minutes.

13 MS. EMRICH: For my purpose, can you
14 refer to the minutes and let me -- let us know what
15 changes you're recommending.

16 COMMITTEE MEMBER MINIARD: Page 3, second
17 paragraph.

18 COMMITTEE MEMBER WRIGHT-ESBER: I think
19 it's Page 3 in the minutes where Mr. McClain is
20 talking.

21 COMMITTEE MEMBER MINIARD: It's about
22 halfway down, "The majority of patients in the
23 hospital are treated with chronic conditions with an
24 occasional acute episode and do not require the care
25 of a Certified Nurse Practitioners that have acute

1 care national certification."

2 COMMITTEE MEMBER WRIGHT-ESBER: So that's
3 his second request, so that's where he says....

4 COMMITTEE MEMBER SCORDO: On the 13th --
5 I think, Sandy, on the 13th line down in that same
6 paragraph, "It is a disservice to patients to
7 restrict APRNs to practice" would then be changed to
8 "I would be doing my patients a tremendous
9 disservice...", I think that's the first one.

10 COMMITTEE MEMBER WRIGHT-ESBER: Yes,
11 thank you.

12 COMMITTEE MEMBER SCORDO: Sure. Okay.

13 COMMITTEE MEMBER WRIGHT-ESBER: "I would
14 be doing my patients a tremendous disservice if I
15 were restricted to what I learned in school," so I'm
16 requesting that that gets changed to that comment.

17 And then the second comment where he says
18 what we see inside the walls of the hospital is
19 99 percent chronic conditions maybe with an acute
20 flare here and there. To expect a strict transition
21 from acute care to non-acute care is rarely ever
22 going to happen." That's for that other comment.

23 COMMITTEE MEMBER MINIARD: Then the
24 third --

25 MS. EMRICH: I'm sorry, what I need is

1 what the actual words written and what you're
2 replacing them with. So forgive me, I just want to
3 make sure I've got them, that's all.

4 COMMITTEE MEMBER WRIGHT-ESBER: I think
5 they reference what was written. They reference what
6 is written in this document, Lisa, if you could refer
7 to what's --

8 MS. EMRICH: I need to work from our
9 minutes, please.

10 COMMITTEE MEMBER MINIARD: So there's
11 three, right, total? So I have them underlined here.

12 MS. EMRICH: Could you read -- yes --

13 COMMITTEE MEMBER MINIARD: The first
14 comment from our minutes, yes, do you want to see
15 what I have?

16 MS. EMRICH: Yeah, then I can just read
17 them, and that would be very helpful for me. Thank
18 you so much. So you're taking the sentence, "It is a
19 disservice to patients to restrict APRNs to practice
20 only what we've learned with regard to their national
21 certification and devalue workshops, other types of
22 training with other methods for continuing
23 education," you are replacing that with what?

24 COMMITTEE MEMBER MINIARD: "I would be
25 doing my patients a tremendous disservice if I were

1 restricted to what I learned in school."

2 MS. EMRICH: Okay.

3 COMMITTEE MEMBER MINIARD: Is that
4 correct?

5 MS. EMRICH: All right. And the other
6 part, "The majority of patients within a hospital are
7 treated for chronic conditions with an occasional
8 acute episode and do not require the care of
9 Certified Nurse Practitioners that have acute care
10 national certification," and you are placing that
11 with?

12 COMMITTEE MEMBER MINIARD: "What we see
13 inside the walls of the hospital is 99 percent
14 chronic conditions maybe with an acute flare here and
15 there. To expect a strict transition from acute care
16 to non-acute care is rarely ever going to happen."

17 MS. EMRICH: Thank you. And then the
18 third one is, "Only 30 states have adopted the
19 consensus model, although more states have adopted
20 full practice authority for APRNs," and then your
21 change is?

22 COMMITTEE MEMBER MINIARD: It should be
23 "Only 30 percent of states have adopted the consensus
24 model, though more states have adopted full practice
25 authority for APRNs."

1 MS. EMRICH: Thank you very, very much
2 for all of that.

3 CHAIR KEELS: Any other recommended
4 changes to the minutes?

5 (No response.)

6 CHAIR KEELS: Do I have a motion to
7 accept the minutes with the suggested revisions?

8 COMMITTEE MEMBER SCORDO: I make a motion
9 to accept them with the accepted changes.

10 CHAIR KEELS: Second?

11 COMMITTEE MEMBER MINIARD: I second.

12 CHAIR KEELS: All in favor?

13 (Thereupon, all members voted
14 affirmatively.)

15 CHAIR KEELS: Thank you very much.
16 Motion passes.

17 All right. Second order of business if I
18 look at my notes here, I wanted to take a few minutes
19 and review what I call old business which isn't
20 really old, but at the end of our last meeting, we
21 had four points that we wanted to have addressed at
22 this meeting.

23 One was the request for information or
24 presentation regarding APRN Primary Care practice in
25 Ohio. And at the suggestion of this Committee, we

1 have spent some time and found Barb Safriet, so she
2 is going to be joining us at 11:00 o'clock on the
3 phone.

4 Second goal was information about how the
5 Board of Nursing uses the consensus model and that a
6 draft guidance document is in development, it's in
7 draft form, not completely ready to be reviewed yet.
8 We anticipate this draft guidance document to be
9 presented as a draft at the November Board meeting
10 and then again here as a draft at our next APRN
11 Advisory Committee. So thank you to Lisa and her
12 staff for working on that.

13 The third request was sort of a summary
14 of how other states are using or implementing the
15 Consensus Model. And in your materials, you received
16 a review of the sort of state of states listing state
17 by state on what their No Practice Act states
18 regarding clinical qualifications and population
19 focus certification, as well as administratively
20 related is the N -- yes, the National Council of
21 State Board of Nursing resolution that at the
22 national meeting there will be at least some dialogue
23 around the Consensus Model and see where that leads,
24 and that was a good development.

25 And then the fourth recommendation was

1 the recommendation to take to the Board to appoint an
2 additional Committee member whose practice is in
3 Primary Care. That recommendation was presented to
4 the Board in July, and it was not accepted.

5 The reasons that it was not accepted are
6 the following: Administrative rules do not require
7 proportional representation by population focus.
8 Neither the Board nor any committees of the Board
9 appoint members based on areas of specialty practice.

10 For example, there are two APRNs now
11 appointed to the Board of Nursing. And if we did it
12 by proportion, there should probably be probably less
13 than one APRN at the Board.

14 Former and current Committee makeup
15 provides adequate representation for Primary Care.
16 For example, seven out of the eight initial or
17 primary Committee members included scopes of practice
18 that included Primary Care. And currently we have
19 six out of eight members whose scope includes Primary
20 Care focus.

21 And then fourth, the continuum within
22 scopes of practice as it relates to clinical
23 competence and qualifications to provide APRN
24 services applies to more than just the primary
25 care/acute care continuum.

1 So, for example, and probably what we
2 will be dealing with a lot as psych mental health
3 grows, is that a continuum of psych mental health
4 services between primary care and into the specialty
5 of psych mental health acute care and sedation
6 services, adult primary care and certified nurse
7 midwifery -- sorry about that -- the neonatal
8 population, the pediatric population and the
9 pediatric adult population, those continuums. Any
10 comments on that? Yes, Sandy.

11 COMMITTEE MEMBER WRIGHT-ESBER: Two
12 things. At the last meeting, I had also requested
13 OAAPN to present to us about the acute care/primary
14 care because they are the largest state organization,
15 so I had specifically asked for them.

16 And I think I named Mr. McClain and Mary
17 Jane Maloney as their legislation person to present
18 to this group because I had been worried that we were
19 hearing only one side of the argument. And I really
20 appreciate that we're bringing in Barb Safriet
21 because that was -- sorry, I'm a little parched --
22 that was the other recommendation I had made.

23 So I would again ask that OAAPN be
24 brought to the table to discuss this. I feel like
25 what we're hearing is only part of the story. So I

1 appreciate the efforts of the Board to bring them on.

2 The second thing is Miss Singleton's
3 letter, I think, refers to the fact that what was
4 brought to the Board of Nursing -- I appreciate the
5 other things you're saying, that is not the standard
6 the Board uses, but I think it was misrepresented.

7 And as I reflect it, I'm really here
8 representing employers, I am a peds NP, I am in
9 primary care for ten hours a week, but the rest of my
10 job is administration. So really I'm not
11 representing peds and NPs in this role; I'm
12 representing employers.

13 So I wonder if that would change the
14 Board's mind if they heard this letter I think
15 reflecting what I feel is very skewed towards acute
16 care. And when we're having this critical discussion
17 about acute care or primary care, about NPs, you
18 know, are we getting a skewed view with having so
19 many acute care people.

20 CHAIR KEELS: Comments?

21 (No response.)

22 CHAIR KEELS: No. I guess as I reflect,
23 again, seven out of eight of the initial members of
24 the Board and six out of eight of the current members
25 of this committee -- I'm sorry, not four -- have

1 areas that overlap into primary care. So I guess I'm
2 not understanding your concern.

3 COMMITTEE MEMBER WRIGHT-ESBER: Well, the
4 overlap, I think when we're saying that six
5 percent -- you know, because of this discussion, I
6 guess it doesn't matter for any of the other issues
7 so far, but because we're talking about something
8 about acute care and having academia, having the
9 Board, like I mentioned before, where I feel people
10 have other issues, it's not a clean slate of why
11 we're bringing this forward, I'm very concerned that
12 those with acute care are skewing the conversation in
13 favor of interpreting the Consensus Model a certain
14 way because this is a matter of interpretation as I
15 keep on saying.

16 The law says I can take care of acute as
17 a primary care provider. Ohio law says I can take
18 care of acute conditions. So we're looking at a
19 Consensus Model that isn't law. It's a model, it is
20 not law. And your interpretation, Lisa, I'll point
21 out in particular, is not my interpretation of what
22 it says. So when we have lots of members here that
23 are acute care, does that skew how we're viewing this
24 in favor of acute care?

25 CHAIR KEELS: Do you feel -- do you still

1 feel that way despite the fact that we -- our
2 conversation, I think we landed on the CMS definition
3 of acute care which is really critical care as sort
4 of that domain of where acute care certified NP
5 practice is? Does that still make you feel weary
6 about that?

7 And that was included in your packet as
8 you all know as well, utilizing the CMS definition,
9 if I could find it real quick. Oh, shoot. Hold,
10 please. It's reflected in the minutes, yes.

11 So where critical care, because this is
12 under acute -- it says critical care services, which
13 is what I think we as this Committee sort of agree
14 to, that that is when we say Acute Care Certified
15 APRN, you're really talking about the critical care
16 practice.

17 And critical care is defined as direct
18 delivery by a physician medical care for a critically
19 ill or critically injured patient, critical illness
20 or injury, acutely impaired one or more vital organs,
21 and that there is a high probability of imminent or
22 life threatening deterioration in the patient's
23 condition.

24 So if we utilize that, which is what I
25 think we agreed to again and reflected in the minutes

1 as the definition of acute care practice, does that
2 still cause you pause?

3 COMMITTEE MEMBER WRIGHT-ESBER: Because
4 this has been a year-and-a-half, two years, almost a
5 two-year discussion, it does give me pause because
6 it's taken us this long to get this far, and there
7 have been shifts in who's at the table.

8 And it was more primary care I guess to
9 begin with, but those people were not reassigned to
10 the Committee, so it does give me pause.

11 CHAIR KEELS: Okay. Any other discussion
12 around the table?

13 (No response.)

14 CHAIR KEELS: So, Sandy, are you making a
15 recommendation?

16 COMMITTEE MEMBER WRIGHT-ESBER: I would
17 like the Board of Nursing to hear my concern that
18 there is overrepresentation of acute care for this
19 issue only.

20 CHAIR KEELS: And you would like that
21 reflected in the minutes?

22 COMMITTEE MEMBER WRIGHT-ESBER: Please.

23 CHAIR KEELS: Okay.

24 COMMITTEE MEMBER WRIGHT-ESBER: And taken
25 to the Board.

1 CHAIR KEELS: Okay. So a recommendation
2 to take that to the Board needs a second, so it needs
3 to be a motion.

4 COMMITTEE MEMBER WRIGHT-ESBER: I move
5 that this is taken to the Board. The concerns in
6 Miss Singleton's note is also my concern, and I would
7 like the Board to reflect on that again, so I move
8 that it's taken to the Board again.

9 CHAIR KEELS: Okay. Is there a second?

10 COMMITTEE MEMBER SCORDO: I don't want to
11 second. I just have a question. I thought this did
12 go to the Board. That's why I'm confused.

13 CHAIR KEELS: It needs a second before we
14 can have a discussion.

15 COMMITTEE MEMBER SCORDO: I'll second it
16 then, but I thought this did go to the Board already,
17 that it was already discussed --

18 CHAIR KEELS: That's correct.

19 COMMITTEE MEMBER SCORDO: -- so I'm not
20 sure why doing this again is going to make a
21 difference. That's why I'm not clear, and I'm
22 asking. I don't know.

23 COMMITTEE MEMBER WRIGHT-ESBER: Because
24 I'm feeling, and as Miss Singleton points out, is I
25 think it was misrepresented, so it sounded like we

1 are mostly primary care. And I am -- I'm not --

2 COMMITTEE MEMBER SCORDO: And Sandy,
3 didn't that get presented at the Board meeting,
4 though, this whole issue? I thought it was.

5 COMMITTEE MEMBER WRIGHT-ESBER: Right,
6 right, but the feeling is that that was
7 misrepresented, the numbers were misrepresented.
8 Like I'm not -- I'm here representing employers.

9 COMMITTEE MEMBER SCORDO: Right, I
10 understand that.

11 COMMITTEE MEMBER MINIARD: Where do the
12 numbers come from? Who determined that it was seven
13 out of eight and six out of eight or --

14 CHAIR KEELS: Just simply looking at
15 their population focus.

16 COMMITTEE MEMBER MINIARD: Okay.

17 COMMITTEE MEMBER WRIGHT-ESBER: So if we
18 look at Erin's population of neonatal, that to me is
19 always acute care. I mean, you can --

20 CHAIR KEELS: Sandy, I will pushback on
21 that.

22 COMMITTEE MEMBER WRIGHT-ESBER: I mean,
23 the nursery --

24 CHAIR KEELS: A very large -- a
25 percentage of babies in the NICU are critically ill.

1 Many of them are acutely and chronically
2 convalescing, so it is across the lifespan. And I
3 have staff -- yeah, sorry, across the levels of
4 acuity and I have staff in well baby nurseries. So
5 it is across that -- that continuum of convalescent
6 care to critical care and in some areas primary care.

7 COMMITTEE MEMBER WRIGHT-ESBER: I might
8 be nitpicking, but since -- would you hire a Peds NP
9 to take care of those chronic --

10 CHAIR KEELS: Yes, I have.

11 COMMITTEE MEMBER WRIGHT-ESBER: NPs in
12 your NICU?

13 CHAIR KEELS: Yes, I have.

14 COMMITTEE MEMBER WRIGHT-ESBER: I have
15 not in our NICU. I have not.

16 CHAIR KEELS: Yeah, I have a -- I have a
17 group of Acute Care PNPs take care of babies in our
18 VT unit that are on ventilators.

19 COMMITTEE MEMBER WRIGHT-ESBER: But
20 that's acute care.

21 CHAIR KEELS: And I have hired a Primary
22 Care PNP to take care of convalescing babies on our
23 floor, yes.

24 COMMITTEE MEMBER WRIGHT-ESBER: So like a
25 step-down which is different than ICU where you only

1 have neonatal.

2 CHAIR KEELS: I can hire into the ICU
3 right now. It's actually an issue of staffing and
4 how to work that with the teams.

5 COMMITTEE MEMBER WRIGHT-ESBER: You'd
6 hire a Peds NP, a Primary Care PNP?

7 CHAIR KEELS: To help with convalescence
8 and discharge of neonates, yeah, I would.

9 COMMITTEE MEMBER WRIGHT-ESBER: Well,
10 that -- and that's not critical care then.

11 CHAIR KEELS: But that's not --
12 (Inaudible.)

13 COMMITTEE MEMBER SCORDO: The issue is --
14 that's not the issue. The issue is going back to the
15 Board. I'm still not clear on why we're going to
16 repeat this back to the Board when it's already been
17 to the Board.

18 CHAIR KEELS: That's correct.

19 COMMITTEE MEMBER SCORDO: I want people
20 to feel comfortable, but I don't understand this
21 duplication and taking up the Board's time if this
22 was already discussed, and apparently it was.

23 COMMITTEE MEMBER WRIGHT-ESBER: I -- I
24 agree with Miss Singleton's letter that I think it
25 was misrepresented.

1 COMMITTEE MEMBER SCORDO: It was
2 misrepresented because of the numbers that were
3 presented?

4 COMMITTEE MEMBER WRIGHT-ESBER: And how
5 they're skewed. Like, I don't -- I think I'm
6 included when I'm the employer representative. I
7 think I'm included in primary care which I think I
8 should be separated out as representing employers
9 which is a different take. I do agree that I can
10 talk --

11 CHAIR KEELS: But then Jody and Chris
12 would then only be here as educators and not as a --

13 COMMITTEE MEMBER SCORDO: Right.

14 COMMITTEE MEMBER MINIARD: Right.

15 COMMITTEE MEMBER WRIGHT-ESBER: And
16 that's their appointment?

17 CHAIR KEELS: Yeah. And you would be a
18 nurse anesthetist, like mental health, and Pete
19 would -- the two of you would be actually primary
20 care.

21 COMMITTEE MEMBER WRIGHT-ESBER: I guess I
22 feel because this has taken us so long to get this
23 far and it has been rather contentious to get this
24 far, that I'm concerned about the distribution.

25 CHAIR KEELS: Okay.

1 COMMITTEE MEMBER WRIGHT-ESBER: That's
2 what I'm saying for this issue.

3 CHAIR KEELS: Okay. And to address those
4 issues was the adoption or at least I think agreement
5 to adopt the CMS critical care definition as well as
6 the guiding document that is in development and we'll
7 be able to review at our next meeting.

8 With that said, Sandy has made a motion
9 and Kris has scored -- Kris has seconded it. So all
10 in favor.

11 MS. EMRICH: One in favor.

12 CHAIR KEELS: Any abstain?

13 COMMITTEE MEMBER KONKOLY: Abstain.

14 CHAIR KEELS: And those that oppose?

15 COMMITTEE MEMBER KONKOLY: I abstain.

16 COMMITTEE MEMBER SCORDO: I abstain.

17 CHAIR KEELS: I mean --

18 COMMITTEE MEMBER SCORDO: I abstain.

19 CHAIR KEELS: Please raise your hand if
20 you abstain.

21 MS. EMRICH: One abstention. Ann.

22 COMMITTEE MEMBER SCORDO: I'll abstain.

23 MS. EMRICH: Two abstentions, okay.

24 CHAIR KEELS: Those opposed?

25 MS. EMRICH: Five opposed.

1 CHAIR KEELS: Thank you, Sandy.

2 MS. EMRICH: Motion fails.

3 COMMITTEE MEMBER SCORDO: Sorry, sorry.

4 COMMITTEE MEMBER WRIGHT-ESBER: No, I
5 appreciate the conversation.

6 CHAIR KEELS: I appreciate it as well.

7 Okay, so that was sort of old business,
8 and this is still semi old, but the second item on
9 our agenda is the acute and primary care
10 conversation. So the recommendation for -- from this
11 Committee, that Ohio continue to follow the Consensus
12 Model was taken to the Board meeting in July and that
13 was reviewed and voted upon and it was accepted.

14 As I alluded to at the National Council
15 of State Boards of Nursing, there has been some
16 discussion among some states that perhaps the model
17 could be relooked at, so there will be some
18 conversation around that and I'll let Lisa handle
19 that.

20 MS. EMRICH: At the meeting, the
21 representatives from the South Dakota Board of
22 Nursing addressed a concern that not all states are
23 interpreting the Consensus Model the same and asked
24 for some dialogue around that because of the way some
25 states are doing it and other states are doing it

1 differently, they are -- they are not addressing it
2 consistently or as it should.

3 So all I can say is that they're -- they
4 agreed to have a forum for some dialogue among the
5 regulators. And then I have no bank for that, and I
6 have no other information about that. You were
7 provided with a copy of the resolution itself, so you
8 can see the way it was drafted. It doesn't mean the
9 Consensus Model is going to be looked at or reviewed
10 or revised. It's really about how states are
11 interpreting the Consensus Model.

12 CHAIR KEELS: Hopefully something good
13 will come out of that.

14 So for purposes of those in attendance
15 today and those that may be new to the conversation,
16 we just put this slide up to just briefly review the
17 model, especially for students that are in our
18 audience that might not be quite as familiar with it
19 or those that are somewhat new to the conversation.

20 This slide is just a picture of what the
21 model sort of entails in that. For APRN practice,
22 there are four roles: The Nurse Anesthetist, the
23 Nurse Midwife, the Clinical Nurse Specialist and the
24 Nurse Practitioner.

25 And those four roles are nationally

1 certified in a population focus which includes family
2 or across the lifespan, adult gerontology, neonatal,
3 pediatrics, women/health gender related or psych
4 mental health.

5 And that within the pediatric and the
6 adult gerontology population focus, there are now two
7 certifications, either primary care or acute care,
8 and that those, both the role and the population
9 focus, are regulated by the individual state
10 typically through the Nurse Practice Act.

11 So when we talk about some of the
12 confusion has been around special -- the word
13 specialty practice and that this Committee agreed
14 that population focus is what some people use
15 especially, the -- right, that the term per the APRN
16 Consensus Model, when they use specialty is
17 additional specialty practice training or
18 certification within your population focus.

19 So, for instance, some primary care PNPs
20 may then specialize in either orthopedics or urology
21 or even neurology and there may be certification
22 exams that you can take within that population focus.

23 MS. EMRICH: In that specialty.

24 CHAIR KEELS: Yes.

25 COMMITTEE MEMBER SCORDO: At the top.

1 CHAIR KEELS: And that specialty is not
2 regulated by the Board, that is not regulated, but
3 the population focus is.

4 I think when I review the state of
5 states, it seemed like the majority of them
6 acknowledged that, that the population focus, as well
7 as the roles were regulated by the states. Not all
8 of them are that clear, but I felt that way.

9 So speaking of the state of the state
10 regulations, any comments on that?

11 (No response.)

12 CHAIR KEELS: Was it helpful? Not
13 helpful?

14 COMMITTEE MEMBER SCORDO: It's a good
15 summary.

16 COMMITTEE MEMBER MINIARD: Yeah, I liked
17 it.

18 CHAIR KEELS: Okay. That took a lot of
19 work, so thank you, Lisa.

20 COMMITTEE MEMBER SCORDO: Yes, thank you.

21 CHAIR KEELS: Comments? Is there more --
22 yes, ma'am.

23 COMMITTEE MEMBER WRIGHT-ESBER: So for
24 the interest of newer members, I know I've been
25 saying this for a while, so, for example, Kris is

1 acute care and she works in outpatient heart and
2 vascular but you just said primary care in those
3 specialties like urology, heart/vascular so this is
4 where the gray areas get so tricky.

5 So Kris is trained and certified in acute
6 care but is in heart and vascular which is an
7 outpatient setting and those patients aren't
8 critical.

9 COMMITTEE MEMBER SCORDO: Can I correct
10 you? It's not that, it's the population, cardiology.
11 So it would be class 3, class 4 heart failures that
12 primary care is not trained in. And I do do
13 hospitals.

14 And there's a lot of acute -- this -- I
15 don't know where this number came from, but at least
16 my experience, and I do also do intensivists in
17 infectious diseases and there are pretty sick people
18 in the hospital setting.

19 Now, we'll see them back in the office,
20 the endocarditis and all the infections that we see,
21 that population, so that there's a variety of
22 individuals. So even in the -- it's not -- as you
23 well know, Sandy, it's not setting specific, it's
24 population specific.

25 So in my cardiology practice, I see

1 the -- you know, the really bad arrhythmias. I'll
2 see the real bad heart failures and things of that
3 nature. Just because it's an outpatient, it's a
4 follow-up from the hospitals, so that it's not -- I
5 don't do -- I mean, I don't do -- yes, we make sure
6 they have their immunizations and stuff, but we've
7 worked with primary care and other NPs and other
8 family physicians in caring for these individuals in
9 concert with one another. I mean, that's -- that's
10 the case.

11 COMMITTEE MEMBER WRIGHT-ESBER: And
12 that's why I want to flip back to family, you know,
13 that when they're seeing something more acute or
14 critical --

15 COMMITTEE MEMBER SCORDO: They usually
16 refer out, the chest pains and the syncopes and
17 whatnot.

18 COMMITTEE MEMBER WRIGHT-ESBER: Well, I'm
19 sure you wouldn't keep a chest pain in your
20 outpatient setting either.

21 COMMITTEE MEMBER SCORDO: They bring them
22 to the hospital and they take care of them there
23 obviously. And I understand what you're saying. I
24 don't --

25 COMMITTEE MEMBER WRIGHT-ESBER: I don't

1 mean to pick on you, but you're a great example.

2 COMMITTEE MEMBER SCORDO: This is
3 definitely not black and white, and that's why we
4 have so many white papers from -- you know, not --
5 the angio guidelines and things along those lines.

6 And that when we go in and we see --
7 we're looking at where are the students doing their
8 practicums; do we have an FNP in a trauma bay? No, I
9 would hope not. Do you have an acute care person in
10 internal medicine? No, they're not supposed to be
11 there, so that -- and I agree, there's a lot of
12 overlap.

13 COMMITTEE MEMBER WRIGHT-ESBER: Do you
14 have in your area, are there Primary Care NPs
15 functioning like you are in outpatient?

16 COMMITTEE MEMBER SCORDO: Well, what
17 happened at Tri-Health is that they recently went
18 to -- now, whether I agree with this or not, they
19 recently went to only acute care there and there's
20 other hospitals that have kind of moved in that
21 direction because we all -- we do know now certain
22 hospitals, and they're not fortunate to have somebody
23 like you, but that the credentialing committees
24 really don't have a good handle on scope of practice.

25 We saw that with the presentation the

1 last time around where unfortunately we had these
2 primary care providers putting in chest tubes of
3 which there was unfortunate consequences. So that we
4 have -- and we have a grant in process now, hopefully
5 we get funding, to look at these credentialing
6 committees.

7 We do know because we did have somebody,
8 but it was a state out west, that did look at all
9 these credentialing boards. 95 percent of them had
10 no clue what are the differences. So to say, oh,
11 yeah, the hospital's going to regulate this,
12 unfortunately that's not the case all over the place.

13 So where I'm at, you need to have acute
14 care, and I know a lot of places are going to this.
15 And it shouldn't just be setting specific because
16 when we transfer these individuals from the Intensive
17 Care Units, they're still complicated individuals and
18 we can comanage. I comanage with a lot of primary
19 care people all the time.

20 COMMITTEE MEMBER WRIGHT-ESBER: Right,
21 but when we talk about the specialties like we just
22 did --

23 COMMITTEE MEMBER SCORDO: Like I said,
24 there's a lot of gray areas, but I think where this
25 whole thing started, and I'm trying to wrap my head

1 around where did all this come from. This has been
2 like this a long time.

3 And I think the issues that were told to
4 me, and some are coming from the site people, I've
5 had a lot of calls and e-mails from psychiatry there,
6 and that's the law case that's going on down in
7 Texas, is that we have primary care managing these
8 extremely complex, more severe psychiatric cases.
9 And you can talk to what you recently heard, but --
10 where was I going with this?

11 So that -- It was I think -- I know, I
12 have quite a few years, I'm sorry. I think where
13 this started was that I think from what I heard, I
14 mean, I don't know, is that you had all of these
15 primary care providers that were taking care of
16 vents, putting in chest tubes and things along those
17 lines, and they're like wait a minute, where is this
18 in your training? And I know because we have a Nurse
19 Practitioner program and we all lecture for one
20 another.

21 So I'm like to me that's really clear.
22 That's really clear that even though it's not setting
23 specific, that usually in these critical areas I
24 don't think that even comes close to being primary
25 care. And I think you would agree with that, but

1 there's a lot of gray areas. I totally agree with
2 you, Sandy.

3 COMMITTEE MEMBER WRIGHT-ESBER: With that
4 argument, then I wouldn't put -- I would put a
5 primary care NPN in heart and vascular. Now,
6 inpatient, if they're ICU, if it's CCU, I would put
7 an Acute Care NP. So your argument is this slippery
8 slope of specialty for taking the specialty issue.

9 Then this is why it's so difficult and
10 this is why I think it's so important that the Board
11 doesn't rule, Lisa even said it was very subtle, but
12 when you were talking about the state boards of
13 nursing, you kind of implied that they were doing it
14 wrong. There was a little statement, I wish we could
15 roll it back, saying your mind is made up where I
16 think our minds shouldn't be made up. It's too gray.

17 COMMITTEE MEMBER SCORDO: I think they
18 said they were interpreting --

19 CHAIR KEELS: Can I pause and let some
20 other folks be heard?

21 COMMITTEE MEMBER WRIGHT-ESBER: Absolutel
22 y.

23 CHAIR KEELS: And also remember that what
24 we heard that practitioners in Ohio do not want
25 additional regulations, which is why we are working

1 on a decision-making guide, to help with these areas
2 of gray that exist between the population foci.
3 Jody, and then Chris, please.

4 COMMITTEE MEMBER MINIARD: So I agree
5 that there are some gray areas, but I think that
6 primary care and family -- I think as an educator
7 going into this, the acute care program isn't solely
8 based on placing chest tubes and lungs.

9 It is very -- most of the education in
10 the acute care program is primary care based. They
11 all -- all population focuses, including neonatal --
12 well, neonatal and pediatrics are a little bit
13 different -- but anybody in the adult population
14 takes the same core classes and even further classes
15 beyond that in clinical management, differential
16 diagnosis, health assessment, pathophysiology,
17 pharmacology.

18 So in most programs across the country,
19 there's this core primary care base and then there is
20 an additional population focused course. At the
21 University of Cincinnati, that course is called Acute
22 Care Topic. And it is two classes based on critical
23 care, trauma, vents, intubation.

24 Then in the Family Nurse Practitioner
25 program, there's women's health, there's pediatrics,

1 there's some other population focused courses, but
2 the main courses that all of the students take are
3 primary care based.

4 I teach pathophysiology and I don't teach
5 any critical care medicine in that course.
6 Everything I teach is primary care, chronic. So I
7 don't want to get lost in the acute versus chronic
8 because I think that it all comes down to how you're
9 educated more than it is setting specific.

10 CHAIR KEELS: Thank you.

11 COMMITTEE MEMBER MINIARD: And the acute
12 care, all of the statements, and we said this before
13 because you said this, is very true, that the
14 statement is not that acute care is just critical
15 care. It is acute and chronic; whereas, the
16 statement for Family Nurse Practitioners and primary
17 care is chronic.

18 Now, I interpret that as acute meaning
19 critical is decompensating patients, but it says
20 nowhere in that statement on population focus for
21 acute care does it say that they cannot care for a
22 chronic condition which is what you're getting in the
23 outpatient.

24 COMMITTEE MEMBER SCORDO: Yes, exactly.

25 CHAIR KEELS: Chris.

1 COMMITTEE MEMBER KALINYAK: Thank you.
2 When I first started out as a Clinical Nurse
3 Specialist in psych mental health, I was board
4 certified through ACC. Then I became board certified
5 as an Adult Nurse Practitioner in psych mental
6 health, then lastly being certified as a Family Nurse
7 Practitioner in psych mental health, all through the
8 ACC.

9 Since that time, you don't see anymore
10 certification exams for the CNS or the ANP now. It's
11 all FNP now. So my question is, not all the schools
12 are teaching the students psych FNP in the CNS
13 programs or ANP programs. Why is it that the ANCC
14 still recognizes and provides certification for Acute
15 Care Nurse Practitioner when they could have just
16 dissolved that when they dissolved two of my three
17 certifications if there wasn't such an important
18 differentiation between the two practices, not --

19 COMMITTEE MEMBER SCORDO: But you have
20 gotten recertification. You have psych mental health
21 certification, right?

22 COMMITTEE MEMBER KALINYAK: Okay, CNS,
23 ANP, FNP, okay, Family Nurse Practitioner psych
24 mental health, Adult Nurse Practitioner psych mental
25 health and Clinical Nurse Specialist psych mental

1 health.

2 The ANCC, as far as for prescriptive
3 practices, CNS's can only prescribe for ages 18 on
4 up. For adults and peds, it's from age 13 on up.
5 And FNPs can see the entire range. That's how
6 specific it was.

7 And there was a point -- because I would
8 call the Ohio Board of Nursing and say, "Who can I
9 see" when I was a CNS. They said, "Well, check with
10 ANCC." ANCC would turn around and say Ohio should
11 decide on their own. Then when I got my ANP, before
12 I got out at the same time, then I realized it was
13 from the age of 13 on up, and this is old ANCC
14 certifications and prescriptive authority. Now, as
15 an ANP, I can see from age whatever.

16 COMMITTEE MEMBER WRIGHT-ESBER: From a
17 year and a half....

18 COMMITTEE MEMBER SCORDO: Cradle to...
19 what is it? Cradle to grave.

20 COMMITTEE MEMBER KALINYAK: So all I'm
21 asking is why is that the ANCC is still certifying
22 Acute Nurse Practitioners if there wasn't such a huge
23 discrepancy between the two professions. And why is
24 it that the schools with psych mental health all of a
25 sudden they abolish this?

1 You will not find another CNS or ACNP
2 program at the end. You can still maintain your
3 certification, but if you miss out, then you're done.
4 But then these schools have programs specific to
5 Acute Care Nurse Practitioners and family and peds,
6 so I don't know what the gray area is, I really
7 don't.

8 COMMITTEE MEMBER WRIGHT-ESBER: I'm lost.

9 COMMITTEE MEMBER MINIARD: I think he's
10 being supportive. What I'm hearing is, there's
11 obviously a difference in the education, and I think
12 in mental health, my opinion and not being a mental
13 health provider but being in the education system and
14 the guy that runs the program sits right next to me,
15 is there's a crisis for providers in that, so it was
16 better to train everyone to be across the life span.

17 And not all Acute Care NPs can provide
18 care from 13 and up. You have to have an AG ACNP
19 certification which I do not. I can't provide care
20 to anyone under the age of 18.

21 COMMITTEE MEMBER KALINYAK: So I just
22 don't understand why there's a gray area.

23 COMMITTEE MEMBER SCORDO: Why a CNP
24 certification? I mean, we have psych and we have
25 peds.

1 CHAIR KEELS: Sandy had her hand up next.
2 I'll remind you, one, to raise your hand.

3 COMMITTEE MEMBER MINIARD: Oh, I'm sorry.

4 COMMITTEE MEMBER SCORDO: I'm sorry.

5 CHAIR KEELS: And speak loudly so that
6 our court reporter can record it.

7 COMMITTEE MEMBER WRIGHT-ESBER: Sure.
8 I'm loud enough. Chris makes a great point about the
9 fluidity of programs and how the needs change and why
10 the Board wouldn't want to rule on something as fluid
11 as this because things do change and because these
12 gray areas that AANC and others have not spelled out
13 correctly.

14 You know, nursing is just this hodgepodge
15 put together, unlike the PAs, right, where it's just
16 easier and more cut and dry to hire a PA because they
17 can see any age and there's none of this business
18 going on where uh-oh -- and I've said this in my
19 organization, I don't want you to hire an acute care,
20 I'm not sure, it's too gray or vice versa, it's too
21 gray. I've said that on many hires.

22 And a great candidate may be with great
23 background but I don't -- because our Board of
24 Nursing is still formulating this, I think, you have
25 to be too cautious in Ohio, where other states, we're

1 not seeing that.

2 CHAIR KEELS: I think if I may make a
3 comment, I think that these are great examples of how
4 and what we need to keep in mind as we develop that
5 decision-making guide.

6 When these types of questions come up,
7 how will someone go to this decision-making guide and
8 figure out the answer, how does it address the
9 fluidity because I read a lot of Professor Safriet's
10 work, and it is anticipated that our profession will
11 continue to evolve with new evidence, new science,
12 new technology that then the core within that
13 population focus will evolve as well. So how do we
14 maintain that?

15 And I do caution us to compare ourselves
16 to PAs, Physician Assistants, because remember that
17 they are in a supervisory role and their license is
18 tied to a physician which does make scope of practice
19 easier when talking with that, but we have an
20 independent license and want to work through full
21 practice authority. Even so... Chris.

22 COMMITTEE MEMBER KALINYAK: As far as
23 certifications for PAs, I don't know -- Physician
24 Assistants, whether they have various certification
25 groups for acute care or Family Nurse Practitioner

1 or --

2 COMMITTEE MEMBER SCORDO: They can
3 specialize.

4 COMMITTEE MEMBER KALINYAK: Okay. So the
5 specialization for psych mental health is 1,500 CEUs,
6 where a PA could get all that's required, they have
7 no educational training, just the CEUs. So would you
8 rather go to a PA with 1,500 CEUs versus a trained
9 Acute Care Nurse Practitioner, a trained Primary Care
10 Nurse Practitioner or a Psych Mental? 1,500 CEUs
11 define their specialty.

12 CHAIR KEELS: Sandy's hand went right up.

13 COMMITTEE MEMBER WRIGHT-ESBER: Yeah, I'm
14 not a fan of that. I'm just saying as an employer
15 when we look at the employer model, I hear a
16 physician saying, "It's just easier to hire a PA, I
17 don't have to worry about that issue."

18 COMMITTEE MEMBER KALINYAK: That's always
19 been the case.

20 CHAIR KEELS: Jody's hand went up.

21 COMMITTEE MEMBER KALINYAK: Sorry.

22 COMMITTEE MEMBER MINIARD: Well, I mean,
23 isn't that why we're here?

24 CHAIR KEELS: Yes.

25 COMMITTEE MEMBER MINIARD: I mean, we

1 obviously have some issues and definition problems.

2 CHAIR KEELS: And how we clarify our
3 roles and population to employers and how we make the
4 case that the care that APRNs provide is exceptional
5 and what those differences are. But it's going to
6 become very, very, very important to us in the coming
7 months. Sandy?

8 COMMITTEE MEMBER WRIGHT-ESBER: Because I
9 think we're getting close to Barb Safriet speaking, I
10 wondered -- well, two things, I wondered -- maybe
11 just one, I wondered if I needed to make a motion to
12 have OAAPN come here to present about the acute care.

13 CHAIR KEELS: I felt like that was a
14 topic. I don't feel like that needed a motion. I
15 felt like that was a topic.

16 MS. EMRICH: Similar to your request for
17 Barb Safriet, we can have so many in one day, and
18 Barb was readily available today.

19 COMMITTEE MEMBER WRIGHT-ESBER: Well, I
20 do have a second thing, I guess. I'm worried about
21 the public comments being at the end of the meeting
22 and then we don't meet again for months. So I
23 wondered if instead of -- knowing some people don't
24 come until the afternoon, too, I wondered if we could
25 maybe have comments after Barb's call on the acute

1 care/primary care issue and then comments again at
2 the end because I think it helps inform this
3 Committee.

4 Some on the Committee don't talk to as
5 many APRNs as I do. I talk to 250 APRNs and 50 PAs
6 across the organization, so I feel like I understand
7 a lot of what they're saying at least in my
8 organization. So I wondered if we needed public
9 comments sooner to inform this group.

10 CHAIR KEELS: That would be up to the
11 Committee. We have a lot --

12 COMMITTEE MEMBER SCORDO: I'm fine with
13 that.

14 CHAIR KEELS: I want to make sure we have
15 time to get to everything.

16 COMMITTEE MEMBER SCORDO: Just as far as
17 recommendations go, I think a perfect person to speak
18 to this group particularly with all the legal
19 ramifications is Carolyn Buppert who we know is an
20 NP, she's well known. She's a lawyer.

21 She represents a lot of these NP cases
22 already so that -- and I think most of us have heard
23 her speak, use her books and things because she's
24 well known throughout the United States. So if we
25 wanted to get some additional help really from a

1 legal standpoint, Carolyn would be really a good
2 person to have and to talk to this group.

3 CHAIR KEELS: We could put that on the
4 topics. Okay.

5 COMMITTEE MEMBER SCORDO: While we're on
6 the topic. Thank you.

7 CHAIR KEELS: Sure, sure. So Sandy's
8 suggestion to move public comments after Barb's,
9 although we're going to break for lunch at that
10 point, so do we have -- if we do have public comment
11 after lunch, we would need to stick to a fairly
12 strict timeline so that we could get through all of
13 our business.

14 COMMITTEE MEMBER DiPIAZZA: Could we do
15 that as far as our future meetings so that the agenda
16 can be worked differently? I think it would be
17 helpful to have comments at multiple times, but given
18 that we haven't spoken about some of the newer
19 information, I'd like to make sure we get through
20 that.

21 COMMITTEE MEMBER MINIARD: Yes.

22 COMMITTEE MEMBER WRIGHT-ESBER: I would
23 love to see comments maybe by the morning session and
24 the afternoon session. That gives the public an
25 opportunity to weigh in, so, again, because we don't

1 meet frequently, are you remembering all these
2 comments, you know.

3 CHAIR KEELS: Okay.

4 COMMITTEE MEMBER WRIGHT-ESBER: That
5 would be my suggestion.

6 CHAIR KEELS: We'll just have to be
7 really specific with the time management and get
8 through the business and not keep you here until 4:00
9 p.m.

10 COMMITTEE MEMBER WRIGHT-ESBER: Yes,
11 thank you.

12 CHAIR KEELS: I just got vaporized by
13 Chris. So do I hear that after lunch we'll take,
14 what, 20 minutes for public comment from 12:30 to
15 12:50? Is that okay with everyone?

16 COMMITTEE MEMBER KONKOLY: And then again
17 from 1:30 to 1:50, 40 minutes later?

18 CHAIR KEELS: If there's time at the end.

19 COMMITTEE MEMBER KONKOLY: Okay. So
20 we're proposing to just shift it up?

21 CHAIR KEELS: I believe so, yes.

22 COMMITTEE MEMBER KONKOLY: And then for
23 all those people who are coming for the afternoon,
24 what do we say to them?

25 COMMITTEE MEMBER WRIGHT-ESBER: We'll

1 just say sometime after 12:00 just in case --

2 CHAIR KEELS: So in future meetings, you
3 would like to have a.m. and then afternoon comments
4 for discreet amounts of time? We can do that.

5 COMMITTEE MEMBER WRIGHT-ESBER: And this
6 afternoon, too, as much as I would like to give --
7 because I know some people don't come until the
8 afternoon, and I want to make sure that they have
9 time to weigh in as well.

10 COMMITTEE MEMBER MINIARD: Since the
11 agenda is already there, they're coming at 1:30 to
12 make a comment so we should allow them that
13 opportunity.

14 COMMITTEE MEMBER WRIGHT-ESBER: Yes.

15 CHAIR KEELS: Okay. Then we will have to
16 make sure we get through all the information. So
17 next up is Professor Safriet, and we're going to get
18 her on the phone. Thanks everyone.

19 (Phone dialing.)

20 MS. SAFRIET: Hello.

21 MS. EMRICH: Hello, Barb. This is Lisa
22 Emrich with the Board of Nursing in Ohio.

23 MS. SAFRIET: How are you?

24 MS. EMRICH: I am well. Thank you again.
25 We're here in the Board of Nursing Advisory Committee

1 on Advanced Practice Registered Nursing. And I'm
2 going to introduce you to our Chair, Erin Keels, and
3 she will make the formal introductions here.

4 MS. SAFRIET: Okay.

5 CHAIR KEELS: Good morning, Professor
6 Safriet. Thank you. Welcome and thank you so much
7 for joining us at the Ohio Board of Nursing APRN
8 Advisory Committee. I'm the Chair, Erin Keels. I'm
9 a Certified Nurse Practitioner and a member of the
10 Board. I will ask the Committee to briefly introduce
11 themselves starting with Pete.

12 COMMITTEE MEMBER DiPIAZZA: Sure. So I'm
13 Pete DiPiazza, I'm an FNP.

14 COMMITTEE MEMBER SCORDO: Kris Scordo,
15 acute care.

16 COMMITTEE MEMBER KALINYAK: Chris
17 Kalinyak, Psych and Peds ANP.

18 COMMITTEE MEMBER KONKOLY: Ann Konkoly,
19 Certified Nurse Midwife.

20 COMMITTEE MEMBER WRIGHT-ESBER: Sandy
21 Wright-Esber, I'm a Nurse Practitioner and I'm the
22 Director of Advanced Practice Nursing at the Metro
23 Health System in Cleveland, Ohio.

24 COMMITTEE MEMBER MINIARD: Jody Miniard,
25 I'm an Acute Care Nurse Practitioner and I am

1 representing educators.

2 COMMITTEE MEMBER FURSTEIN: Jamie
3 Furstein. I'm a Nurse Anesthetist, as well as a
4 Nurse Practitioner.

5 CHAIR KEELS: Thank you.

6 Professor Safriet, an extensive biography
7 has been provided to the members of the Committee, so
8 in the interest of time, I won't read it aloud;
9 however, Professor Safriet has worked extensively in
10 the area of legal authority of various healthcare
11 professions.

12 A few questions have been previously
13 submitted to Professor Safriet, so I'll turn it over
14 to her, and again, thank you for joining us.

15 MS. SAFRIET: Well, thank you. I'd
16 rather be there in person, but I couldn't meet my
17 class this afternoon if I did that, so thank you for
18 the invitation to contribute to your ongoing
19 discussion of national certification and the
20 Consensus Model and more specifically the application
21 to Advanced Practice Nursing regulations at the state
22 level.

23 And also let me take a note or time to
24 thank your program manager Lisa and your Board
25 attorney Anita for taking the time last week to

1 review the agenda with me and answer any questions I
2 had. And let me also just note I may sniffle and
3 sneeze because I have a cold, so pardon me if I do
4 that. And if I mute my phone, I cut it off.

5 First let me ask, and I would do this if
6 I were there in person, so I'll do it electronically,
7 if any members of the Committee have any questions
8 about my CV or experience?

9 MS. EMRICH: I see heads shaking no.

10 CHAIR KEELS: You're supposed to be able
11 to see that.

12 MS. SAFRIET: I should note that I am
13 speaking as an individual, not for any organization.
14 And I've researched the regulation of healthcare
15 providers, including Advanced Practice Nurses, for
16 over 40 years as a legal academic both because this,
17 you know, this whole topic is, this issue melds my
18 ongoing academic interests in health foreign policy
19 and administrative law with my belief instilled while
20 growing up in eastern Kentucky that the first goal of
21 any governmental action should be to serve the
22 public.

23 In this regard, I recognize that access
24 to healthcare has a dramatic effect on the public
25 everyday lives and future prospects. So that's why I

1 am interested in this.

2 As I understand it, a good deal of your
3 focus has been on Advance Practice Nurses national
4 certification in primary or acute care, and more
5 specifically whether or not a nationally certified
6 Nurse Practitioner in family practice or another area
7 but not nationally certified in acute care can and
8 should be authorized to provide care for acute,
9 urgent and emergent Ohio patient needed services
10 across a variety of cities.

11 I think this is an extremely important
12 and difficult issue, as you no doubt found out,
13 affecting both the public's reliable access to
14 competent care as well as the continued development
15 and deployment of a vital provider profession, in
16 this instance Nurse Practitioners.

17 So let me begin with the questions I was
18 asked to respond to or comment on, and let me know --
19 I was asked to comment on health policy, not specific
20 statutes and rules. As I said last year when I
21 submitted comments requested by the Ohio Attorney
22 General's Office on an advisory opinion on this
23 topic, there are many more on-the-ground experts on
24 Ohio laws and regulatory norms and political dynamics
25 and factors than me. I have a hard enough time

1 keeping up with Oregon.

2 So as for the first question concerning
3 the Consensus Model, I appreciate the correction
4 which explained that I did not have any formal role
5 in the model development, and I wasn't running from
6 that, I just wanted to be factually accurate.

7 I did and continue to know and respect
8 many people who were directly and continuously
9 involved in the model's evolution. And my strong
10 perception and deep belief is that it was developed
11 and promoted by truly publicly and professional
12 altruistic clinical educators, clinicians and
13 administrators.

14 And I know based on discussions with
15 many of those people that one of the underlying
16 concerns was the proliferation at that point of Nurse
17 Practitioner academic programs which weren't in my
18 words, not theirs, up to snuff. And it was also
19 intended to streamline Advanced Practice Nurse's
20 education and career pathway.

21 And in this regard, I think
22 standardization has important value especially for
23 educational and licensure purposes especially given
24 the reality that we have national educational
25 accreditation standards and national licensure and

1 certification exams, but the implementation
2 regulation of Advanced Practice Nurses and other
3 health care providers is dependent upon state based
4 licensure and regulations.

5 However, as everyone knows, the devil is
6 in the details. And often in this particular area
7 you all have been exploring, I think the details have
8 been influenced by and embedded in a variety of
9 interpretations of the consensus model which elevate
10 two forms of qualification metrics: Formal education
11 and population based certification over another
12 filter which is competence base -- a competence-based
13 metric, and that includes demonstrated additional
14 education and training and clinical experience.

15 So while I don't question the original
16 impetus for the development of the Consensus Model, I
17 do question its current interpretation and
18 implementation in the service of the public, and
19 secondarily, which is always a concern of mine but
20 it's only secondarily, to the Nurse Practitioner or
21 Advanced Practice Nurse profession.

22 So let me comment on some specific
23 Consensus Model issues. Excuse me. I think I need a
24 Nurse Practitioner.

25 COMMITTEE MEMBER WRIGHT-ESBER: Acute

1 care or primary care?

2 MS. SAFRIET: Well, I don't know. I'm
3 going to use the term which I've used before and I
4 don't mean it to be pejorative but rather
5 descriptive, and that is by slicing and dicing
6 Advanced Practice Nurses' scopes of practice and
7 licensure by population based national formal
8 education and certification, it's problematic.

9 The Consensus Model, in my view, which is
10 not as old as I am but it's been around a while, has
11 not followed, for example, the more recent peer
12 review studies, for example, that show that the vast
13 majority of patients who show up in emergency
14 departments which many would surely designate as an
15 acute setting, do not need emergent or urgent care.
16 Rather, they present with primary care issues.

17 Yes, they -- and, in fact, all ages and
18 how this population would be defined, I don't know if
19 we're based in a population based structure, the ages
20 are across the life spectrum from newborn, pediatric,
21 adolescent, adults, elderly, whatever else.

22 And the most common conditions that would
23 be seen in an emergency room would not be categorized
24 as acute at all: Earaches, coughs, ticks, lice,
25 chest congestion like me, asthma, high blood

1 pressure, sprains, nausea, rashes and sadly
2 increasingly mental illness and alcohol abuse.

3 And just as what some might consider to
4 be an outlier in this, quote, acute setting is a
5 significant portion of ER patients across the country
6 each year are there for relief from dental pain which
7 I don't think is taught very often in any population
8 based program.

9 Yes, there are heart attacks, atrial fib,
10 car wrecks, traumatic heart injuries, strokes and the
11 rest, but when these conditions are presented,
12 they're presented in a context in which physicians
13 and others are available to deal with them. And
14 hospitals regularly review and credentialed
15 appropriately experienced Nurse Practitioners, and
16 yes, let's be honest, Registered Nurses who I value,
17 to deal with the presenting issues and include others
18 as needed for proper patient care.

19 There are many well verified, competent
20 Family and Primary Care Nurse Practitioners who have
21 been and are working in acute care settings including
22 the ER, ICUs, NICUs, CCUs, all the rest, for years.
23 All have been regularly credentialed by their
24 institutional employers as to their abilities for a
25 variety of reasons.

1 One, the institution has both an ethical
2 and a legal obligation to review and approve all the
3 credentials of the people it employs. Secondly, it
4 concerns about legal liability, but even as a lawyer,
5 more appropriately a law professor, I don't want
6 legal liability to be the tail that wags the dog.

7 And here in this case, an institutional
8 setting, the dog is the ethical and legal obligation
9 responsibility of an institution to make sure as best
10 they can that the people it employs, especially on an
11 ongoing basis, are capable of doing what they are
12 asked to do.

13 And sadly for me over the last three
14 years, I've heard from several Nurse Practitioners in
15 various states that despite their continual
16 positively assessed experience and performance, they
17 are being fired or discharged because they don't have
18 national certification in acute care by a national
19 certification body. I don't know what that noise is.

20 COMMITTEE MEMBER WRIGHT-ESBER: Sorry.

21 MS. SAFRIET: Maybe it's the AMA. But
22 they're being fired because of this lack of national
23 certification of acute care population focusing even
24 though they're experienced, they're qualified and the
25 rest, and they view this as resulting from either

1 directives from or confusion created by state boards
2 of nursing's interpretations and application of the
3 Consensus Model vis-a-vis this population foci.

4 So my comments on this, these
5 developments are the Consensus Model while surely
6 initially well intended, it's a bit outdated and it's
7 interpreted by a variety of academics, educational
8 departments and national organizations and some
9 boards of nursing.

10 It is, rather than streamlining and
11 promoting the public's access to qualified Nurse
12 Practitioners and other Advanced Practitioners, it's
13 become an impediment to the public's access to safe
14 and effective care.

15 And I should note something which I'm
16 sure your aware of, which is the Consensus Model is
17 not a governmentally enacted law. Rather it's a
18 recommendation by a private organization of licensure
19 boards which strive to promote consistencies and
20 propose model practices between and among state
21 licensing board members and their executive
22 directors. So it has no direct legal effect unless
23 it's included in the state's statute or agency
24 regulation.

25 And I'm not picking on the Consensus

1 Model and holding it out as unique. Rather, there
2 are counterparts to this across all the professions,
3 the Federation of State Boards of Physical Therapy,
4 the Federation of State Medical Boards, Optometry,
5 Occupational Therapy, Veterinary Medicine.

6 They propose model acts, but it's just
7 that, a proposed model. And it depends upon official
8 state action at some level, either by the legislature
9 or an appropriate administrative agency like a Board
10 of Nursing or others to implement all or part of its
11 board's modified whatever else.

12 Further, some of my problems with the
13 Consensus Model currently is boards and others have
14 conflated population foci with specialties, and they
15 use those terms interchangeably, and I don't think
16 that's appropriate, especially for certification and
17 licensure purposes.

18 There are other issues with the
19 Consensus Model, for example, what is acute care.
20 And I know the Consensus Model says that care is not
21 said in specific but it also is not very expansive or
22 detailed in determining what is acute and what is
23 primary, and actually I think that's good.

24 I would rather have regulation be more
25 general and still effective than more specific

1 because there's always something new that's happening
2 that doesn't fit within the specifics, but the whole
3 question of what is primary, what is acute is a real
4 issue.

5 And does it, for example, mean that a
6 well experienced, competent Nurse Practitioner who's
7 certified in acute care could not work effectively in
8 an urgent care clinic or a convenient care clinic or
9 a nursing home? I don't know. But these are some of
10 the problems I have with the model.

11 And it also has not, in my view -- I
12 think it strives but it doesn't accommodate ever
13 evolving know how and experience across the
14 population.

15 I know we now have a new
16 certification -- professional association and
17 certification exam for Emergency Department Nurse
18 Practitioners, and that's fabulous, but that didn't
19 exist five or six years ago. And there are lots of
20 questions about who should be able to sit for those
21 kind of -- that kind of certification and licensure.
22 And there are other evolving areas.

23 And more specifically as to Ohio's laws,
24 I have them all here spread across my desk, there are
25 lots of references to the value of clinical

1 experience, in fact, some required for educational
2 purposes throughout. But the thing is, somehow when
3 it gets to whether or not primary care certified
4 nurses, Family Practice Nurses, for example, are
5 qualified to work in the emergency department or an
6 ICU or in a hospital generally, somehow the value of
7 clinical experience is abandoned. It's all what you
8 did originally, not what you've learned in the last
9 15 years and been demonstrated to be able to do. So
10 that's kind of my view on the Consensus Model.

11 As to the second question saying --
12 we're faced with two questions, should we continue to
13 follow the Consensus Model or should we decide to no
14 longer follow the Consensus Model and what would that
15 mean, just let me right off the bat say there are
16 other options.

17 One, which I won't go into, but one,
18 just, for example, is you could -- the Board and
19 others in regulating could follow scope of practice
20 statements by national professional organizations
21 and/or accrediting agents.

22 So I'll just throw that third one in to
23 the mix, but let me go back and say as to these two
24 questions, these two options, there are few scenarios
25 in life with only two options. We always think heads

1 or tails, but you need to remember that a coin has
2 three dimensions: Heads, tails and then edge. And
3 it's the edge which holds it all together. So it's
4 seldom either this or that.

5 So I won't recommend one or the other of
6 the proposed options but rather offer the following
7 consistent with what I was asked to do which is look
8 at it from a policy approach. In regulating,
9 especially restricting various provisions of needed
10 services, the government, both the legislature, the
11 executive and the agencies, in my view, should
12 implement the least restrictive requirements
13 available to achieve and address a demonstrated
14 public health and safety need.

15 And there is I'm sure you're familiar
16 with -- I know the debate's been going on in the
17 legislature and the executive in Ohio as well as in
18 other states, Arizona and the rest -- there's a new
19 public awareness that many of our occupational
20 licensure restrictions are basically legacy
21 restrictions and they're outdated and they are
22 unnecessarily restrictive.

23 And I'm all for licensing in the health
24 arena and licensing generally, but I think we need to
25 continually assess is this restriction necessary to

1 meet the demonstrated need for restrictions.

2 So far, and I follow your all's minutes
3 and whatever else for now two or three years, and I
4 have seen no negative health consequences offered as
5 evidence for the need for continuing to what I call
6 slice and dice various options for competent Nurse
7 Practitioners.

8 I see nothing offered by the Hospital
9 Association of Ohio or others that the current and
10 widespread provision of services in acute care or in
11 emergency department settings by experienced Advanced
12 Practice Nurses, and let me add once again or
13 Registered Nurses, has caused.

14 So in the absence of any evidence that
15 I've seen of a need for more restrictive, rigid
16 regulations, I think we need to remember that there
17 are other longstanding quality controls.

18 Professionalism, I hope, of the Nurse
19 Practitioners, knowing what you know, what you don't
20 know, know when to refer and consult and the rest is
21 to me an essential attribute of professionalists.
22 Also, hospitals and other institutions have filters,
23 longstanding ones, to assess periodically --
24 initially and periodically the qualifications, yes,
25 based on education, yes, licensure and additional

1 experience and post graduate education for quality.

2 And they have a built-in, if you want,
3 need and reason to be perhaps more scrutinizing than
4 what graduation from a particular school NP program
5 and passage of a certification exam would indicate
6 because it's person specific while taking in all
7 these other accounts.

8 So I see no need here demonstrating a
9 basis for continuing or even perhaps promoting a
10 rigid delineation of who needs what. Then even so,
11 then let's assume there is a need. You have to go on
12 and say does any proposed regulation and regulatory
13 restriction actually address the demonstrated health
14 and safety need. So, one, you've been assuming
15 there's a need. I don't see that this addresses it.

16 And I saw in some of the minutes that
17 one of the reasons that was offered for the need for
18 this of precluding Primary Care Nurse Practitioners
19 from working in what might be deemed to be an acute
20 care settings, although I don't say, well, I won't go
21 into the ED, it's a liability, a practice beyond your
22 scope.

23 First, that's not a public health and
24 safety issue. It's a secondary issue. Thirdly,
25 practicing beyond your scope applies to every, every

1 health professional in the country. And I don't know
2 of any professional regulation that has been based
3 upon we want to diminish, mitigate the opportunity
4 for a potential liability concern for the
5 professional based on practicing beyond the scope.
6 So I don't -- I kind of searched all around trying to
7 find if there is justification for this.

8 Then once you've said is there a
9 demonstrated need and does this proposal address the
10 need or not, you need to take a further step and in
11 many ways it's not nice, it's not just nursing
12 boards, it's all sorts of licensing boards, they
13 don't take this step which is to say let's weigh and
14 balance the cost and the benefits of this proposed
15 additional restriction as it affects the public's
16 access to needed care.

17 In my research and experience in talking
18 with truly thousands of Nurse Practitioners and
19 Advanced Practice Nurses, any more restrictions on
20 population focused formal education licensure on
21 nationally certified NPs won't serve the public's
22 much needed health services nor the profession.

23 And I honestly believe, and these are
24 all my opinions and I will finish and then you can
25 bombard me with questions, I honestly believe based

1 on 40 years of working with Nurse Practitioners and
2 Advanced Practice Nursing regulation and others, I'm
3 pretty sure that the initial population practice area
4 foci for initial education and certification would be
5 abandoned because no other profession I know of does
6 it.

7 When you go to pharmacy school, you
8 don't say, "Oh, if you're going to practice in a
9 commercial pharmacy, go through this board." "Oh, no
10 if you're going to practice in a retail pharmacy, go
11 and do this Board." "Oh, if you're going to be a
12 research pharmacist, you go in through this door."
13 You go in all the same door and then you begin to
14 focus later.

15 So I understand why this happened, and I
16 know many of our educational, and surely programs are
17 built around it, but if we were starting over, I
18 don't think we'd do it this way. And I truly believe
19 that post NP formal education should be open to
20 specialty education and clinical experience as
21 counting for something for licensure.

22 And let me just finish with what you may
23 think would be a far flown -- that's not exactly what
24 I want to say, a stretch hypothetical, but it's
25 actually not a hypothetical at all based on a recent

1 experience. I find it odd that a freshly minted
2 Emergency Medical Technician was able and authorized,
3 which are two different things, able and authorized
4 to care for me while I was lying on the floor of a
5 gas station near death.

6 Without this freshly minted EMT, who had
7 no initial population based training or education, so
8 treated me as a 71 year old who cared for me and
9 stabilized me and transported me to a hospital ER.

10 Now, once I get to the hospital, under
11 some current interpretations of the ER, under some
12 current interpretations of the Consensus Model and a
13 variety of board rules, I might be deprived of the
14 skill and ability of an experienced Family Nurse
15 Practitioner especially since I was in a rural area
16 of Washington state because he or she wasn't educated
17 30 years ago in a population foci which accommodated
18 me and certified as an Acute Care Nurse Practitioner.

19 Now, that's -- I like -- life, to me,
20 influences my views, and I'm going -- if we continue
21 to slice and dice, put up rigid barriers for people
22 demonstrating what in my view is personal practice
23 should be based first on ability, then we're going to
24 not only continue to fragment the profession which I
25 see happening a huge amount, but we're also denying

1 old codgers like me who nearly croke on I-5 in rural
2 Washington from much needed care. And I think that
3 would be -- well, for me, it would be bad, but I
4 think it's bad for a lot of people involved.

5 So otherwise, my nuptial summary is
6 don't act unless there's a demonstrated need, don't
7 deprive because the need is competent services and
8 don't continue regulatory provisions which result in
9 more rigid status based authorization regardless of
10 demonstrated abilities. It hurts the profession
11 which I care about deeply, but it hurts the public
12 more.

13 So that's all I have to say. How long
14 did that take? I don't know.

15 COMMITTEE MEMBER SCORDO: About 35
16 minutes. That's not bad.

17 MS. SAFRIET: Okay. Yeah, I majored in
18 economics, not math.

19 CHAIR KEELS: Thank you, Professor
20 Safriet. We really appreciate your time. I think
21 people may have some questions. I see Kris Scordo's
22 hand up.

23 COMMITTEE MEMBER SCORDO: Hi. Thank you
24 so very much. The emergency room is definitely a
25 problem. We did ask a lot, I don't know if you were

1 there or not, for them to open up that model because
2 I think ED is a huge issue, but outside of the
3 emergency room dealing with our current educational
4 system, all right, so bear with me, and that's what
5 you didn't bring up was the physicians.

6 I mean, obviously if I'm a family
7 physician and I want to go in and do neurosurgery, A,
8 the hospital's not going to let me, the Medical
9 Board's definitely not going to let me and I would
10 hope my patient would not, but I would have to go
11 back to school. So we do have this specialization.
12 And we have the same thing as you well know in
13 nursing.

14 So dealing with the current system, are
15 you saying that -- and I'll go both ways -- so that
16 an acute care person who has no training in women's
17 health or colposcopies or this, that and the other
18 thing, but Lord knows I happen to be a staff nurse
19 someplace, so I didn't diagnose, I didn't treat, do
20 anything like that, but I'm just going to go in and
21 do these things because you're saying that maybe we
22 don't need that kind of regulation?

23 Or at the other end of the schtick, a
24 primary care person that may have been a staff nurse
25 in the Intensive Care Unit, really didn't diagnose,

1 prescribe and do those things and have the training
2 as the NPs do would then be able to take care of any
3 trauma, sepsis, just name your poison, acute MIs and
4 things of that nature, and I'm talking about now with
5 our current educational system, we really don't have
6 this generalization as we do in undergraduate, is
7 that what I'm hearing you say, that you're
8 comfortable if you were, God forbid, that person in
9 that unit?

10 MS. SAFRIET: Well, first off, I would
11 fall back on most acute care is provided in an
12 institutional setting.

13 COMMITTEE MEMBER SCORDO: I would hope,
14 but maybe at a gas station.

15 MS. SAFRIET: Well, it was fabulous in
16 the gas station, I was saved from a pretty wicked
17 concussion because I took out a huge display of chips
18 and candy, and my head fell on all the Fritos and
19 squashed them.

20 COMMITTEE MEMBER SCORDO: Oh, my word.
21 Good Lord.

22 MS. SAFRIET: So we should add to any
23 kind of educational requirement Fritos, but I'm very
24 appreciative of the two different kind of different
25 spectrum issues, but I'm also pretty confident that

1 in the institutional setting, the acute care person
2 who had never done a colposcopy, and I've had
3 several, or colonoscopy, and I've had those, too,
4 would be allowed to do that. So there are other
5 quality assurance filters.

6 Similarly for a staff nurse who's been a
7 floor nurse, staff nurse for how long in the ICU,
8 wherever, first, one would hope would recognize
9 sepsis or cellulitis unlike my mother's cardiologist
10 failed to do three times.

11 COMMITTEE MEMBER SCORDO: Understandably
12 so.

13 MS. SAFRIET: And first would probably
14 have knowledge, but secondly would be in a setting
15 where there are others around to collaborate with,
16 monitor, take over, all the rest. So I'm -- I can
17 appreciate your hypotheticals and they could be real
18 except I think there are other quality measures in
19 place already that aren't tied to what education was
20 15, 20 years ago.

21 COMMITTEE MEMBER SCORDO: All right. I
22 totally agree with you, but that's the issue. And we
23 did have an incident south of the border here where
24 we had unfortunately, I'm sure this is going to
25 happen to somebody else, but you had people

1 credentialed to do something that was totally out of
2 their scope of practice and there was not such a good
3 outcome.

4 So that we know that in working with the
5 hospital systems, which we've been doing, that
6 they're not real clear on scope areas of practice. I
7 would hope that primary care, acute care, psych, OB
8 and whatnot would practice within their national
9 organization's scopes and standards of practice which
10 you alluded to.

11 And that's really when we look at the
12 APRN Consensus Model, that if I'm acute care, I am
13 going to practice within my scope and standards of
14 practice as such. And believe me, I'm not going to
15 be the one doing anybody's colposcopies, whatever
16 that might be, but thank you very much.

17 MS. SAFRIET: Well, I'll give you a
18 tentative if you ever have to do one.

19 COMMITTEE MEMBER SCORDO: No, that's
20 okay. I have no desire, no training. When you talk
21 about competencies, I'm not sure how you would
22 measure that. And that's another huge issue is, you
23 know, the incompetencies. There's not
24 standardization.

25 MS. SAFRIET: Right, right.

1 CHAIR KEELS: Any other questions for
2 Professor Safriet?

3 Yes, Sandy.

4 COMMITTEE MEMBER WRIGHT-ESBER: Hi,
5 Professor, it's Sandy Esber. I appreciate your
6 information. And you beautifully said what we've
7 been saying for a year-and-a-half, so I really
8 appreciate that recap and so well said.

9 So this Committee, we've been talking
10 about this at every meeting that we've had, and I
11 think we're getting closer to realizing a good
12 solution to this, we have brought up and I have
13 brought up ad nauseam about the whole issue of what
14 does acute care mean, critical care, all those
15 definitions.

16 The gray areas are really what we're
17 talking about when we talk about these things. And I
18 agree with you that competencies, quality,
19 credentialing, all those processes are a separate
20 issue from the Board of Nursing regulating individual
21 clinical practice because the Board isn't there
22 seeing the clinical practice.

23 They're reacting to complaints or
24 whatever happens that would bring it to their
25 attention if someone is practicing out of scope and

1 it came to the Board of Nursing. It is the employers
2 that need to regulate those individuals and
3 individuals knowing their scope of practice is
4 critical.

5 So one of the solutions that we're
6 working on is a stronger decision-making tool. We
7 have a decision-making tool in Ohio for Advanced
8 Practice, and so our Board of Nursing is trying to
9 make it more understandable, I guess, or
10 comprehensive is maybe the right word.

11 Have you seen those types of foundational
12 documents in looking at other boards of nursing? I'm
13 trying to pick your brain for ideas of keeping it
14 broad enough but helpful enough for the APRN in
15 practice to make it really useable but not too
16 restrictive.

17 MS. SAFRIET: I think the decision-making
18 tools, one, that you all have and some others I've
19 seen are very helpful for a variety of reasons. One,
20 it's the Board hopefully in consultation with state
21 and national associations are setting out and it's
22 hard to set out step-by-step-by-step what you should
23 do, so just having to do that I think is very
24 helpful.

25 And for example, we talk in the law all

1 the time about, well, fairness. Well, then you go,
2 well, what's fair? And you have to explain what's
3 going into the question of fairness. So I think
4 specifying things and decision-making tools is
5 helpful. I think it provides guidance to the Board.
6 I think more importantly it provides guidance to the
7 profession and the professionals. And it could be
8 either expanded or approved and be fine.

9 I read through it. I can't see it right
10 here at the moment, but I read through Ohio's
11 Exhibit, and I think one of the issues that it could
12 help anyway is to better explain to the hospitals and
13 institutions how this decision-making model augments
14 and should augment both the professional's scope of
15 work, as well as the hospital's credentials because
16 in some ways, the worst thing -- and I don't think
17 it's intentional -- but the worst thing that I've
18 seen come in the last two or three years is proposals
19 to hint or whatever that only those who are certified
20 in acute care can work in acute care settings.

21 Now, most people wouldn't -- if I were a
22 hospital administrator or surely their Risk Manager,
23 I'm going, "Oh, okay." The last thing I need is a
24 suit brought by somebody. So a lawyer and a risk
25 manager are risk averse.

1 But I think that's where the more
2 education is needed and where the Board and the
3 others to say, "Look, institution, you have your own
4 ethical and legal obligation, and we want to work
5 with you so that when you credential someone
6 initially on an ongoing basis, you're on the same
7 page as the Nurse Practitioner or any Advanced
8 Practice Nurse, CRNAs and all the rest both for her,
9 him, as well as you and surely for the patient."

10 So I think decision-making models have
11 lots of benefits, but confusion and the lack of
12 clarity from boards or whoever else is -- it triggers
13 all the risk managers in the universe to set their
14 hair on fire. And what they will do is take the
15 least risky approach which may not be justified from
16 a health and safety point of view, but you can
17 understand why they do it.

18 And here, I'm not sticking up for
19 attorneys, trust me, but I'm just saying, you know,
20 so I do think a decision-making tool, the
21 decision-making model could, if it can be improved
22 and then distributed to -- I mean, the Board should
23 go make a presentation to the... it starts with an O,
24 Ohio Hospital Association, distribute it and say,
25 "Here's how it's intended to work." I think that

1 would be good for the Nurse Practitioners, it would
2 be good for the hospitals, good for the Board and for
3 the patients as well.

4 CHAIR KEELS: Professor Safriet, thank
5 you so much for joining us. I think we're out of
6 time unless you can hang on for one more question. I
7 don't know if you have to run to a class.

8 MS. SAFRIET: No, that's not until later,
9 but I do want to go back and explain how to do a
10 colposcopy.

11 CHAIR KEELS: Pete has one quick question
12 and then we will need to take a break.

13 MS. SAFRIET: Okay.

14 COMMITTEE MEMBER DiPIAZZA: I just wanted
15 to know if you could shed some light as to why the
16 Consensus Model did not take into account APRN's
17 prior clinical experience as a nurse.

18 MS. SAFRIET: This is my candid view, and
19 often I'm too candid for my own good, but based on as
20 I saw it developing, this was built at a time when
21 there was a movement toward master's (phonetic) and
22 surely doctors and the key seemingly was more formal
23 education as a way to if you want to progress
24 professionally with and have status especially in
25 academic institutions of which I've worked my whole

1 life.

2 So it's also in some ways hard to
3 measure, but how do we go about evaluating competency
4 in the rest. Well, that's a question for the Board.
5 But I honestly think it was an easier way to go in
6 saying here's a marker, education from now, not
7 previous experience.

8 And a part of that was influenced, and
9 I'm not attributing this to anybody except kind of
10 what I know from talking to thousands of faculty
11 members and Nurse Practitioners over the years, of
12 professionalizing, you need markers, you need badges.
13 And a badge of formal education counts more than
14 experience, so -- and that's just my opinion.

15 COMMITTEE MEMBER SCORDO: I haven't been
16 involved with that. You're right, it was the lack of
17 a competency standardization that you would have like
18 with the different accrediting bodies so that's why
19 they went with that education. You're absolutely
20 right, it was in the competencies because there's too
21 much diversity.

22 MS. SAFRIET: Right, right. Because I
23 mean, I said your Nurse Practitioners for years
24 probably starting before even some of you were born,
25 let's not poo poo the Registered Nurse who became a

1 Nurse Practitioner initially through a certification.
2 Who taught you originally?

3 And so I don't like this we get ahead by
4 stacking more levels on others especially if it
5 denigrates what they've done. Some of the best Nurse
6 Practitioners I know and have known for 40 years
7 started out Registered Nurse, floor nurse, staff
8 nurse, and then through a six-month certification
9 program became a Nurse Practitioner and has practiced
10 now for years, has mastered and all the rest now, but
11 covers for the physicians, in this too large rural
12 county in a state I won't name, for physicians, and
13 it's fabulous, so let's not denigrate things. So
14 don't get me started or you'll be here through your
15 lunch hour.

16 CHAIR KEELS: Well, thank you so much for
17 joining us. We really do appreciate your insights
18 and your expertise and your candidness and wish you
19 well, and perhaps we'll hear from you in the future.

20 COMMITTEE MEMBER SCORDO: And feel
21 better.

22 MS. SAFRIET: Thank you. You know where
23 I am if I can help in any way in the future, you know
24 how to reach me.

25 CHAIR KEELS: Thank you.

1 MS. EMRICH: Thank you so much.

2 MS. SAFRIET: Thank you. Bye-bye.

3 CHAIR KEELS: We're going to take a break
4 for lunch. Be back in your seats at 12:30.

5 (At 11:55 a lunch recess was taken until
6 12:30.)

7 CHAIR KEELS: Let's go ahead and get
8 restarted. We have a quorum present. I'm sure they
9 are making their way up. So we have four requests to
10 speak, so thank you very much, and Chantelle is going
11 to be the timekeeper. Each speaker has five minutes
12 to speak, and then we will have to stop straight at
13 5:00 o'clock (sic) so that we can get all four of you
14 in and continue on with the Board meeting.

15 So the first person is Joscelyn Greaves;
16 is that correct? Joscelyn Greaves is affiliated with
17 OAAPN and she wishes to speak about patient access.
18 Welcome, Joscelyn.

19 MS. GREAVES: Hi Erin.

20 CHAIR KEELS: Hi.

21 MS. GREAVES: So actually remarkably I
22 did not talk with Barb, but I did like a lot of what
23 was said, and like Barb, I'm kind of reiterating, so
24 I'm going to do it anyway.

25 Access to patient care. This seems to

1 have been and will continue to be an ongoing issue in
2 the State of Ohio. Our goal as providers,
3 legislators and regulators should be to improve that.
4 However, the attempts to regulate specialty practice
5 will further limit access to adequate care for our
6 patients.

7 Most of these attempts for further
8 regulation stem from critical care and what it is and
9 the concern for patient safety. There has been much
10 discussion regarding critical care and how do we
11 define that, and until today, I was not really sure
12 what that answer was.

13 As Barb had mentioned, data has not
14 proven that there are any concerns for patient safety
15 and other organizations like Ohio Hospital
16 Association, Ohio Association of Nurse Executives are
17 unaware of any either.

18 So then why are we trying to change
19 things from what we are already doing? Why can we
20 not leave the credentialing up to the hospitals? Can
21 we not continue our current roles and allow APRNs to
22 practice with no specialty certification
23 requirements?

24 There has been nothing to prove that it
25 is necessary to provide specialty regulation. We

1 learned at our last Committee meeting that the case
2 that Miss Scordo was talking about was the Nurse
3 Practitioner was not even credentialed to do the
4 chest tube, so it wasn't a credentialing issue.

5 Regulation for APRNs will cause even less
6 supply of adequate healthcare providers in the
7 hospital setting. This will however --

8 COURT REPORTER: Ma'am, could you slow
9 down?

10 MS. GREAVES: I'm sorry. I can give you
11 this when I'm done.

12 COURT REPORTER: Sure, but just slow
13 down.

14 MS. GREAVES: Regulating APRNs will cause
15 even less supply of adequate health care providers in
16 the hospital setting. This will make more demand for
17 acute care NPs, but maybe that is what certain
18 individuals are wanting for themselves or for their
19 programs.

20 Allowing APRNs to continue to practice
21 in their scope and not be over -- Allow APRNs to
22 continue to practice in their scope and not be
23 overregulated by the Board of Nursing. Allow APRNs
24 to continue to follow the current decision making
25 model and maintain documentation for their

1 competencies. This will help to provide access for
2 patients, continue to ensure patient safety and
3 provide APRNs the ability to function to their full
4 potential.

5 Since patient access is an issue, that
6 brings up the lack of primary care providers in our
7 state. Roughly half, or 55 percent, of the patient
8 demand is actually being met by our current provider
9 workforce. This is suspected to worsen in the
10 foreseeable future. APRNs can help to fill that gap,
11 but we are limited by our standard care arrangements.

12 We know that the biggest areas of need
13 are those in rural communities and lower social
14 economic status. In my area in just the last several
15 months, I have had two perfect examples. One is a
16 Nurse Practitioner who worked with a primary care for
17 five years. She found out her physician was getting
18 deployed.

19 Our current law thankfully provides us
20 120 days to find another -- find another
21 collaborator; however, she was unable to do so, so
22 she had to leave her practice. This unfortunately
23 resulted in her patients, along with her physician's
24 patients, to seek care elsewhere.

25 Another example is a local rural

1 community that had two -- a Nurse Practitioner -- two
2 Nurse Practitioners with a physician. The physician
3 was retiring and they were desperately trying to
4 locate a collaborator so they would continue to
5 provide care in that small community. No physician
6 wanted to move there, so they began looking for
7 someone to just sign their standard care in the
8 surrounding area but not have to relocate.

9 This goes to show it's just a piece of
10 paper. These APRNs wanted to continue to care for
11 their patients in their community as they always have
12 but are limited due to their difficulty in finding a
13 physician collaborator.

14 APRNs are trained in primary care. They
15 can function autonomously. Ohio ranks 36 out of 50
16 based on the measures of healthcare access and health
17 quantity. APRNs can help to improve that. OAAPN
18 with Representative Gaverone have recently launched
19 House Bill 726 which I'm sure you guys are talking
20 about in a little bit.

21 This will do just that. It will provide
22 better access to better care to ensure that Ohioans
23 will receive the access of the care that they
24 obviously need and deserve. I'm asking all of you
25 and our listeners to support improving healthcare in

1 practice restrictions. I can't say for sure why this
2 is happening, but I can say that its basis derives
3 more from fear mongering than from scientific
4 evidence.

5 An important article by Bureau House
6 published by the American Enterprise Institute in
7 2018 makes the following points. State level scope
8 of practice restrictions do not help protect the
9 public from sub par care. State level scope of
10 practice restrictions provide no evidence that
11 Medicare beneficiaries receive better quality care.

12 Some organizations have justified their
13 support for state regulations to limit NP scope of
14 practice on the grounds that they are necessary to
15 protect the public from low quality healthcare, but
16 the research found no evidence of this. In fact, his
17 analysis found that states with restrictions utilized
18 more resources and made care more expensive than
19 states without scope restrictions.

20 This summer I lost one of my partners who
21 had been with us over four years. She was a Family
22 NP and a leader in her field of neurology. She cared
23 for my family, including my wife. She was reported
24 by an Acute Care NP for following her patients in the
25 hospital which for a CMS, the emergency department is

1 an outpatient unit.

2 She was exonerated after an
3 anxiety-filled investigation, but her tension never
4 diminished. Knowing of the discussions in the Board
5 of Nursing about scope restrictions and familiar with
6 recent committee appointments, she was plagued with
7 fear. She was afraid of being investigated again for
8 practicing outside of her scope.

9 Though she was exonerated, the
10 investigation left her scarred and scared. Despite
11 her numerous years of experience, countless training
12 programs and educational activities completed, she
13 still felt she had little impact on this committee's
14 decision-making and questioned her future in Ohio.

15 Rather than stay here with fear of being
16 reported again, she chose to transfer her license and
17 commute to Pittsburgh. Now I must absorb her
18 practice. My ex-partner is not unique. This
19 two-year campaign has created uncertainty amongst
20 employers of Ohio CMPs and has negatively impacted
21 Ohioans' access to healthcare.

22 1.4 million Ohioans lack necessary access
23 to vital services. The federal government has
24 designated 150 healthcare provider shortage areas
25 across the state. The U.S. News and World Report has

1 Ohio ranked 36th in healthcare, meaning that
2 75 percent of states have better healthcare than this
3 state.

4 Every state with full practice authority
5 is ranked above Ohio. Nine of the top ten healthiest
6 states have FPA. None of these nine states regulate
7 by specialty. Many report they categorize APRNs by
8 population, for example, adult, gero, family,
9 pediatric, neonatal, women's health and psych. No
10 mention of acute care and no mention of primary care.
11 They also do not mention the word subpopulation.

12 In July, the Board of Nursing voted
13 unanimously to continue to follow the Consensus
14 Model, but as stated by this committee in June, no
15 one understands what that even means. For the state
16 to adopt a Consensus Model, a state must have FPA for
17 APRNs, national licensure, independent practice as
18 well as prescribing for CRNAs.

19 Let us not forget that 66 percent
20 majority was utilized when setting the definition of
21 consensus in the Consensus Model. To even call it a
22 Consensus Model is, in fact, misleading.

23 Since the Board has voted unanimously to
24 follow the Consensus Model, I presume this means that
25 you will now allocate resources to help us accomplish

1 their goal of adopting it. One helpful step would be
2 to offer both OSANA and OAAPN space in their
3 quarterly Momentum magazine for articles discussing
4 the benefits of House Bill 191, Senate Bill 301 and
5 House Bill 726.

6 It would also be a tremendous show of
7 support if members of the Board of Nursing would join
8 key person programs at both organizations in order to
9 demonstrate support of pending legislation geared
10 toward adopting the Consensus Model.

11 Ohio APRNs do not need further
12 regulation. We have provided no data of safety
13 concerns. We have provided no data demonstrating the
14 public is at risk. Help us advance Advanced Practice
15 Nursing in Ohio. Help us improve healthcare in Ohio.
16 Further regulation will worsen healthcare in our
17 state. The data shows this.

18 Let us not forget that 75 percent of
19 states have better healthcare than Ohio. We do not
20 want to do anything to make us drop further on this
21 list, do we? Thank you, guys.

22 CHAIR KEELS: May I ask a question?

23 MR. McCLAIN: Please.

24 CHAIR KEELS: And I know we're risking
25 running over time, are you -- in your statement, are

1 you not in agreement with us developing a
2 decision-making tool that would help guide some of
3 the questions that the Board gets from APRNs that are
4 in practice?

5 MR. McCLAIN: That's a very good
6 question. I appreciate the opportunity to answer
7 that. I have some concerns because I do feel that a
8 decision-making tool does not have to go through the
9 common sense initiative or JCARR process, so the
10 Board is at privy to develop a tool without any
11 public input.

12 So I have concerns of what this tool is
13 going to look like and what it's going to say without
14 public input or at the very least OAAPN at the table
15 to help the Board of Nursing develop this tool.
16 Because as of right now, the Board of Nursing has a
17 neonatology APRN and a CRNA as the APRN
18 representative which isn't really ideal in developing
19 a tool where Ohio represents 70 to 80 percent of
20 FNPs. So I would like more representation on the
21 Board of Nursing or in the drafting of this model.
22 So I think the tool is a great idea if the right
23 people are developing it.

24 CHAIR KEELS: And you're recognizing
25 moving forward with more collaboration between the

1 professional organization and the Board?

2 MR. McCLAIN: Absolutely. That would be
3 wonderful.

4 CHAIR KEELS: I agree. Thank you.
5 Thanks so much for your comments.

6 Next up we have Jeana Singleton who's
7 representing OAAPN as well, and she would like to
8 speak on meeting minute corrections and past
9 Committee recommendations.

10 MS. SINGLETON: Actually, I think you
11 already covered it. I want to thank you very much.
12 We appreciate that and we appreciate the effort to
13 correct the minutes and be heard on the issue of what
14 was presented to the Board of Nursing.

15 The only other point that has arisen
16 since we submitted the form was OAAPN wanted to
17 formally request the ability to collaborate or
18 participate in the development of that revised
19 decision-making tool. So our phone is always open.
20 You guys can find us. So we would just request the
21 opportunity to participate.

22 CHAIR KEELS: All right. Thank you very
23 much. I appreciate that.

24 Then last but not least, we have Marcia
25 Kiesling who is an APRN CNP at Aultman Hospital,

1 Chair of the Aultman Allied Health and Credentialing
2 Committee, and she would like to address the
3 credentialing process. Thank you.

4 MS. KIESLING: Thank you. This is my
5 first time at one of your meetings. I really
6 appreciate being here. I'd like to lead with I'm
7 also an elected official in the City of North Canton.
8 I've been a councilman for a little less than 17
9 years, and I believe public input it's the epicenter,
10 it's everything.

11 And I appreciate you recognizing that
12 public speaks was coming at the end of your meetings
13 because that's not very helpful to those of who want
14 to speak. I say that from being on your side of the
15 aisle where I don't know what you're thinking unless
16 you come up and tell me.

17 So when you only meet four times a year
18 and you recognize us at the end of a meeting, that's
19 not very helpful and not very user friendly. And I
20 believe you're all here to represent the Nurse
21 Practitioners here in the State of Ohio and the Board
22 of Nursing you're going to report to and give your
23 recommendations to, and unless you hear from us, it's
24 really hard to know what we're thinking. So I
25 appreciate you moving us up a little bit.

1 But I also appreciate that I'm able to
2 speak at this moment because the credentialing
3 process did come up, and I originally was not going
4 to speak today, but I am Chair of the Allied Health
5 Credentialing Committee at Aultman Hospital in
6 Canton, Ohio, and I'm a Family Nurse Practitioner.

7 And in this process, it is very well
8 spelled out. We credential our allied health
9 professionals, CRNAs, Nurse Practitioners, PAs the
10 same way we credential our physicians, in our
11 education. And I believe most organizations do it
12 that way. I think that's law.

13 We have an ethical responsibility and a
14 legal responsibility regardless of whether you're a
15 doctor or a Nurse Practitioner. If there are
16 hospitals, organizations out there not following the
17 law and the ethics, then that is an issue, but that's
18 not the issue at hand. The issue at hand is
19 credentialing.

20 We are credentialing everybody as if they
21 were doctors. They go through a very set process.
22 They all come to my committee. They have to be
23 proctored if they want to do any type of procedures.
24 They have to go learn those procedures, perform those
25 procedures in front of collaborators, doctors,

1 whoever's going to help them learn. They have to be
2 signed off on those procedures.

3 Then three months later, they have to
4 bring me back ten charts and they have to be signed
5 off by a collaborator. And they have to bring me
6 back their logs if they're putting in chest tubes or
7 if they're intubating or if they're just doing pap
8 smears like I do on a daily basis.

9 I have to present my logs. That Allied
10 Health Credentialing Committee, there are no names,
11 it's just how many did I do and what date did I do
12 them on. If somebody wanted to go back and audit it
13 like the State of Ohio, then that audit trail would
14 be available.

15 So we don't credential our Nurse
16 Practitioners or our PAs any differently than we
17 credential our doctors. And I was very offended when
18 there was a comment about credentialing, "Well, I'm
19 not sure how we do it," and I believe that was you,
20 Kris.

21 COMMITTEE MEMBER SCORDO: That case was
22 not knowing how you do it; that most of the hospitals
23 that we talked to are not clear on scope of practice
24 differences for the various types of Nurse
25 Practitioners --

1 MS. KIESLING: For the scope of
2 practice --

3 COMMITTEE MEMBER SCORDO: That's what I
4 meant. Scope of practice.

5 MS. KIESLING: I'm going to get some of
6 my time back, right?

7 COMMITTEE MEMBER SCORDO: No. So scope
8 of practice is --

9 MS. KIESLING: According to the national
10 organization.

11 COMMITTEE MEMBER SCORDO: Right.

12 MS. KIESLING: But if you come through
13 our committee, we tell you what you can and cannot
14 do.

15 COMMITTEE MEMBER SCORDO: That's
16 fantastic that you do that, but I'm here to tell you
17 that's not the case.

18 MS. KIESLING: Well, it is law, so if
19 it's not happening, then that's a totally different
20 subject.

21 COMMITTEE MEMBER SCORDO: Believe me, I
22 know.

23 MS. KIESLING: Okay. So I just want to
24 make it very clear that I think we all take our job
25 on our committees very seriously and we credential

1 our APPs, Nurse Practitioners and PAs, the exact same
2 way we do docs and I hope that never changes.

3 CHAIR KEELS: Are you done?

4 MR. KIESLING: Yes.

5 CHAIR KEELS: Okay. Sandy.

6 COMMITTEE MEMBER WRIGHT-ESBER: I just
7 also wanted to say at Metro, UH, Cleveland Clinic,
8 they all credential like this, so I'm not sure what
9 you're talking about when you talk about places that
10 aren't credentialing properly. So, again, I don't
11 like the hearsay versus evidence.

12 MS. KIESLING: Exactly.

13 COMMITTEE MEMBER SCORDO: It's not
14 hearsay.

15 COMMITTEE MEMBER WRIGHT-ESBER: I'd like
16 to see the evidence that people aren't properly --

17 COMMITTEE MEMBER SCORDO: 95 percent of
18 them do not know the differences in scope of
19 practice.

20 MS. KIESLING: Well, shame on them.

21 COMMITTEE MEMBER SCORDO: Well, I know, I
22 agree with you absolutely, and that's one of the
23 issues, that people that are doing things totally out
24 of their scope of practice are being allowed to do
25 certain things.

1 COMMITTEE MEMBER WRIGHT-ESBER: I've not
2 seen that.

3 CHAIR KEELS: I'm going to take -- Pete
4 had his hand up, and then Jody.

5 COMMITTEE MEMBER DiPIAZZA: I was just
6 wondering if we could clarify, are the med staff
7 credentialing rules driven by joint commission,
8 right?

9 MS. KIESLING: Yes.

10 COMMITTEE MEMBER DiPIAZZA: Not law, but
11 joint commission. I just wanted to know.

12 MS. KIESLING: That is our law.

13 COMMITTEE MEMBER DiPIAZZA: I just wanted
14 to make sure it wasn't anything Ohio law.

15 CHAIR KEELS: Jody, you had a question?

16 COMMITTEE MEMBER MINIARD: Thank you very
17 much for that. So it's nice to hear from somebody
18 who actually does a lot of that because I don't have
19 any experience doing that. I do know that there are
20 a lot of hospital systems who don't have -- are not
21 lucky enough to have someone like you who is an APRN
22 sitting on their committee.

23 MS. KIESLING: Our committee is all
24 APRNs. It's all APPs, so there's nobody --

25 COMMITTEE MEMBER MINIARD: But there are

1 a lot of hospitals that don't have that, and so that,
2 I think, is a problem. It's not -- I agree totally
3 with your statement that it's not a problem for this
4 Committee as much as it is a problem for that
5 hospital and how they're not appropriately
6 credentialing.

7 And I think there's one other thing that
8 sort of plays into that as well, is most NPs, I
9 agree, are very good at understanding where their
10 line in the sand is, but there are a lot that don't.

11 MS. KIESLING: But there are also doctors
12 that don't. That's why we have the committees at the
13 hospitals.

14 COMMITTEE MEMBER MINIARD: Right. So I'm
15 just saying that that is something that concerns me a
16 little bit more as an educator, is the way that I
17 educate my students is you got to know where your
18 line in the sand is, but so I really appreciate what
19 you had to say.

20 MS. KIESLING: Thank you.

21 CHAIR KEELS: James has his up first, and
22 then Sandy.

23 COMMITTEE MEMBER FURSTEIN: I have a
24 quick question I was wondering if you could clarify.
25 Certainly you're saying the credentialing process is

1 pre-described by JCAHO law, but yet there still seems
2 to be some confusion regarding that as some of the
3 hospitals are saying in-house it has to be an acute
4 care. So if it's predescribed and predefined in law,
5 what do you think is still driving some of the
6 confusion then?

7 MS. KIESLING: I think hospitals that
8 don't have allied health credentialing committees, so
9 they don't have APPs available to consult with,
10 discuss with, understand us. I'm also part of our
11 Board for our big medical group, and I gave a
12 presentation a couple weeks ago, and it's me and 16
13 doctors and I'm the only female as well, and I gave
14 the presentation and we spoke for 45 minutes because
15 they did not understand all of our population foci,
16 how we even go through school.

17 So if that hospital system does not have
18 an Allied Health Credentialing Committee that has
19 APPs on it that hopefully understand their law, and
20 mind you, I realize some APPs don't, PAs essentially
21 do, but Nurse Practitioners, I think there are a few
22 that potentially don't understand the law, but those
23 of us who do understand the law and who can be there
24 and credential our employees appropriately, I think
25 you run into trouble when you have physicians trying

1 to understand our process.

2 And they're in a hurry -- right now
3 healthcare is out of control and they're in a hurry
4 to get people to help them take care of patients who
5 desperately need help. We're running people in and
6 out through our on-boarding process because we need
7 an NP on the ground right now. They're not even
8 taking into consideration what kind of training, have
9 they been proctored, what's going on. That's where
10 our stop gap is.

11 COMMITTEE MEMBER SCORDO: That's what's
12 going on.

13 CHAIR KEELS: Sandy's next and I think
14 we'll need to move on.

15 MS. KIESLING: I'm sorry, I'm sure I'm
16 over my limit.

17 CHAIR KEELS: No, you're good. Good
18 dialogue.

19 COMMITTEE MEMBER WRIGHT-ESBER: These
20 vague -- I think like an attorney sometimes. These
21 vague statements that a lot of NPs that are
22 practicing don't know what they're doing, I --

23 COMMITTEE MEMBER MINIARD: I think that
24 was a misspoken --

25 MS. KIESLING: That is not true. I can

1 show you -- we don't have -- we've not had an issue
2 and I've been there 28 years.

3 COMMITTEE MEMBER MINIARD: Right, but I'm
4 just saying that not everybody works for a hospital
5 system that has very strong credentialing. There are
6 many NPs who are working in outpatient privately
7 owned practices.

8 MS. KIESLING: But they're not acute
9 care.

10 COMMITTEE MEMBER MINIARD: No, but I am.
11 And I work for a large group that is completely
12 independent. I do round in the hospital, I'm
13 credentialed by them, but within my group, my
14 clinical practice is totally different than -- I
15 don't go in the hospital that much.

16 MS. KIESLING: I don't go in the hospital
17 at all. So you're making my point for me. You are
18 credentialed as a credentialed employee, therefore,
19 you went through the rigmarole and joint commission.
20 You're also on the outside. We don't have to be
21 credentialed. That's up to your employer to
22 credential you or proctor you or make sure you know
23 how to do paps or skin biopsies or the things that
24 we're doing on the outside.

25 But on the inside, we take it a whole lot

1 more seriously because you're putting chest tubes in
2 and lines and people's lives are on the --

3 CHAIR KEELS: I think Sandy needs to get
4 to her question and then Chris and maybe we can move
5 on.

6 COMMITTEE MEMBER WRIGHT-ESBER: I wasn't
7 quite done.

8 COMMITTEE MEMBER MINIARD: Sorry.

9 COMMITTEE MEMBER WRIGHT-ESBER: That's
10 okay. No, it's a valid point. So I also sit on
11 credentialing for seven years with another NP in my
12 organization, so definitely that needs to be promoted
13 more. And as we mentioned before, maybe this is
14 something that the Board can do, that we go to OHA
15 and Barb Safriet mentioned and tell them about the
16 credentialing process and making sure that they have
17 APPs that sit on the Credentialing Committee so
18 they're aware of how it needs to be done.

19 CHAIR KEELS: That might be a great
20 rule and I think it's excellent --

21 COMMITTEE MEMBER SCORDO: I think that's
22 excellent and on point because I will not mention a
23 hospital setting, but within the past couple of
24 weeks, FNPs were hired to work in the ICU/CCU doing
25 all sorts of things, so it is still going on. And

1 that's what I mean, that they're not looking at scope
2 and standards of practice within national
3 organizations. You need to go around and talk to
4 everybody. And I would totally agree with what you
5 and Sandy is saying. We don't have that in every
6 hospital.

7 MS. KIESLING: I'll agree with you.

8 COMMITTEE MEMBER SCORDO: We don't.

9 CHAIR KEELS: Can I ask one final
10 question and then we'll let you go?

11 MS. KIESLING: I'm staying around, don't
12 worry.

13 CHAIR KEELS: And I sit on our
14 credentialing for APPs, and so what criteria are you
15 using today to determine which privileges the
16 provider may have?

17 MS. KIESLING: So they have to ask for
18 them. Then they have to be proctored by the
19 collaborator. Then those logs -- I don't know if
20 that's me -- those logs have to come back to us on
21 the Committee. So before they're allowed to be able
22 to go out and do it on their own with charts on
23 reviews, so the doc has to sign off, yes, this was
24 done appropriately, I feel confident.

25 In the end, the doc signs off on whether

1 they're allowed to go do those procedures by
2 themselves. Three months later, they're coming back
3 with more logs, more chart reviews. Three months
4 later, they're coming back with more charts and more
5 logs. It is a six-month process, that if they don't
6 come back in three months with enough, then they're
7 bumped out three more months. It's very, very
8 specific, very cut and dry.

9 COMMITTEE MEMBER MINIARD: What's the
10 long-term follow-up?

11 MS. KIESLING: Every two years they are
12 recredentialled just like the doctors.

13 CHAIR KEELS: And I think I heard you
14 mention that you've used the scope of practice?

15 MS. KIESLING: Correct.

16 COMMITTEE MEMBER SCORDO: So if I wanted
17 to do primary care and I wanted to do burr holes,
18 you're not even going to let me do any of that stuff,
19 right, because that's totally out of my scope?

20 MS. KIESLING: We are not doing burr
21 holes at Aultman Hospital. I can't tell you what
22 they're doing at other hospitals.

23 COMMITTEE MEMBER SCORDO: Well, whatever.
24 I see my neuro brains over here --

25 MS. KIESLING: I can't attest to anybody

1 but Aultman Hospital. They're not doing casts, but
2 they're doing cardioversions, tilt tables, putting
3 lines in and out, cutting pacer wires.

4 COMMITTEE MEMBER SCORDO: Your primary
5 care people?

6 MS. KIESLING: Yes, because they are
7 proctored to do so, yes, they are. They are
8 proctored.

9 COMMITTEE MEMBER SCORDO: So even if it's
10 out of their scope and standards of practice --

11 MS. KIESLING: If it's not out of their
12 facility, they can proctor --

13 COMMITTEE MEMBER SCORDO: -- their
14 national organization.

15 COURT REPORTER: I can only take one at a
16 time.

17 COMMITTEE MEMBER SCORDO: I'm sorry, I
18 forgot we've got to. I'm sorry. I'll stop. It
19 doesn't make any sense.

20 MS. KIESLING: It does if you're
21 proctored and credentialed and your collaborator --

22 COMMITTEE MEMBER SCORDO: But you're out
23 of your scope and standards of practice according to
24 the national organization.

25 MS. KIESLING: I don't agree. We

1 disagree.

2 COMMITTEE MEMBER SCORDO: So putting in a
3 chest tube is primary care?

4 MS. KIESLING: If you are trained to do
5 so. A doctor isn't trained to do -- as soon as he
6 becomes a doctor, he has his three years of
7 residency.

8 COMMITTEE MEMBER SCORDO: We're not the
9 medical board.

10 MS. KIESLING: Well, I'm not saying that,
11 but they come out and do not know how to put chest
12 tubes in. They learn in their residency. You've got
13 to look at us as our first year is probably a
14 residency. We're an intern. You have to be
15 proctored to learn how to do your job.

16 CHAIR KEELS: Thank you. I appreciate
17 it.

18 MS. KIESLING: I appreciate the
19 questions, thank you.

20 CHAIR KEELS: So, good dialogue. Things
21 for us to keep in mind as we move towards creating a
22 helpful guideline to help boots on the ground APRNs
23 answer questions when they come up with some about
24 could and should and may and can I do these things.

25 Yes, ma'am.

1 COMMITTEE MEMBER WRIGHT-ESBER: I'm
2 sorry, I don't know if I need to move to do this, but
3 I would like to move that OAAPN have representatives
4 that help build the decision-making tool because they
5 have such wide scope with all the four types of APRNs
6 that are on there and members. I would like to make
7 sure, so I would like to move that we -- this group
8 suggest that OAAPN is involved, has representatives
9 on that decision-making tool with the Board of
10 Nursing.

11 COMMITTEE MEMBER MINIARD: I'll second.

12 CHAIR KEELS: Second, and then we can
13 have conversation. I'm not familiar with the
14 process.

15 MS. EMRICH: It's a recommendation.

16 CHAIR KEELS: Uh-huh, it's a
17 recommendation.

18 MS. EMRICH: This Committee can make a
19 recommendation to the Board.

20 CHAIR KEELS: Okay. So we take it to the
21 Board. Well, it's under development. It will go to
22 the Board for review. I'm sure it will be in
23 materials made available to the public for comment,
24 but what I hear Sandy is recommending, that OAAPN --
25 and I would hedge to then involve other APRN

1 organizations like OSANA and other -- like the nurse
2 midwives.

3 COMMITTEE MEMBER WRIGHT-ESBER: OAAPN
4 just encompasses all of them is why that's a neat --
5 you get a group that's too big, it gets hard to work
6 on. Most teams can't get bigger than 13.

7 COMMITTEE MEMBER MINIARD: But I think it
8 would be good to have a very unbiased...
9 unbiased....

10 COMMITTEE MEMBER KONKOLY: Representative?

11 COMMITTEE MEMBER MINIARD: Yes.

12 CHAIR KEELS: And Jamie, the point that
13 CNAs are not represented by OAAPN?

14 COMMITTEE MEMBER WRIGHT-ESBER: Well,
15 they've done work on -- on some numbers.

16 COMMITTEE MEMBER FURSTEIN: They've just
17 recently started to work more collaboratively.
18 That's not historically --

19 COMMITTEE MEMBER WRIGHT-ESBER: Well, and
20 CRNAs are supervised too, so it's a little bit
21 classification. I know you're not -- I hate to say
22 it because I know supervised is a --

23 CHAIR KEELS: I think anything that would
24 improve collaboration is a wonderful thing, so I have
25 a recommendation, a second and then all in favor for

1 the recommendation that we'll go to the Board, all in
2 favor say -- raise your hands.

3 MS. EMRICH: Seven in favor.

4 CHAIR KEELS: One, two, three, four,
5 five -- so that's unanimous, so motion moves, passes
6 and we'll take it to the next Board meeting which in
7 November and then go from there.

8 COMMITTEE MEMBER WRIGHT-ESBER: Thank
9 you.

10 CHAIR KEELS: Let's move on talking about
11 some general information especially related around
12 some legislation, upcoming legislation -- work in
13 progress legislation changes, and I'll ask Tom to
14 come and talk with us, please.

15 MR. DILLING: Good afternoon. I'm going
16 to I think be brief here. We had talked about it
17 several meetings, I believe, of the Board, as well as
18 the HR and Advisory Committee about at the time
19 imminent legislation to I guess go a step further
20 than what occurred in 2016 at the end, what was
21 adopted into law and to pursue APRN scope of practice
22 without a necessity for a written standard care
23 arrangement.

24 And recently, I think as of August 29th,
25 2018, Representative Gaverone introduced House Bill

1 726 which will hopefully accomplish that and
2 described it as the Better Access/Better Care Act.
3 It's over a hundred pages long.

4 A lot of that is due to the fact that the
5 standard care arrangement impacts lots of different
6 practices, so it's not all being done at 4723. There
7 are a lot of billing and a lot of other types of
8 practices ranging from the treatment of concussions
9 and how schools view those persons and to what
10 standards they're held and what requirements are held
11 for that collaboration versus the day-to-day practice
12 and how that's affected.

13 And I think we've had some comments today
14 and certainly going back on the Committee, several
15 committees ago, I believe it was Candy Rinehart,
16 Miss Rinehart talked about this legislation was
17 coming. It's here now.

18 At the time, she had asked whether or not
19 this Committee would entertain discussions with Bill,
20 whether -- I think -- I think I'm correct in saying
21 this, whether OAAPN as an organization can come in
22 and talk to the Committee about this and then relate
23 that back to the Board, and I thought we were all in
24 on that as a possibility.

25 So today's discussion here wanting to do

1 that in the future I see as just following up on what
2 was eventually going to happen. It's here now.
3 We're not going to get anywhere discussing it today,
4 and I don't think with the General Assembly ending
5 December 31st, I don't think it's going to move
6 through, you know, in three months and pass. So
7 we'll have some time to sit down and discuss. If it
8 does, then we're going to have a different agenda at
9 the next meeting. I'm all for it. That's the big
10 bill that just was created out there.

11 For the book of the 132nd General
12 Assembly, again, the House Bill 191 for the CRNAs and
13 their practice, and we discussed that there was
14 another bill, Senate Bill 275, that offered some type
15 of alternative, a view towards giving certain --
16 making certain changes to the CRNAs' practice
17 sections in the Code, but they've both been heard but
18 none have passed out of their respective chambers.

19 Whether something happens here in the
20 last couple months, you never know. It's a lame duck
21 session. People are going to come back after the
22 legislature is out, and whether or not those bills
23 are going to be heard and whether people are going to
24 move off of their positions in their respective
25 bills, I'm not going to sit here and make a

1 prediction.

2 I'm just saying that there have been
3 hearings on here, there's been more substantive
4 discussions on the parts of -- the different
5 associations that are interested parties to this bill
6 and the legislature itself.

7 So I would say that's always a
8 possibility, more so than perhaps on House Bill 726
9 which was, again, just recently introduced and hasn't
10 had any process per se in the legislature thus far of
11 this session. As far as APRNs, I think that that's
12 it directly.

13 CHAIR KEELS: So 726 has been introduced
14 but has not had any proponent or opponent testimony
15 yet?

16 MR. DILLING: No.

17 CHAIR KEELS: And we're not sure that it
18 will have any because of the lame duck session and
19 then going into elections?

20 MR. DILLING: There will be limited
21 hearings, and then it's up to the chair as to what's
22 heard. You might get introductory testimony. You
23 might even be heard. It's certainly a good thing to
24 be in the General Assembly or at least I've seen over
25 time to be introduced now. You get a better number

1 than 726 in the next General Assembly, the bill's
2 written, you know, parties can talk, you know, frame
3 issues and maybe hit the ground running in the next
4 year.

5 So, again, if we come back at the next
6 Committee and we have the proponents of the bill come
7 in and talk about it, you have a robust discussion,
8 I'd love to hear it and do whatever I can to be a
9 part of it.

10 CHAIR KEELS: Sounds great. Sandy.

11 COMMITTEE MEMBER WRIGHT-ESBER: Thanks,
12 Tom, for that. So you mentioned when Candy Rinehart
13 mentioned the Board being involved in the
14 legislation. So I would love to see the Board
15 involved. I know other state boards of nursing are
16 very involved in helping that legislation. So if
17 that could be, I'm sure the Board will see our
18 minutes, but have our Board of Nursing support the
19 legislation, help us move it forward as APRNs, I
20 would love to see that in Ohio.

21 CHAIR KEELS: Yeah, it actually brings up
22 a great question, Sandy. I was wondering about this,
23 if Tom could talk about what the role of the Board is
24 and the relationship between the Board and the
25 professional organization and the legislature, the

1 sponsor, for moving things forward and kind of who
2 does what and when and how.

3 MR. DILLING: Yeah, well, I certainly
4 think in all my years in service to the boards and
5 being involved in the legislative process for a time
6 on behalf of those entities, there's certainly a lot
7 of room for collaboration in terms of discussing and
8 forming and so forth.

9 From the outset, though, it's important
10 to understand that the associations and the Board
11 have a different role, different constituency of
12 sorts. The associations are advocating for their
13 members specifically. We have a mission here at the
14 Board to protect the public. That's the primary goal
15 and issue.

16 I think the common point is that, you
17 know, no matter how you approach those things, I
18 think we all share this desire to see what's best for
19 the patient in the end. Whether or not we agree on
20 different points in terms of how broad some language
21 should be versus how many questions should be
22 answered in the legislation itself, what should be
23 left to rule making, what are those definitional
24 boundaries, guardrails and so forth, that's where I
25 think discussion helps the understanding on both

1 parties, but it sometimes becomes difficult for one
2 side or the other to be all in on any of those
3 particular language pieces, you know.

4 So there's a difference but much
5 similarity as well. There is nothing that precludes
6 us from working side-by-side, discussing further,
7 getting better understanding. I think that that's
8 why this Committee was created in 2016, was to more
9 formalize that. And sometimes you need a jump start
10 to these type of discussions.

11 There will be growing pains and all that,
12 but, again, in the end, I've seen it. Certainly it's
13 been advantageous to get in the same book, same
14 chapter, let alone be on the same page on different
15 issues.

16 CHAIR KEELS: Go ahead, Sandy.

17 COMMITTEE MEMBER WRIGHT-ESBER: Just a
18 comment, too, when we hear the stats in Ohio how
19 poorly we perform and when we compare full practice
20 states that have better healthcare outcomes, I think
21 that's part of the motivation for this bill. I know
22 it's not full practice, but it's a step towards that.

23 I think the Board of Nursing can embrace
24 the fact that this legislation is trying to help our
25 Ohioans and our patients to get better access to

1 care. So knowing your mission is to protect
2 patients, I think this also makes our patients
3 healthier and protects them in that way.

4 CHAIR KEELS: Absolutely. So I'm
5 wondering when does the Board get involved in these
6 activities? Does the Board have to be invited to
7 work with the sponsors or is it assumed? Or I guess
8 I'm not clear on how that process goes.

9 MR. DILLING: I think that there's no
10 formalized pathway. It's political. And the
11 Board -- let me give you an example, okay. House
12 Bill 191, it was getting ready to be introduced, that
13 would have been, what, a year-and-a-half ago or so,
14 and there were a number of interested party meetings.

15 Again, I wasn't attending. I'm just
16 giving you hearsay here, spoken like a true attorney
17 as well. And various interested parties at various
18 times and the sponsor and proponents heard what are
19 arguments against, what are arguments for and so
20 forth.

21 At a certain point in time, we were
22 called by let's say the sponsor of the bill who's
23 working with the proponents. That's normally the
24 course of things. Only a sponsor, only a legislator
25 can introduce the legislation. They say, "We want to

1 talk with the Nursing Board." So I reported this,
2 you know, way back when, might have been precursor to
3 this Committee but at the Board level at the very
4 least.

5 So we go in there and we're asked a
6 number of different questions about the legislation:
7 Do you have issues as a Board about House Bill 191?
8 And we basically couched it in terms of, wait, you
9 just -- you're getting ready to introduce this?
10 We've seen perhaps a copy of what you just gave us,
11 the Board hasn't had discussions about it as of yet,
12 but if you as a legislature want to make these
13 changes, the Board has no problem with you making
14 those changes.

15 Now, there are a couple areas here we
16 said at the time we'd like a little better
17 understanding of where things begin and end here;
18 what do you mean by this language. In order for us
19 to regulate, we have to have a little bit better
20 understanding.

21 Without getting chippy, clinical support
22 functions was clearly something where parties had
23 different understandings as to what that language
24 meant, okay. So it was a great discussion. We left
25 that meeting and the sponsor and the proponents, as

1 far as I understood, it was "Thank you so much;
2 you've been great. This will help; we'll go back,
3 we'll talk about this, but we see some areas which we
4 can firm up that language and that might help us
5 answer some of the questions we had gotten previously
6 from the other parties; give us a call; if you need
7 anything further, we'll take a look."

8 So, again, I don't wish to get any deeper
9 into subsequent hearings and questions that were
10 raised and so forth, but the Board's been an
11 interested party to 191. We were involved at that
12 level, and we have not yet been pulled in. We were
13 requested to be pulled in further for I'm sure for a
14 a variety of reasons and we're respecting that at
15 this point in time.

16 CHAIR KEELS: So you anticipate in the
17 future that the Board would be asked to comment on
18 191?

19 MR. DILLING: Very well could. And we
20 could be asked to comment from a variety of different
21 perspectives as a regulatory board. It's just -- I
22 think that that's where it gets tactical on the parts
23 of the associations as well. You know, do they want
24 us to be involved at this point in time and what
25 point in time is it best to be involved.

1 We have our own view as to when we have
2 to be involved or we feel we do to clarify something,
3 but early on in the process, a lot of that time is
4 shapen by these interested parties, especially on a
5 legislative change, a scope magnitude which again we
6 will regulate what scope they are given -- we are
7 given.

8 CHAIR KEELS: Jamie had his hand up.

9 COMMITTEE MEMBER FURSTEIN: Prior to the
10 Board commenting back, I come back to this board a
11 little bit, I know... as opposed to House Bill...

12 COMMITTEE MEMBER KONKOLY: Can you speak
13 up?

14 COMMITTEE MEMBER FURSTEIN: I was just
15 asking before the Board would maybe comment back of
16 interested parties....

17 CHAIR KEELS: So would the 191 come to
18 this Committee --

19 COMMITTEE MEMBER FURSTEIN: Right,
20 prior to comment.

21 CHAIR KEELS: -- for input prior to going
22 to the Board? Oh, I see what you're saying, so that
23 this committee can make recommendations to the Board?

24 COMMITTEE MEMBER FURSTEIN: Right, as
25 opposed to 191?

1 CHAIR KEELS: Because as opposed to one.

2 UNIDENTIFIED SPEAKER: Not as opposed to
3 the Burt's bill.

4 MR. DILLING: 275 Senate Bill....

5 CHAIR KEELS: ...and that pigeon holes
6 your practice.

7 UNIDENTIFIED SPEAKER: There's another
8 Senate bill that is a mirror image of House Bill 191,
9 so I'm just trying to clarify. I'm not trying to
10 speak out of turn.

11 MR. DILLING: Right. We don't generally
12 talk about the 301 or whatever because tactically
13 speaking when you introduce mirror bills in each
14 session, you want to try to hear them both and then
15 they meet and there's a different reason for that. I
16 don't know what the reason was for that, but it
17 hasn't even been introduced.

18 The two bills that have been heard on
19 either side: 191, 275. If you want to talk further
20 about 275, it is a different bill. There are some
21 changes that you might find in 191 but it certainly
22 goes nowhere near what was being asked for in 191, so
23 they are different. So people have different
24 positions on that. We have not been an interested
25 party with both bills.

1 CHAIR KEELS: But isn't it within the
2 Board's scope to endorse a bill or is it simply to be
3 an interested party and then if the General Assembly
4 passes it, then adopt the rules around that?

5 MR. DILLING: We could support a bill. I
6 mean, we have in the past. Certainly on some of the
7 opioid bills, the smaller chunks, which I'm sure are
8 important not only for the treatment of addiction,
9 opioids, prescribing and so forth, but yeah, we
10 actually were supportive. We did have joint
11 regulatory statements.

12 I think we were kind of out front in
13 terms of the Naloxone and statements supporting that,
14 and we felt strongly enough as a Board that we were
15 going to get out ahead of that. But that was one
16 where I'm sure the associations were just as
17 supportive, just people came in at different times in
18 different ways. That's part of the legislative
19 process.

20 CHAIR KEELS: So I'm not sure we have a
21 clear answer for you right now, but we can find out.

22 MR. DILLING: As to what?

23 CHAIR KEELS: If 191 gets into its final
24 stages, does it come to this Committee then for the
25 Committee then to make a recommendation to the Board?

1 MR. DILLING: I guess it's a matter of
2 course because we haven't had this Committee all that
3 long and I would say this last General Assembly has
4 not been rich post 2016 in APRN bills. If something
5 were to have changed, we would have as a matter of
6 course absolutely bring it to the Committee and say
7 what's going on.

8 However, I would couch that in terms of
9 you're meeting four times a year, the Board's meeting
10 six times a year, the legislature meets when the
11 legislature wants to meet, so it's hard to time
12 things exactly, but -- so the more -- I think that
13 that goes toward the more collaborative we are in
14 terms of understanding what each other intends, what
15 other questions are, then that allows different
16 parties to adapt accordingly, comment accordingly at
17 the time.

18 The sum of it is we're not the same.
19 This is not -- this isn't the Board but it's an
20 advisory committee and the Board isn't the
21 association. It's just -- that's the way it is.

22 CHAIR KEELS: Sandy, final question?

23 COMMITTEE MEMBER WRIGHT-ESBER: I'll
24 segue on that and then I have something else. On
25 that, I would recommend that this Committee always be

1 involved in any recommendations for the Board like
2 the CRNA bill, like House Bill 726, that this
3 Committee does their homework and then weighs in.

4 If we needed to meet a special session,
5 we've done that before and pulled this together. If
6 there's imminent legislation or reasons to meet
7 sooner, then I think we should do that because the
8 Board needs to be informed by all these different
9 specialties and all these different minds, I think,
10 to make an informed decision themselves.

11 The other comment I wanted to say is I
12 know in Minnesota, my colleagues there when they have
13 full practice authority, they went for it twice. It
14 did not pass the first time. And then they got very
15 big support from their Board of Nursing when it did
16 pass a few years back. And I will reach out to my
17 colleagues there to see if there's other things that
18 our Board of Nursing could do that would help promote
19 this important bill for our patients.

20 CHAIR KEELS: That sounds great.

21 MR. DILLING: I would say that from an
22 informational perspective, perhaps we can do
23 something different here, but when we have the Board
24 meeting, at the time the Board meeting is posted, a
25 lot of information, a lot of materials and so forth,

1 routinely you'll see my memo on legislation, so I'm
2 bringing back to you that these are the APRN-led
3 bills.

4 But all bills affect APRNs like they
5 affect RNs and LPNs, so you're all affected to some
6 degree. There's so much time, there's so much focus
7 and effort, I'm not bringing you the whole thing
8 unless something's further on and I think, hey,
9 there's a special APRN issue.

10 But if you all want to take a look, look
11 at when we time out with the Board meeting, take a
12 look at the memorandum, if you think I'm missing
13 something, let us know. There are certainly
14 associations that let us know when we're missing
15 something.

16 So I assume that that will come back and
17 that's all good. If you communicate, then a better
18 chance to be in the same book, same chapter, same
19 page, so to speak. I will tell you while I have you
20 here, it jogged my mind, we're going to talk about
21 rule making here in just a moment too, and we brought
22 those, the opioid bill and so forth I think rightly
23 back here, especially the MAT part of it.

24 But I just got something from the Medical
25 Board, I get them routinely, associations probably

1 get them routinely as well, they're notices, a common
2 sense initiative we filed with them, we want comments
3 and so forth.

4 The massage therapists who had their
5 scope put into statute also have their scope further
6 defined in rule as well. So the Medical Board is
7 amending those rules. And in the amending of the
8 rules, there's a couple of add-ons, and one is
9 allowing the massage therapists who have used heat
10 for a long period of time in their formal rule, the
11 rule's being adapted to update and put in ultrasound
12 diathermy and so forth.

13 The APRN regs are mentioned in that part
14 as somebody that can take that order from those
15 persons on that issue, massage therapists, who are
16 licensed. There's a second paragraph that talks
17 about TMJ and the APRNs are not mentioned, Nurse
18 Practitioners, CNPs. I haven't had a chance to go
19 back and talk with legal staff here or practice staff
20 with respect to that. I forwarded it on just the
21 other day. This is very recent here.

22 So that period of time to comment is into
23 October. We're not going to be here. I'm not going
24 to be able to bring that back to you, but that's
25 something you might be interested in. And certainly

1 if we're missing something on the rule, too, you can
2 bring all that back.

3 The rule making process is a longer
4 period of time, too, so you have to go through all
5 these different steps, and so chances are, we may
6 meet again before they even have the public hearing,
7 but I'll send you off on that. That will help me out
8 if you all take a look there.

9 CHAIR KEELS: Thanks, Tom.

10 Anybody have any questions for Tom?

11 (No response.)

12 CHAIR KEELS: All right, thank you.

13 COMMITTEE MEMBER WRIGHT-ESBER: I'm sorry
14 if you missed my hand. Well, speaking of that, it
15 triggered my memory about chronic opioid prescribing
16 because you had brought that to this Committee before
17 and you mentioned that maybe in October that the
18 boards of Medicine, Pharmacy, Boards of Nursing might
19 adopt the chronic pain opioid prescribing because
20 we're waiting with bated breath at our organization
21 of when that's going to hit.

22 MR. DILLING: So that's another effect, I
23 mean, like a hidden effect somewhat of the whole
24 written standard care arrangement being tied to those
25 practices because these rules, definitely you're tied

1 into those. And as such, the administration,
2 interested parties, somebody's got to take the lead
3 and by virtue of where all the rules are right now,
4 it's the Medical Board.

5 So Holly's been updating you as this has
6 progressed through. We are working with everyone.
7 There is a good collaborative effort going on. It's
8 just when we file things, we have to kind of wait
9 until the whole group is ready. So we're going to
10 talk about that right now. We're going to update
11 you, I believe. Are we?

12 CHAIR KEELS: Yeah, we are. Holly's not
13 here, but the final rules for the sub acute and
14 chronic, they're included in your packet. The JCARR
15 hearing for the sub acute and chronic rules is
16 October 15th. And assuming all goes well, that
17 effective date will be November 5th, and that's the
18 sub acute and chronic rules.

19 The other set of rules that we reviewed
20 and had provided comment were the medication assisted
21 treatment. It is being filed on October 22nd, should
22 have a rules hearing on November 28th, and hoping for
23 an effective date of January 7th.

24 COMMITTEE MEMBER WRIGHT-ESBER: Thank
25 you.

1 CHAIR KEELS: You're welcome. And those,
2 again, are included in your packet.

3 MR. DILLING: Yeah, and I would just go
4 one step further in telling you that, as for that
5 hearing that we had the other day, the public hearing
6 on the -- it was the chronic pain, right, Lisa?

7 MS. EMRICH: Uh-huh, that hearing?

8 MR. DILLING: Yeah, so we had just one
9 person that testified, and she was the APRN that
10 testified in the first hearing and would basically
11 say, "Hey, you guys got to link up with the Medical
12 Board, why are these things not here?" And we were
13 like, well, that's out of our hands somewhere else.

14 And eventually I think it came through
15 that we got on that same page and certainly we have
16 more FAQs and so forth that kind of filled in some of
17 the blanks necessarily. But she had similar
18 questions this time but they were answered to her
19 understanding, and she was very -- I think I could
20 characterize it as commending how far it's progressed
21 and they've been able to work with it.

22 But in her position, she needs to know
23 more exactly the nature of some of this because she's
24 teaching that on to other APRNs that are working
25 there. So, again, I was glad to hear that. I think

1 we progressed certainly in this set of rules versus
2 the last set.

3 CHAIR KEELS: Questions? No questions?
4 (No response.)

5 CHAIR KEELS: Okay, great. Thanks, Tom.
6 Appreciate it.

7 MR. DILLING: Thank you.

8 CHAIR KEELS: Next on our agenda, so we
9 covered the administrative rules, so that was your
10 update, and we discussed the Board vote. So that
11 takes us down to Advisory Committee 2019. Yes, ma'am.

12 MS. EMRICH: You might want to check to
13 see if anybody --

14 CHAIR KEELS: Oh, okay. Yeah, yeah,
15 that's a great point. Is there anybody else in the
16 audience that would like to make public comments, and
17 if so, I'd ask that you sign in and so we can
18 anticipate that moving forward.

19 MS. EMRICH: I'm not seeing anybody.

20 CHAIR KEELS: I don't see anyone. Okay,
21 thank you.

22 Next up is election of Chair, so the
23 election of Chair will be handled in this manner.
24 Number one, there will be nominations. Once the
25 nominations are made, then a paper ballot will be

1 created. Chantelle will run off to make paper
2 ballots and bring it back to us.

3 You will check the box and sign your
4 ballot, check your selection and sign the ballot
5 which becomes a public record of the vote. Because
6 there's eight of us, we could end in a tie
7 potentially, and if there is a tie, in the event of a
8 tie, you just continue to revote.

9 COMMITTEE MEMBER MINIARD: Change your
10 vote.

11 CHAIR KEELS: So is there anything else I
12 missed? I think I got it all.

13 MS. EMRICH: We will announce it by who
14 prevailed.

15 CHAIR KEELS: Yes, we won't -- we won't
16 announce by numbers, just -- when someone is elected,
17 announce that, or if it's a tie, then we announce
18 that. So first up, nominations.

19 Kris.

20 COMMITTEE MEMBER SCORDO: I think you
21 have done a magnificent job, and I would hope that
22 you would run for a second term, so I nominate you.

23 CHAIR KEELS: Thank you for the
24 nomination. I would be happy to serve a second term
25 to help provide some continuity. Thank you. Any

1 other nominations? Sandy.

2 COMMITTEE MEMBER WRIGHT-ESBER: I would
3 like to nominate Jody.

4 COMMITTEE MEMBER SCORDO: Very well
5 spoken.

6 COMMITTEE MEMBER MINIARD: I will accept.

7 CHAIR KEELS: Thank you. Anybody else?

8 (No response.)

9 CHAIR KEELS: Okay. Thanks, guys. So
10 Chantelle will run off and quick like a bunny make
11 the ballots.

12 COMMITTEE MEMBER WRIGHT-ESBER: Sorry.

13 COMMITTEE MEMBER MINIARD: No, that's
14 fine.

15 CHAIR KEELS: Moving forward, she'll come
16 back in a minute, our scheduled meeting dates are
17 tentative scheduled meeting dates, so it's time to
18 get your calendars out if you have them. I don't
19 know that there are any major outstanding issues.

20 And to Sandy's point, if something
21 pressing comes up, we can always schedule sort of an
22 emergency meeting. Ready? February 25th, these are
23 all Mondays, June 17th.

24 COMMITTEE MEMBER WRIGHT-ESBER: Sorry,
25 sorry, what was your February?

1 CHAIR KEELS: February 25th.
2 June 16th -- sorry, June 17th and October 28th. Seem
3 okay for everyone?

4 COMMITTEE MEMBER WRIGHT-ESBER: I just
5 want to ask the group, does that seem like enough
6 meetings or too many?

7 COMMITTEE MEMBER MINIARD: I thought
8 there were four.

9 COMMITTEE MEMBER KONKOLY: I thought
10 there were four a year.

11 MS. EMRICH: Three were scheduled. We
12 held an extra one. We added one to address rules,
13 et cetera, but it really is three typically for the
14 advisory committee.

15 COMMITTEE MEMBER WRIGHT-ESBER: We didn't
16 discuss it. We kind of threw it out there the first
17 time, and then we added the fourth.

18 COMMITTEE MEMBER MINIARD: That's fine
19 with me. I thought there were four, too.

20 COMMITTEE MEMBER WRIGHT-ESBER: I just
21 wanted to let -- with House Bill 726 coming, I think
22 that's going to be an important topic, will go lame
23 duck I think and be reintroduced in January, but
24 there will be a lot to talk about, the CRNA bill too,
25 whatever the group thinks.

1 CHAIR KEELS: Yeah, what's everybody
2 think?

3 COMMITTEE MEMBER KONKOLY: Four.

4 CHAIR KEELS: Would you just prefer to
5 preschedule four or preschedule three and do a fourth
6 so we can kind of time it with whatever is going on?

7 COMMITTEE MEMBER KONKOLY: Preschedule
8 four.

9 CHAIR KEELS: Where would you like that
10 to fall? Between February and June?

11 COMMITTEE MEMBER WRIGHT-ESBER: Maybe
12 it's every three months if we do quarterly.

13 CHAIR KEELS: So in order to try to get
14 materials out in a more expedient manner, I think
15 we're trying to stay away from the actual Board
16 meetings. So what are the recommendations? An April
17 meeting? April 29th okay? Then my grandbaby might
18 be born at that time. April 29th sound okay?

19 COMMITTEE MEMBER WRIGHT-ESBER: That's
20 good.

21 CHAIR KEELS: Okay, 4-29. So to
22 reiterate, February 25th, April 29th, June 17th and
23 October 28th. All right, great.

24 And so topics for next time, I have OAAPN
25 to present on acute care/primary care. Perhaps we

1 could also request an update on 729 at that time.

2 COMMITTEE MEMBER WRIGHT-ESBER: What's
3 729?

4 CHAIR KEELS: I'm sorry, 726. Apparently
5 I need more caffeine. Let's see, Kris has
6 recommended Carolyn Buppert as another speaker. I'm
7 not sure if we can get two speakers on one day, but
8 that might need to be kind of spaced out is what I
9 would think.

10 We'll reorder the agenda to provide for
11 public comments in the beginning. We can try to do
12 that in the afternoon, too, like we did today, and
13 there were no other speakers. Just need to manage
14 the time really well. Okay, anything else that I
15 don't have in my notes for topics for next time?

16 COMMITTEE MEMBER WRIGHT-ESBER: Chris, do
17 you want anything with --

18 COMMITTEE MEMBER FURSTEIN: I'm Jamie.

19 COMMITTEE MEMBER WRIGHT-ESBER: -- I'm
20 sorry, Jamie, with OSANA?

21 COMMITTEE MEMBER FURSTEIN: That's okay.
22 With OSANA, yes. Yeah, we'll probably include
23 something about our bill.

24 CHAIR KEELS: Do you know, is there
25 somebody that we can ask?

1 COMMITTEE MEMBER FURSTEIN: Right, I'll
2 find somebody.

3 CHAIR KEELS: Sounds great. So we'll
4 talk about the impending legislation, 191 and 726,
5 which you all have in your packet to review. Maybe
6 we can get bullet points. That would be nice.

7 COMMITTEE MEMBER WRIGHT-ESBER: And if I
8 can reiterate having stuff out two weeks in advance
9 would be very, very helpful.

10 CHAIR KEELS: So the request is for OAAPN
11 to present acute care/primary care. So I don't know,
12 Sandy, is there something specific you would like for
13 them to present?

14 COMMITTEE MEMBER WRIGHT-ESBER: Maybe
15 focusing on moving forward with the decision-making
16 tool and anything else they can enlighten us. As to
17 biggest representative in Ohio, I feel like we've
18 covered it all, but I want to make sure that we're
19 well versed on every issue, but Barbara today brought
20 up a few more things that I thought were helpful that
21 we hadn't quite -- I thought we had addressed
22 everything ad nauseam, but we hadn't, so....

23 CHAIR KEELS: More rocks to uncover there
24 apparently.

25 COMMITTEE MEMBER WRIGHT-ESBER: Yes.

1 CHAIR KEELS: And then we'll have some
2 presentations -- was that good, Pete -- on the two
3 bills and we'll reorder the agenda, and I guess we'll
4 go from there.

5 MS. EMRICH: Did everyone get a ballot?

6 CHAIR KEELS: Did everybody get a ballot?
7 Kris, you have a perplexed look on your face.

8 COMMITTEE MEMBER SCORDO: Well, I wanted
9 to get clarification from one of the speakers because
10 I'm really confused and I need to know....

11 CHAIR KEELS: Should that be done like
12 after the meeting?

13 COMMITTEE MEMBER SCORDO: Yeah, maybe. I
14 have my... to talk about. That's my pea brain.

15 CHAIR KEELS: Okay. Anything else? For
16 order of business....

17 (Off the record.)

18 CHAIR KEELS: Is there something else you
19 wanted to talk about?

20 COMMITTEE MEMBER MINIARD: I don't know.
21 She did.

22 COMMITTEE MEMBER SCORDO: I just wanted
23 to ask....

24 CHAIR KEELS: It's probably best after
25 the meeting, I think, okay? Anything else? From you

1 Chris, anything?

2 Ann, thanks for coming.

3 COMMITTEE MEMBER KONKOLY: Thank you for
4 having me.

5 CHAIR KEELS: Is it Ann Marie?

6 COMMITTEE MEMBER KONKOLY: Ann.

7 CHAIR KEELS: Sandra, thank you for
8 driving down. Jody, glad you got to see the
9 patients.

10 (Off the record.)

11 CHAIR KEELS: We have one more area of
12 business.

13 MS. EMRICH: Erin Keels is your new
14 elected chair.

15 CHAIR KEELS: Thank you. I think then
16 our meeting is adjourned. Thank you. Great
17 dialogue. Thanks for all your thoughts.

18 (The meeting was concluded at 1:40 p.m.)

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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, October 1, 2018, and carefully compared with my original stenographic notes.


Cynthia L. Cunningham
