

BEFORE THE OHIO BOARD OF NURSING  
ADVISORY COMMITTEE ON ADVANCED PRACTICE OF  
REGISTERED NURSING

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COMMITTEE MEETING

Held at the Ohio Board of Nursing, 17 South High  
Street, Suite 400, Columbus, Ohio, on Monday,  
February 25, 2019, called at 10:00 a.m.

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ADVISORY COMMITTEE:

Erin Keels, APRN-CNP, Chair  
Peter DiPiazza, APRN  
Christopher Kalinyak, APRN  
Kristine A. Scordo, APRN  
Sandra Wright-Esber, Employer

BOARD STAFF:

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

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AGENDA

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ITEM	PAGE
Welcome/Introductions	3
Public Participation Guide	4
Summary of Discussions to Date	5
Public Comment	10
Sample APRN Questions Received	16
Joscelyn Greaves, President OAAPN	17
General Information and Updates	34
Legislative Report, APRN-Related Issues	35
Medical Marijuana: NCSBN Guidelines for BONs	44
Discussion: Format of Guidance Document	47
Other Business	72
Public Comment	74
Adjournment	83

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1 Monday Morning Session,  
 2 February 25, 2019.

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4 WELCOME/INTRODUCTIONS

5 CHAIR KEELS: Good morning, everyone.  
 6 Welcome to the Ohio Board of Nursing Advisory  
 7 Committee on Advanced Practice Registered Nursing.  
 8 I'd like to take a few minutes to welcome everyone  
 9 and to go around the table and start with the  
 10 introductions. To my left.

11 MS. EMRICH: Lisa Emrich, program manager  
 12 of the Board.

13 MS. DiPASQUALE: Anita DiPasquale, Staff  
 14 attorney.

15 MR. DiPIAZZA: I am Pete DiPiazza, and I  
 16 represent FNPs.

17 MS. SCORDO: Kris Scordo, faculty at  
 18 Wright State.

19 MR. KALINYAK: Chris Kalinyak, APRN in  
 20 practice.

21 MS. ANDERSON: Rosemary Anderson, court  
 22 reporter.

23 MS. WRIGHT-ESBER: Sandy Wright-Esber,  
 24 director of advanced practice nursing at MetroHealth  
 25 and I am the employer representative, and I am a

1 pediatric nurse practitioner.

2 MS. SUNDERMAN: Chantelle Sunderman, for  
3 Staff.

4 CHAIR KEELS: And I am Erin Keels. I am  
5 a member of the Board of Nursing and I am an APRN  
6 here in Columbus.

7 - - -

8 PUBLIC PARTICIPATION GUIDE

9 CHAIR KEELS: So I believe there are  
10 public participation guidelines available for you to  
11 read. This is not an open forum, but we will,  
12 however, take public comment, both at the beginning  
13 and at the end of the meeting to hear from the  
14 public.

15 I'd like to ask the committee members to  
16 raise your hand for questions when you wish to speak.

17 I would like to read the committee  
18 charge. Our charge is that this committee shall  
19 advise the Board regarding the practice and  
20 regulation of advanced practice registered nurses and  
21 may make recommendations to the Committee on  
22 Prescriptive Governance.

23 For the purposes of the official  
24 proceedings, we have a court reporter with us today.  
25 Please speak clearly and loudly so she can record

1 what you have said. And in your packet you have the  
2 official transcript from our last meeting. It is  
3 also posted on the Board website for those of you who  
4 wish to review those under Practice APRN.

5 For those in the gallery, if you want to  
6 make public comments, please make sure you sign in  
7 and fill out one of these yellow forms.

8 - - -

9 SUMMARY OF DISCUSSIONS TO DATE

10 CHAIR KEELS: So next I want to take five  
11 minutes to review where we've been for those who  
12 might be joining us for the first time and to  
13 summarize what we've been talking about.

14 So in 2000, the year 2000, APRNs gained  
15 title protection in the state of Ohio. In 2008,  
16 the APRN Model for Consensus was released, which  
17 establishes a model for APRN regulation that  
18 includes definition and characteristics for APRNs in  
19 practice that includes the titles to be used. It  
20 differentiates licensure and national certification  
21 in the population that is regulated by nursing boards  
22 from specialization, describes the emergence of new  
23 roles and population foci, and presents strategies  
24 for implementation.

25 It seeks to standardize expectations for

1 licensure, accreditation, certification, and  
2 education. It defines scope of practice as formal  
3 graduate degree or post-graduate degree education,  
4 which includes the 3Ps and appropriates clinical  
5 experiences and national certification in a role and  
6 population foci.

7 Specialty practice is additional  
8 education and training obtained within that role and  
9 the position is not regulated by the Board of  
10 Nursing.

11 It also acknowledges that population foci  
12 have areas of overlap, and in those situations, it is  
13 optimal to consult.

14 In 2008 and subsequently, the Board of  
15 Nursing reviewed the APRN Consensus Model and the  
16 related NCSBN Model Laws and Rules. The Consensus  
17 Model is congruent with Ohio statute and rule.

18 Ohio licenses and regulates the RN, APRN  
19 role and population-focused national certification.  
20 The Consensus Model is not a rule or law but is a  
21 nationally adopted standard that is congruent with  
22 current Ohio rules.

23 The Board of Nursing receives many  
24 e-mails from Ohio APRNs about scope of practice and  
25 prescribing, particularly ones in which their

1 population focus overlaps with another.

2 In 2016 the Momentum article that was  
3 published by the Board of Nursing was meant to  
4 clarify questions around scope of practice. This led  
5 to more questions and concerns by the public and by  
6 practicing APRNs.

7 Ohio House Bill 216 established the APRN  
8 Advisory Committee. Our first meeting was June 12,  
9 2017. The mission of the committee is to advise the  
10 Board regarding the practice and regulation of APRNs  
11 and may make recommendations to CPG, as I previously  
12 stated.

13 The APRN Advisory Committee has spent  
14 past meetings focusing and discussing acute care and  
15 primary care scope of practice, including  
16 presentations from national experts, surveys of other  
17 states' scope of practice rules, input from the  
18 NCSBN, public comments. Additionally the Board of  
19 Nursing has met with OHA and OONE to discuss concerns  
20 and questions.

21 Primary care certified NPs are the  
22 largest segment of APRNs in Ohio and in the country,  
23 and the overlap between and among all populations  
24 occurs and leads to questions related to scope.

25 The APRN Advisory Committee was charged

1 with making a recommendation to the Board whether  
2 Ohio should continue to follow the Consensus Model as  
3 articulated in current rule or pursue additional  
4 rule-making. The committee voted to recommend  
5 continuing with the Consensus Model and the current  
6 rule.

7           The Advisory Committee agreed that  
8 clarifying terms such as "specialty practice" and  
9 "acute care," along with an Interpretive Guideline to  
10 Scope of Practice Questions that may help support  
11 APRNs with their questions.

12           We have all agreed to use clear language  
13 when discussing APRN role, population-focused  
14 certification, and specialty practice. We are  
15 considering the use of the CMS definition of critical  
16 care to clarify where the primary care scope of  
17 practice ends.

18           The Board of Nursing is working to  
19 development an Interpretive Guideline to help clarify  
20 population foci that will need to be reviewed by the  
21 Attorney General's Office to ensure that it is not  
22 improper rule-making.

23           It is important for Ohio APRNs to clearly  
24 articulate our scope of practice in order to  
25 successfully move towards retirement of the standard

1 of care arrangement and the full practice authority.

2 That's my summary to date. I wanted to  
3 follow up from our last meeting. There were a couple  
4 requests from our last meeting that meeting materials  
5 would be sent at least two weeks prior, and that was  
6 accomplished.

7 Than you, Lisa and Staff, for your hard  
8 work on that.

9 As I mentioned before, the transcript and  
10 all the materials are also posted on the website  
11 under Practice APRN.

12 Since our last meeting, the subacute and  
13 chronic pain and the MAT rules went into effect.  
14 That information is published in the Momentum and  
15 also published on the Board website.

16 We have reordered the agenda to allow for  
17 public comment near the beginning and at the end of  
18 the meeting.

19 And the prescribing flow chart was also  
20 updated, related to the subacute and chronic pain  
21 rules. Sorry about that.

22 The OAAPN is here today to provide an  
23 update. We reached out to Carolyn Buppert to speak,  
24 and we will be following up with her on some dates  
25 that she might be available.

1           We have a very initial draft of an APRN  
 2 Interpretive Guideline to review for input today. We  
 3 also had a request from the OAAPN to provide input  
 4 into the Interpretive Guidelines and to place  
 5 information into the Momentum.

6           The Board cannot professionally work with  
 7 a professional trade fraud organization. OAAPN and  
 8 the public will have an opportunity to review and  
 9 comment during public comments, and we are  
 10 considering an APRN Advisory Committee update in the  
 11 Momentum to publish key takeaways from the APRN, so  
 12 that might be a good way to help get the news out.

13           So that's the update. Any questions?  
 14           Thanks.

15                           - - -

16                           PUBLIC COMMENT

17           CHAIR KEELS: All right. So next up we  
 18 have public comments, and I see one yellow sheet by  
 19 Jesse McClain.

20           MR. McCLAIN: Just me?

21           CHAIR KEELS: Are you ready?

22           MR. McCLAIN: I guess so. Did it start  
 23 already?

24           CHAIR KEELS: No.

25           MR. McCLAIN: I apologize. I forgot my

1 suit coat at home. As Chris can tell you, coming  
2 from Youngstown, once you get halfway here, it's,  
3 like, forget about it.

4 Thank you, you guys, for allowing me to  
5 speak today. I also want to start off by thanking  
6 you all for your dedication as volunteers on this  
7 committee. I know only five of eight are here today.  
8 I appreciate you guys being experts in your field,  
9 and trying to help health care in Ohio, and I realize  
10 the few times I've spoken here, I have not advertised  
11 that.

12 CHAIR KEELS: Jesse, who are you  
13 representing?

14 MR. McCLAIN: OAAPN.

15 CHAIR KEELS: I just need you to say it  
16 for the record.

17 MR. McCLAIN: Although we may not always  
18 see eye to eye on topics, that is what makes our  
19 country, our state and our practice as APRNs so  
20 fantastic, the ability to come together in meetings  
21 like this and discuss a variety of topics trying to  
22 achieve the same goal, and that is improving health  
23 care for all Ohioans.

24 So, again, though I've not said it  
25 before, thank you all. You are all leaders in your

1 field, and your knowledge is respected and  
2 appreciated.

3 Allow me to move on because I know we all  
4 know I'm being timed here. A topic that is near and  
5 dear to my heart, as I fight for something I believe  
6 we all can agree on, over 1.4 million of Ohioans lack  
7 access to basic necessary primary care services. In  
8 fact, the federal government has designated over 150  
9 health-care, provider-shortage areas across this  
10 great state of Ohio.

11 As a result of continuing health-care  
12 provider shortages, increased demand from an aging  
13 population, the growing incidence of chronic disease  
14 and the rising health care disparity in rural areas,  
15 Ohio is at a crossroads.

16 According to the U.S. News & World  
17 Report, Ohio is ranked 36th in regard to health care  
18 access and quality. In fact, eight of the ten  
19 healthiest states have removed barriers to patients'  
20 access to care. This barrier, these states removed  
21 the requirement to obtain a mandatory  
22 standard-of-care arrangement. By removing the  
23 requirement that Ohio APRNs sign a contract with a  
24 physician in order to practice would drastically  
25 expand Ohioans' access to care by allowing APRNs

1 to expand to the full extent of their training  
2 statewide, especially in necessary primary-care  
3 shortage areas.

4 Millions of patients chose APRNs because  
5 of the extra time, personal attention, and care they  
6 provide. Fifty-plus years of research demonstrates  
7 that APRNs provide quality care similar to, if not  
8 better than their physician colleagues. In fact,  
9 APRNs delivered care to more than one billion  
10 patients in 2017. I don't have 2018 data, sorry.

11 People who chose to see an APRN are more  
12 likely to continue doing so in the future. To  
13 address similar challenge accesses, 40 percent of  
14 states and the District of Columbia, Guam, and Puerto  
15 Rico, have enacted legislation that gives patients  
16 direct access to APRN care and eliminates the  
17 requirement of the SCA, which the SCA amounts to  
18 little more than a fee-for-service piece of document.

19 Ohio has yet to follow suit. By removing  
20 this barrier, APRNs will be able to help the 150  
21 health-care provider shortage areas. A recent  
22 article distributed by the Board of Nursing -- thank  
23 you to the staff, Lisa. I mean, it was tremendously  
24 helpful, so I truly mean it -- demonstrates that 32  
25 percent of the APRN respondents practice in rural

1 areas, so it is obvious we were here, available, and  
2 definitely willing to help.

3 OAAPN is committed to working with the  
4 Ohio legislature and the Ohio Board of Nursing in  
5 order to update its state licensure laws so patients  
6 get the high-quality health care that they need. It  
7 is time to close the gap between APRNs that are  
8 trained to deliver and outdated state licensure laws  
9 that restrict patients' access to provider care.

10 Last year Representative Gavarone  
11 introduced House Bill 726, which attempted to improve  
12 patient access to health care. This bill was known  
13 as the Better Access, Better Care Act. We are  
14 hopeful to introduce a bill soon in the GA to improve  
15 access to health care to millions of Ohioans.

16 Ohio has many universities training  
17 highly educated and trained APRNs. Let's keep them  
18 in Ohio rather than watch them leave the state to  
19 practice in less restrictive neighboring states.  
20 Let's keep jobs in Ohio. We need them right here.  
21 Let's improve health care in Ohio.

22 Thank you.

23 CHAIR KEELS: Thank you. So is  
24 Representative Gavarone going to reintroduce?

25 MR. McCLAIN: So she moved to the Senate.

1 She was appointed as a senator. So she was reelected  
2 in the House. She was moved to the Senate. We are  
3 still early in this General Assembly, and I know a  
4 lot of people are focused on the new Governor  
5 DeWine's budget, so we'll have to see how things  
6 shake out with her new office and new digs over  
7 there, so...

8 CHAIR KEELS: Okay. So ongoing  
9 conversations?

10 MR. McCLAIN: Ongoing conversations.

11 CHAIR KEELS: Great.

12 MR. McCLAIN: Seems to be the way of the  
13 Ohio legislature.

14 CHAIR KEELS: Patience is a virtue.

15 MR. McCLAIN: Yes. Possess it if you  
16 can.

17 CHAIR KEELS: Any questions for Jesse?  
18 Thank you very much.

19 MR. McCLAIN: Thank you, guys.

20 MS. SCORDO: Yes, nice job.

21 CHAIR KEELS: Okay. In your packet --  
22 oh, yes, okay. In your packet during public comment,  
23 we received late Friday a letter from the Ohio State  
24 University College of Nursing, Dean Melynk. I will  
25 give you guys a moment to read through this.

1 Questions, comments?

2 MS. SCORDO: It's just a public comment  
3 right?

4 CHAIR KEELS: Yes.

5 MS. SCORDO: Okay.

6 - - -

7 SAMPLE APRN QUESTIONS RECEIVED

8 CHAIR KEELS: Okay. Then we will move  
9 on.

10 Next up, Sample APRN Questions Received.  
11 So we thought as we work on some sort of guidance  
12 document, that it would be helpful to see a sampling  
13 of what are some of the questions the Board actually  
14 receives from APRNs around Ohio. So that is in your  
15 packet, and it's the Practice Unit Sample Summary of  
16 APRN Questions Received. And that was sent in your  
17 packet, so hopefully you had a minute to review  
18 those.

19 MS. EMRICH: This is not specific even to  
20 the Interpretive Guidance. It is more to give you  
21 some insight really as to what we are receiving here  
22 and what are some of the informational needs at the  
23 grassroots level for APRNs.

24 MS. WRIGHT-ESBER: I found these to be  
25 very much (indicating).

1 CHAIR KEELS: There's only five of us  
2 today.

3 MS. WRIGHT-ESBER: I thought that was  
4 helpful to see them, and, you know, they do echo what  
5 I hear from the APRNs I work with, so I think that  
6 maybe we could continue that for this group.

7 CHAIR KEELS: Yeah. I think it's helpful  
8 to be aware of what some of the questions are. I  
9 know the Board receives hundreds of questions a  
10 month.

11 MS. EMRICH: Uh-huh.

12 CHAIR KEELS: All right. Anything else  
13 from that?

14 - - -

15 GUEST: JOSCELYN GREAVES, PRESIDENT OAAPN

16 CHAIR KEELS: We will move on. Next we  
17 have a guest, Joscelyn Greaves, the president of  
18 OAAPN. She will provide an update of the goals and a  
19 legislative update.

20 MS. GREAVES: Good morning. I am  
21 Joscelyn Greaves. I am the current president of  
22 OAAPN, and I am super thankful to Erin and the  
23 Advisory Committee for allowing us to talk a little  
24 about what we are working on, and what some of our  
25 goals are this year, and then maybe some things maybe

1 we can look at working together on in the future of  
2 things we see as a problem, and I'm sure you all may  
3 even see them because we are all in practice in  
4 different areas.

5           So I have a kind of list of them that I  
6 sent in advance and just wanted to talk through some  
7 of them with you and then answer any questions that  
8 you may have at the end.

9           So currently we'll talk about what we are  
10 doing, and a few of the things that we are doing is,  
11 of course, education. Education is huge for us. And  
12 flushing out CEs and updating and clinical practice  
13 guidelines are very important for all of us as  
14 providers to be aware of to make sure we are staying  
15 up to date and current in our practice.

16           So we are holding different conferences  
17 around the region, and then, of course, our state  
18 conference, and then in our info that we send out to  
19 our members every month, we include any new clinical  
20 practice guidelines, so it's something different  
21 every month. You know, this month was, like, on  
22 blood transfusions and what our guidelines are for  
23 that, and then previously it was on arm stroke. So  
24 we are just looking at how do we help our members  
25 stay up to date. Then our state conference is the

1 big one that we look at doing in October every year.

2 We also started a new thing this year.  
3 It's called Ask the Specialist, and so we are having  
4 these different specialists to log in once a month,  
5 and our members are allowed to ask them general  
6 practice questions. So we did our first one this  
7 month on urology, and then we're doing one next month  
8 with sleep. So it gives us an ability to kind of  
9 collaborate with different specialists and to ask  
10 them things that maybe we would find helpful in that  
11 area that we might not really be aware of.

12 And then we hold a Transition to Practice  
13 course every year for our new grads or within the  
14 first couple of years to help with that transition.  
15 We know that's hard from when we were back in school  
16 coming out and learning how to function from a nurse  
17 to an APRN. And so we are working on helping with  
18 that transition to go a little more smoothly.

19 There is always reimbursement topics that  
20 we are trying to combat. And you've probably seen  
21 some of those questions, Lisa, as they come into the  
22 Board. We get several of those a month. And so we  
23 are trying to look at how can we help with the  
24 reimbursement for APRNs across the board and meeting  
25 with different stakeholders in regards to that or

1 helping them in the background, that maybe they just  
2 need to tweak a little bit on their end of billing.

3           One of the things that we have seen a lot  
4 of is the Ohio wrestling forms. I'm not sure if you  
5 are familiar with that, but there is -- currently in  
6 order for a person to be able to go back as a  
7 wrestler and get cleared from a dermatological, they  
8 have to see a derm nurse practitioner or a medical  
9 physician or DO.

10           And so we're looking at why can't other  
11 APRNs, like primary care APRNs, be able to clear  
12 them, who have the ability to treat rashes all of the  
13 time in primary care, so having them to be able to  
14 decrease the length of time there may be to be able  
15 to get in to a dermatology person or to a derm nurse  
16 practitioner, which may be three to six months and  
17 minimize that to get them to have increased access to  
18 that care.

19           So that is one thing we are working on as  
20 well with the wrestling side -- it's not the  
21 wrestling. My brain has stopped for one second. --  
22 that we are working on with the Ohio Athletic  
23 Association. I'm sorry. I couldn't think of that.

24           Then we, of course, are likely to get  
25 numerous questions that we are being asked from

1 our -- being answered by our legal team on a monthly  
2 basis, and they're complex. It goes to a specific  
3 case scenario, and we're working on getting them  
4 their responses back and helping them to work through  
5 the legal jargon that we all may not be aware of.

6 We have developed an FAQ page that are  
7 just the most common member questions that we've had  
8 over the last year that people can kind of go through  
9 and look at.

10 So that's what we're currently doing  
11 right now. Some of our goals that we have for this  
12 coming year, Jesse mentioned one, which is our  
13 legislation and continuing educating our legislators  
14 and talking about the need for health care. We all  
15 know that there is a huge access issue. And I read  
16 the article that you all provided, which was an  
17 awesome article and had some great information about  
18 how we can, as nurse practitioners, still provide  
19 that quality care that is comparable and as safe as  
20 it is for physician providers.

21 But as we all know that we are the ones  
22 going out into those rural areas, and we're providing  
23 that access, that there is not as much providers to  
24 be able to increase the access that patients get.

25 So that is one of our big top priorities

1 for this year, working on providing a more costly way  
2 for our health care to be managed instead of using  
3 DRs or stat care as primary care providers.

4 We do know that Gavarone introduced the  
5 bill last year, and, of course, we are still in talks  
6 with her about moving forward this coming year. That  
7 bill did die when the General Assembly died in  
8 December, so we are hoping that we can move forward  
9 and make progress.

10 What the bill does do -- and if you don't  
11 mind, I have a handout. It is a basic info sheet  
12 about what the bill does and what the bill does not  
13 do for your information to kind of look through. Of  
14 course, it does remove the standard of care and gets  
15 rid of that paper document that we have. But it also  
16 does a few different other things, and one of them  
17 you may have been aware of, is it allows there to be  
18 a maintenance of Schedule IIs not provided for in the  
19 retail clinics.

20 The retail clinics are mostly run by  
21 advanced practice providers and not by physicians,  
22 and we know that APRNs in that area cannot prescribe  
23 the Schedule IIs in retail clinics, so we are just  
24 kind of maintaining that.

25 And then it allows health-care systems to

1 optimize cost efficiencies and provide health care  
2 access by allowing them to determine the appropriate  
3 health care mix, whether it's including nurse  
4 practitioners and physicians or just nurse  
5 practitioners, depending on what community they may  
6 be around.

7 So hopefully that kind of helps keep you  
8 all up to date. If you ever have questions about  
9 that, myself or Jesse or our lobbying team would be  
10 happy to go over that with you all.

11 So that is our big goal. We are also  
12 holding an APRN Day at the Statehouse, kind of like  
13 ONA has Nurses Day at the Statehouse, next week,  
14 actually. Ours is looking at October. Tentatively  
15 October 8 is what we are looking for. We're just  
16 waiting to finalize the location, so that will be an  
17 area of time that we can come as APRNs and talk about  
18 where we are and meet with our legislators and just  
19 continue that process of educating them.

20 So where are we on things maybe we can  
21 kind of collaborate with? One is preceptors. So we  
22 know the schools and students, and we see all the  
23 Facebook posts looking for preceptors, and one thing  
24 that we've talked about looking at is a preceptor tax  
25 credit, and maybe that's an option of incentivizing

1 people to want to precept, because we know as APRNs,  
2 sometimes that does take time out of our day, and  
3 sometimes does maybe make things a little bit slower  
4 for us in seeing our patients, but we also have all  
5 been there, and we are continuing to work together  
6 and nurturing those new people coming in so that  
7 someday they may be the great quality that we want  
8 and hope for.

9           So we are looking at -- we looked at a  
10 couple of other areas around, for example, you have  
11 states like Georgia, Hawaii, Colorado, New York,  
12 Maryland that have legislation currently for a tax  
13 credit, and that has been passed; and then states  
14 like Kentucky, Minnesota, South Carolina, who are  
15 working on it, and a tax credit may range from 500 to  
16 1,000 per student.

17           At times there are states that allow for  
18 multiple students to be able -- for that one  
19 preceptor so they cannot just have one. They can  
20 precept three students, they might get that same  
21 amount for those three students. And some of the  
22 states include other positions, dentists or other  
23 disciplines or not just a tax credit for APRNs.

24           The problem, of course, comes to funding,  
25 and so we are trying to figure out and look at

1 different rates that we believe probably we can do  
2 that. So maybe that's something, a conversation that  
3 we can have and see what ideas we can bounce back and  
4 forth to help fill that gap of finding preceptors and  
5 students not having to travel hours to do that.

6 Another thing that we are looking at or  
7 maybe something we can kind of discuss maybe is  
8 global signatures. Included in global signatures are  
9 the ability to sign death certificates and those  
10 simple papers that we can't currently do. That's  
11 some legislation we have kind looked at but trying to  
12 figure out what is going to be the best route for  
13 that.

14 Then the last one is medication-assisted  
15 treatment, or MAT. And for those that don't know,  
16 medication-assisted treatment, or MAT, is the ability  
17 to prescribe bupropion -- I'm sorry, bupropion for  
18 patients who are dealing with different addictions.  
19 And so we want to -- we know there's a huge addiction  
20 crisis out there and mental health issues that we are  
21 trying to work through.

22 And we know that's another area of  
23 deficit besides primary care that the standard of  
24 care removal would help with, but currently CNSs and  
25 CNMs do not have the ability to prescribe for

1 medication-assisted treatment via the abuse and  
2 mental health services.

3 In October of 2018 the Substance Use -  
4 Disorder Prevention -- which promotes opioid recovery  
5 and treatment support for patients in communities --  
6 Act was signed into law. And in that section it does  
7 support that lasting authority for NPs and PAs to  
8 prescribe through the medication-assisted treatment.  
9 This action permanently extends it to these  
10 providers, which would be the APRNs and NPAs, who  
11 were originally granted in 2016 just for five years,  
12 but it extends that and expands the potential pool of  
13 MAT providers, or medication-assisted treatment  
14 providers to include CNSs and CNMs.

15 This waiver does require completion of 24  
16 hours of a CE, which OAAPN currently has available  
17 for free, actually. The SAN and HSA site, which is  
18 the substance use site, has to be updated prior to  
19 the Board of Nursing considering a waiver for them.  
20 We have reached out to them to see if they will do  
21 that, and they actually have until October of 2020 to  
22 do so, so the timing to reach out to them, we have  
23 the next year and a half.

24 So while all APRNs are able to take this  
25 course, the course that OAAPN provides or the waiver

1 course, currently CNNs and CNSs are not able to  
2 obtain the waiver until they do update their site,  
3 and, of course, it has to circle back to our Board of  
4 Nursing to be able to clear that.

5 So we're hoping that their response will  
6 be they are able to do that by the end of the year.  
7 That would be nice. Of course, it passes through to  
8 our patient population.

9 So that's what I have.

10 CHAIR KEELS: Great. Thank you. That's  
11 a lot. There's lots going on. Thank you for the  
12 slate of ideas. I'm sure we can talk to the  
13 appropriate people and see if there's anything that  
14 can be done.

15 As far as the wrestling, is that just --  
16 that's an Ohio high school rule. It's not a rule or  
17 law in statute, right?

18 MS. GREAVES: No, that's correct. So  
19 we're just specifically working with them. It's not  
20 a law.

21 CHAIR KEELS: Okay.

22 MS. EMRICH: Also currently CNSs are  
23 available for a waiver.

24 MS. GREAVES: So we're just actually  
25 trying to do that. I took the 24-hour course, but

1 the federal government, we all know how it works. So  
2 it was Senator Portman's piece of legislation  
3 2.0 that allowed us to take the course. SAMHSA is  
4 under the Executive Branch, and SAMHSA hasn't updated  
5 their website to allow a CNS to apply. So when I  
6 reached out to Portman's office, they say there's  
7 nothing they can do. That's the Executive Branch.

8 So we're waiting on SAMHSA. SAMHSA says,  
9 Well, we don't have to technically implement this  
10 until October -- we have two years, until October  
11 2020. But they said sometime between now and then we  
12 will probably have the site ready.

13 MS. EMRICH: Have you contacted the Ohio  
14 Department of Mental Health and Addiction Services?

15 MR. McCLAIN: So for this issue I have  
16 not. I mean, I can try. We have a relationship with  
17 them. But I'm under the impression it's federal, and  
18 there's nothing the State can do.

19 MS. EMRICH: Right, correct.

20 MR. McCLAIN: I mean, they passed the  
21 legislation. They just have no timetable for  
22 publication. And Senator Portman's office was  
23 actually befuddled when they realized they didn't put  
24 an implementation piece into the legislation. So  
25 they usually put in an implementation piece. Well,

1 they didn't on this one, and so they literally have  
2 two years.

3 MS. EMRICH: Okay.

4 CHAIR KEELS: Would you recommend us  
5 reaching out to them?

6 MR. McCLAIN: I can. Sometimes they have  
7 a lot more information right away for us because  
8 they're implementing that as well.

9 CHAIR KEELS: Okay.

10 MR. McCLAIN: That's the only thing.

11 CHAIR KEELS: Okay. I appreciate that.

12 Thank you.

13 Sandy.

14 MS. WRIGHT-ESBER: I want to thank you so  
15 much. I think this is something we should have  
16 regularly. Some of us know more than others what's  
17 going on in the state, so I really appreciate your  
18 time with that.

19 I want to talk a little bit about the  
20 preceptor issue, and, Kris, you may know this better  
21 than I do. My understanding was that I think it was  
22 not passed, a rule saying that accredited APRN  
23 schools have to help with the clinicals.

24 MS. SCORDO: No. That's from CCME. If  
25 you say on your website -- because I'm a site

1 evaluator, and I talked to Jennifer Putman about this  
2 because there are things all over the Facebook page  
3 that were totally incorrect. There really were.  
4 Everybody take in a deep breath.

5 If the school site says we will get you a  
6 preceptor, then you better be getting them a  
7 preceptor. All right? But most sites say that we  
8 will help facilitate that. But there's no law or  
9 rule that says the school must get a preceptor, and  
10 that comes straight from the accrediting body.

11 MS. WRIGHT-ESBER: Thank you for that.

12 So with the tax credit, you know, I  
13 have -- our APRNs have RVU incentives that can be  
14 very robust, but they don't take a student because it  
15 would slow them down, so I can't see where a \$500 tax  
16 credit is going to be that attractive to them. I  
17 wish we could do something a little bit stronger for  
18 them.

19 MS. GREAVES: Yes. The question comes  
20 then where does that money come from. That's the  
21 hard part. We are definitely open to ideas how we  
22 can help with preceptorship. It's just -- you know,  
23 it's a challenge. There's so many students.

24 MS. WRIGHT-ESBER: Yes.

25 MS. GREAVES: And so how do we --

1 MS. SCORDO: And you do know that some of  
2 the PA schools are paying good money to the  
3 preceptors.

4 MS. WRIGHT-ESBER: APRN schools have  
5 offered to pay me as well, our organization.

6 MS. SCORDO: They must have money there.

7 MS. WRIGHT-ESBER: Yeah. The for-profit  
8 schools --

9 MS. SCORDO: It falls back on the  
10 students.

11 MS. WRIGHT-ESBER: I don't want to go on  
12 the slippery slope of paying for the highest bidder.

13 MS. SCORDO: No, exactly.

14 MS. GREAVES: And sometimes the payments  
15 they do pay doesn't go to the APRN.

16 MS. WRIGHT-ESBER: Oh, it can't go to the  
17 APRN because then you are paying double.

18 MS. GREAVES: Right.

19 MS. SCORDO: It's a very big issue.

20 MS. GREAVES: We are definitely open to  
21 conversations and willing to --

22 MS. SCORDO: You know, at a fellows  
23 meeting a number of years ago, that was the hot  
24 topic. And Elizabeth, you may know her. She's at  
25 Ohio State. I'm trying to think. She's the head of

1 fellows, and she may have some ideas along those  
2 lines. I'm sorry, I'm drawing a blank on her last  
3 name. But that was one of our charges at the fellows  
4 meeting, was look at these issues.

5 MS. GREAVES: Great. If there's anything  
6 we can do.

7 CHAIR KEELS: Let us know if you solve  
8 the problem.

9 MS. SCORDO: We need a central clearing  
10 agency or something in Ohio that knows all -- has all  
11 of the context. And I know that there's somebody  
12 that I met a number of years ago that is doing this  
13 as a business. But it's like we need a central  
14 clearinghouse. We talked about this ten years ago,  
15 that, you know, I know what you've got. You know  
16 what, you know, Ohio State has, Cincinnati, and  
17 whatnot, that we can kind of funnel things and try to  
18 work together, because everybody is competing and we  
19 all know it.

20 MS. WRIGHT-ESBER: Right. And the GME  
21 money, this is what I've been hoping for, you know,  
22 when I've been approached by these private schools.  
23 I'm hoping for GME funding. So I don't know if  
24 that's the route that we take, you know, trying to  
25 do it like medical schools and residencies. There's

1 really no reason not to do that.

2 CHAIR KEELS: Pete, do you have a  
3 question?

4 MR. DiPIAZZA: You know, this may be more  
5 for Kris but chime in. I'm curious as to what keeps  
6 us from doing multi-student precepting, so more than  
7 one on one with a preceptor. I see a lot of -- I  
8 still see a lot of one on one where it's one student,  
9 one preceptor. It's more of --

10 MS. SCORDO: If you have a large  
11 practice, the extent of the group or whatever, I can  
12 put a number of students in that, but I don't -- I'm  
13 not --

14 MS. WRIGHT-ESBER: Space is an issue.  
15 Where are you going to put these bodies, if you're  
16 talking about outpatient or inpatient.

17 MS. GREAVES: And I precept at a couple  
18 of universities, and when you are an APRN, you are  
19 not allowed to have more than one or maybe two at  
20 max. And that goes back to the quality. How much  
21 are you really able to spend time educating that  
22 student if you have multiple students? You don't  
23 have the individual attention from the APRN,  
24 whatever, that they might be getting.

25 CHAIR KEELS: It's a vexing problem. And

1 it, you know, kind of all rolls down together because  
 2 we want students to have good clinical placements and  
 3 gain good experiences and they're prepared when they  
 4 graduate.

5 MS. SCORDO: Right.

6 MS. GREAVES: Thanks for your time, guys.  
 7 I really appreciate it.

8 CHAIR KEELS: Thank you.

9 MS. GREAVES: Have a great day.

10 CHAIR KEELS: All right, thank you.

11 All right. Guess what? We're ahead of  
 12 schedule. How did that happen?

13 MS. WRIGHT-ESBER: Because there's only a  
 14 few of us here.

15 - - -

16 GENERAL INFORMATION AND UPDATES

17 CHAIR KEELS: All right. So we are not  
 18 going to go to lunch right now. Next up we have  
 19 General Information and Updates. Lisa earlier sent  
 20 the video recording of the nurse practitioners  
 21 report, the AEI.

22 MS. EMRICH: It was a companion to the  
 23 earlier article. I thought it was a nice add-on.

24 CHAIR KEELS: Very important information,  
 25 impactful.

1 Next up is the Legislative Report.

2 - - -

3 LEGISLATIVE REPORT

4 CHAIR KEELS: Tom, do you have any  
5 updates you want to provide to us? We have in our  
6 packet your written report of important things for  
7 the Board to know.

8 MR. DILLING: Thank you. If I can try to  
9 fill in. So in follow up to some of the discussion  
10 which is, you're right, it's all integrated in some  
11 way, shape, or form, these discussions. The last  
12 discussion talking about what is happening in APRN  
13 schools and education and so forth, with the audience  
14 here it is probably good to reiterate that we, as the  
15 Board of Nursing, do not regulate the APRN schools.  
16 We do the LPN. We approve LPN schools and RN schools  
17 but not the APRNs.

18 Why that is and so forth, you know,  
19 that's a legislative decision. So all this being  
20 discussed, we don't really have much impact yet, how  
21 you're educated, to what extent you're educated, and  
22 so forth. It does play into the discussion about the  
23 scope of practice and legislation.

24 In my memo, we did talk about the fact  
25 that this last General Assembly ended on December 31,

1 so that ended those bills, as they were written and  
2 where they were sponsored, who their sponsors were  
3 and so forth. But certainly we fully expect those  
4 issues to be reintroduced at this session.

5           There's only been a few bills out so far  
6 this year. We haven't had to worry. Part of that is  
7 because the budget is taking place in these first few  
8 months. The Governor has until March to introduce  
9 his budget. It's a new Governor so he needs to  
10 reacquaint himself with all that is at play that you  
11 probably read in the papers, that there are these  
12 other budgets that are separate of sorts, but, of  
13 course, they're related because it's money coming out  
14 of the General Revenue Fund, such as the gas taxes.

15           Back to the APRN legislation, we reviewed  
16 that well enough that. We're certainly happy to talk  
17 about that as we go through working on the  
18 committees.

19           There is other APRN legislation. That  
20 would be the CRNA, and those bills did not pass the  
21 last General Assembly, but expect to see those bills  
22 reintroduced. There were three bills on the CRNA.  
23 Two were more alike to each other than the third  
24 option, and to get that reintroduced, if the  
25 interested parties are meeting with opponents that

1 sponsor the bill, you know, that may be some reason  
2 why it has not been reintroduced yet and hit the  
3 ground running, I'm sure.

4           The fact that it was discussed in  
5 committees several times is a good sign. It  
6 certainly has kind of set the table for passing those  
7 this General Assembly. Taking it from the Board's  
8 perspective, we would love to have some finality to  
9 some of these discussions. They have been going on  
10 for quite some time.

11           As far as specific legislation that does  
12 impact all nurses, House Bill 119 passed at the end  
13 of General Assembly did include an amendment that the  
14 Board asked for to change the language in our  
15 monitoring programs statute to use the term  
16 "substance use disorder."

17           And I apologize because I got caught up  
18 in the misuse of the term here in my memo. I stated  
19 that they added the term "substance abuse disorder".  
20 Later I used the term "substance use disorder," and I  
21 tied it to this. When the Board initiated this, we  
22 did use the term, I'm pretty sure, "substance use  
23 disorder." But when things got done sort of at the  
24 end, the draft just came back, and there were a  
25 number of different sections where that terminology

1 was misused.

2           Substance use disorder you will find in  
3 our monitoring programs. We had it throughout that.  
4 But there's another reference somewhere in our code  
5 that does use "substance abuse disorder." So we  
6 changed our rules, too, at the end of 2018 to use  
7 "substance use disorder" as well. It's not a biggy.  
8 The legislature will correct it here. That was one  
9 of the typographical errors that happens sometimes  
10 when it's already on the table.

11           But the positive here is, one, it updates  
12 the terminology. It really isn't terminology that's  
13 used throughout the Revised Code, but it needs to  
14 start to change over. And the intent on the part of  
15 the Board to revise it is to capture more people into  
16 the program, which is promoting persons to come  
17 forward to deal with their issues before they  
18 potentially harm someone. So I think we're all the  
19 same in terms of our goals with that in that area.

20           There's also House Bill 541 that passed a  
21 law where a number of regulators got an exception  
22 to the licensure for charitable events under certain  
23 conditions that last no more than seven days. Ours  
24 was a little different in that the exemptions that  
25 were already there, we wanted to state that in the

1 ORC code section rather than a standalone section to  
2 maintain consistent regulation in that part of the  
3 legislation. So they accepted that, so I see that as  
4 a positive. These charitable events occur a lot  
5 throughout the state to provide access to care where  
6 that wasn't great access to such essential services.

7           Senate Bill 255, I commented on briefly.  
8 It's a lot bigger than just one paragraph.  
9 Essentially all boards get sunsetted unless they are  
10 rescued by the Sunset Committee by review over a  
11 five-year period of time. It's done incrementally.  
12 There is not a schedule set up as yet.

13           It's part of a system that throughout my  
14 30 years here there's always been some sort of  
15 conditions on sunset that come up every couple of  
16 years. Some boards go away and some come into the  
17 system. I don't know if that's going to change much  
18 over time.

19           But that type of bill, there is a  
20 follow-up here that introduced Senate Bill 1, which  
21 was part of a group of bills there. I guess the  
22 focus was to lessen the number of rules that each  
23 board has. And, of course, it's being treated across  
24 the board spectrum. So I think when it was  
25 introduced it was like 50 percent of your rules

1 should disappear, and then it was down to 30 percent.  
2 It didn't pass. I think it's back with the  
3 30 percent.

4 Of course, when legislation is passed,  
5 lots of time it's like fill in all the blanks with  
6 rules, which, of course, you find it is  
7 counter-purpose to what the bill is. It will be  
8 heard, Senate Bill 1, so that's one that you should  
9 keep your eye on.

10 The PAs had a bill, Senate Bill 259, that  
11 passed. I would say more than ever, I guess, that  
12 piece of legislation has more to do with board  
13 processes. I've had experience over the years with  
14 both boards. I would say that the gist of it is that  
15 over the years you see that the APRN laws, the PA  
16 laws are becoming more simple, more so than years  
17 ago. We are getting to the point where the Medical  
18 Board was looking to streamline things more so. It  
19 used to be where the Medical Board had to approve so  
20 many different types of individual practices. Now  
21 lots of that is defined in the statutes and less rule  
22 approving this sort of thing. So they move faster.  
23 There's a more broader scope, I would gather, you  
24 know, than what's written in terms of detail.

25 But for the most part that was what

1 happened in that bill. It was introduced with some  
2 language about anesthesia services, the anesthesia  
3 practice. PAs have a statute that is very specific  
4 to that. Instead of trying to look at the scope of  
5 one's practice, it basically tells you, "don't do  
6 this," because PAs scope really depends on that  
7 supervisory relationship that's provided, you know,  
8 even more so than different tracks. Again,  
9 separately they're still subject to the law. I would  
10 guess that the PAs further discussed that portion of  
11 the statute here at the General Assembly.

12 MS. WRIGHT-ESBER: Tom, can I ask you --

13 MR. DILLING: Sure.

14 MS. WRIGHT-ESBER: -- did that get  
15 removed?

16 MR. DILLING: Yes, it was removed during  
17 discussions.

18 MS. WRIGHT-ESBER: I know about the deep  
19 sedation.

20 MR. DILLING: Right. I just always --  
21 you know, things get removed.

22 MS. WRIGHT-ESBER: And put back in.

23 MR. DILLING: A lot of times a bill  
24 passes, and I will just tell you, I heard that will  
25 be revisited, you know, but I don't yet have the

1 specifics of that.

2           There were some nursing things, overtime  
3 requirements and so forth, again, for all nursing  
4 practice. That was one, House Bill 456, that was so  
5 big, it kind of petered out. I think that there was  
6 some agreement on a number of issues. There were  
7 just some issues that just linger and, perhaps, carry  
8 over. So rather than do it piecemeal, the groups all  
9 decided, you know, let's come back a step at a time.

10           As Joscelyn mentioned, the ONAs had their  
11 Nurses Day here in Columbus, so we want to do that.  
12 What was intended by the ONA was really in terms of  
13 proponents for all nurses.

14           I don't know if the people in here have  
15 heard of this House Bill 501, Senate Bill 337.  
16 Remember, we talked about it at the Board, something  
17 the Board is always interested to hear, and that's  
18 the use of the term "veterinary nurse" title, put  
19 that into statute for veterinary technicians.

20           It did pass out of committee, the  
21 Agriculture Committee of the House, rather easily.  
22 There are a lot of people on that committee that work  
23 with veterinarians and veterinary techs, and they  
24 were, like, Hey, I understand it better when they  
25 explain they're kind of like a vet nurse because they

1 do this and that.

2           Certainly the ONA and opponents, I  
 3 understand there were a lot of letters written, phone  
 4 calls made, texts sent in opposition. This would be  
 5 essentially a group that started in a few states in  
 6 terms of legislation, but the committee -- or the  
 7 association for the vets said, this is something we  
 8 want to do and spread across the country. So, you  
 9 know, it's difficult enough to get one state that's  
 10 buried it, you know, those titles.

11           This may be responded to by the ONA with  
 12 some kind of legislation trying to secure more the  
 13 title of nurses. So I'm sure there are ardents on  
 14 both sides, but this one, again, you will probably  
 15 see the next legislative session, and I'm sure there  
 16 be spirited with that.

17           That's about it, you know, without  
 18 getting into -- there's really no way to get into all  
 19 the specifics.

20           CHAIR KEELS: Great. Any questions?

21           Thank you.

22           MR. DILLING: Thank you.

23           - - -

24           2017 NATIONAL CERTIFICATION STATISTICS

25           CHAIR KEELS: Next up is something that

1 was included in your packet, the 2017 National  
2 Certification Statistics.

3 - - -

4 MEDICAL MARIJUANA NCSBN GUIDELINES FOR BONS

5 CHAIR KEELS: The other FYI was NCSBN  
6 published guidelines for BONS for medical marijuana.  
7 The Board at the upcoming meeting will be discussing  
8 that to see if there's anything to do around that.

9 MS. EMRICH: And this was, I think,  
10 raised because at the CPG meeting there was a lot of  
11 discussion, you know, which -- it's really  
12 hospital-policy specific, a hospital saying we're not  
13 going to, you know, allow patients medical marijuana.  
14 It's the hospital policy.

15 MS. WRIGHT-ESBER: Just to clarify, it is  
16 not a prescription; it's a recommendation so --

17 CHAIR KEELS: APRNs cannot recommend and  
18 not prescribe. Don't do it.

19 MS. WRIGHT-ESBER: Don't do it.

20  
21 MR. DiPIAZZA: Nurses can't administer in  
22 Ohio, correct?

23 MS. EMRICH: It is not an approved or  
24 prescribed drug. You would have to otherwise be  
25 registered with the Board of Pharmacy. And because

1 each patient receiving medical marijuana may have up  
2 to two caregivers --

3 Is that the term "registered caregivers"?

4 MS. DiPASQUALE: Registered caregiver.

5 MS. EMRICH: So people, a nurse, not  
6 related to the nursing license, can be a registered  
7 caregiver.

8 CHAIR KEELS: And would that be in a  
9 homecare setting or --

10 MS. EMRICH: It's not a drug and it's not  
11 a prescribed order medication.

12 MS. DiPASQUALE: It's recommended.

13 MS. EMRICH: You know, we sat there, and  
14 we really wanted you to have the one that was  
15 specific to practitioners and educators. It was very  
16 informative. They were actually from a committee  
17 created by the National Council of State Boards of  
18 Nursing. Our legal counsel was a member of that  
19 committee.

20 CHAIR KEELS: Tom.

21 MR. DILLING: Just to reiterate here,  
22 this is not the Board of Nursing taking any type of  
23 position here. It's essentially the Department of  
24 Commerce, the Board of Pharmacy, the Board of  
25 Medicine. They meet on a regular basis. They're all

1 charged with various aspects of this program. Where  
2 nursing becomes involved potentially is through the  
3 caregiver.

4 APRNs are not authorized to recommend  
5 marijuana. But this article about the published  
6 guidelines and information put out in the Momentum, I  
7 would think there's a recommendation that nurses read  
8 that and study that.

9 This is something that's new, and this  
10 doesn't mean we may not be caring for someone who is  
11 using medical marijuana under the recommendation from  
12 somewhere else. My read-through of this document is  
13 saying as a health-care provider, you would be  
14 well-off to understand when faced with those type of  
15 situations what are your options and what are the  
16 potential effects of caring for someone using medical  
17 marijuana.

18 MS. WRIGHT-ESBER: Just to add to that,  
19 Tom, the hospital systems are now bringing out  
20 guidelines. Our providers are not recommending it  
21 but patients may be on it in a customer setting, a  
22 patient setting, so how will we deal with that? So  
23 you will see organizations put in policies so we know  
24 how to manage this because it's new.

25 MR. KALINYAK: We'll just have a bong

1 room.

2 MS. WRIGHT-ESBER: It's no smokeable,  
3 correct? It's no smokeable marijuana. It's all  
4 edibles.

5 - - -

6 DISCUSSION: FORMAT OF GUIDANCE DOCUMENT

7 CHAIR KEELS: Well, next up is a  
8 Discussion of the Format of the Guidance Document.  
9 We are back up to items. So in our packet today, hot  
10 off the press, is a very, very, initial draft that  
11 Lisa and her staff have been working on.

12 Why don't we distribute that. Chantelle  
13 is going to distribute some to the galley to take a  
14 look at. I will give you all a few minutes to read  
15 through it, and then we will start cracking.

16 (Document distributed.)

17 CHAIR KEELS: We are back. All right.  
18 So questions, comments, ideas.

19 MR. DiPIAZZA: Kris has a question.

20 MS. SCORDO: We were talking about the  
21 age thing on here when you do young adult, because I  
22 think we get -- I get a lot of questions on, I have  
23 this person in the emergency room. This is how old  
24 they are. Is it within my scope?

25 I know what I say and what we used to say

1 on the ANCC, but Ohio, the definition for young  
2 adult, do we have an age?

3 MS. EMRICH: Can I respond?

4 MS. SCORDO: Yes. That's what we were  
5 talking about.

6 MS. EMRICH: So, in short, there's -- let  
7 me begin from even ten years ago. You used to -- on  
8 the test plan for all the national certifying  
9 examinations, you would have age. It would say, Put  
10 age and years on there.

11 They are moving away from -- I have  
12 clearly seen all of them are moving away from that,  
13 and they are going by development stages, so this  
14 reflects growth and development stages and no longer  
15 ages.

16 Now, Ohio, we have never, ever, within a  
17 national certification for CNP just said you can  
18 only -- there's nothing in our law and rules that  
19 say, Oh, adult is 18 or above. This is based upon  
20 the national certification, that examination. It's  
21 not about any hard or fast law or rule. We always  
22 refer, CNPs, to determine what is the age range of  
23 patients that you can manage.

24 MS. SCORDO: Right. Exactly. That's  
25 what we thought.

1 MS. EMRICH: So that's why we went -- the  
2 purposes of the boxes and the grid, we went with the  
3 growth and development stages and not an age.

4 MS. SCORDO: Which goes with the  
5 certification exams.

6 MS. EMRICH: Yes, exactly. They're  
7 intertwined.

8 MS. SCORDO: Right. And they're  
9 different state by state.

10 MS. EMRICH: That's why they're tested  
11 over these. For example, the pediatric primary goes  
12 to young adult.

13 MS. SCORDO: Right.

14 MS. EMRICH: And that's clearly stated in  
15 their test plan.

16 MS. SCORDO: Right.

17 MS. EMRICH: Can I walk through it?

18 CHAIR KEELS: Please do.

19 MS. EMRICH: Thank you. This is the  
20 initial draft, as I said. There's a few caveats.  
21 This is specific to CNP. CNPs have a different  
22 scope -- statutory scope of practice than even a CNS,  
23 and this is where we are getting all of our  
24 questions, from the CNPs. So this whole interpretive  
25 guideline is only about the CNPs.

1           We start with the purpose of the  
2 guideline, and it's to provide guidance, and it's  
3 relative to the patient, the patient's state of  
4 growth and development, gender, because we do have  
5 women's health in here, and then managed conditions,  
6 so we thought we would generalize it in that way.

7           And then we have to certainly include the  
8 licensure and scope of practice that's in the statute  
9 as well as the standard of care arrangement, which is  
10 in .431. Then we go into -- we've heard a lot of  
11 discussion at the Committee this last year and a  
12 half, and especially the last year, about the term  
13 "critical." There's been a significant amount of  
14 discussion, especially from the use of the acute care  
15 certification. So everyone seemed to generally agree  
16 on CMS's use of -- and we checked here. This was  
17 reviewed internally, and we can use -- a CMS uses the  
18 term "for purposes of reimbursement," but it is  
19 generally accepted definition that we can use to  
20 describe what we mean by critical or critical care,  
21 so we included that in the IG and gave the  
22 appropriate footnote reference to it as well, of  
23 course.

24           Then we go through what is required for  
25 an APRN-CNP practice. Actually, you need a valid

1 current APRN license. You do have to have maintained  
2 consistently your national certification by a  
3 national certifying organization that is approved by  
4 the Board. You know we have those lists of all those  
5 organizations on the website.

6 We do require CNPs to enter into the  
7 standard of care arrangement with a collaborating  
8 physician or podiatrist, so we go through that, and  
9 there are qualifications for the physician or  
10 podiatrist in the statute so we felt the need to  
11 include it here.

12 We also included the caveat for the psych  
13 mental health CNP that they get a broader range of  
14 physicians with whom they may collaborate because  
15 they are psych/mental health certified.

16 MR. KALINYAK: Excuse me. Did they  
17 change law recently? I mean, where the CMS would do  
18 primary care did they change that to CNPs as well?

19 MS. EMRICH: Yes, the CNPs have primary  
20 care now.

21 MR. KALINYAK: Okay.

22 MS. EMRICH: We included the APRN-CNP  
23 statutory scope of practice, which is just listed in  
24 outline here, which is preventive and primary care  
25 services, services for acute illnesses, and

1 evaluation and promotion of patient wellness. That  
2 was taken from the statute.

3 And then we go through and say the  
4 "APRN-CNP's practice is consistent with master's or  
5 doctoral degree program that qualified the APRN to  
6 sit for their national certification exam and in  
7 accordance with their national certification as  
8 provided" -- and again we go back to section .41.

9 And we mention that because also .46  
10 requires the Board approve national certifying  
11 organizations have testing requirements that are  
12 developed in accordance with accepted standards of  
13 validity and reliability and open to registered  
14 nurses who have successfully completed the education  
15 program required by that organization, so everything  
16 goes back and forth. It is interdependent.

17 And then we recognize what is currently  
18 out there as far as national certification and who is  
19 the national certifying organization that provides  
20 it, because, for example, Family Across the Lifespan  
21 both ANCC and AANPCB both have that certification, so  
22 we included that. Then we have Adult Gerontology  
23 Acute Care, which is ANCC and the AANPC Board, and  
24 Adult-Gerontology Primary Care, ANCC and the AANP  
25 Certification Board.

1           We have Pediatric Acute Care, which is  
2 the PNCB. We have Pediatric Primary Care, which is  
3 soon going to be only PNCB because ANCC is retiring  
4 it. They just do not have enough testers to maintain  
5 that particular certification. Then we have  
6 neonatal, which is the NCC, Women's Health Care,  
7 which is NCC and then, of course, we have  
8 Psych/Mental Health Across the Lifespan, which is  
9 ANCC. So those are the current available national  
10 certifications.

11           MS. SCORDO: The American Association of  
12 Critical Care Nurses.

13           MS. EMRICH: Oh, yes, they have critical  
14 care too. You're right. You're right. I will add  
15 that.

16           MS. SCORDO: Thank you.

17           MS. EMRICH: That's correct. Thank you.  
18 That's why we are looking at this. Thank you very  
19 much.

20           MS. SCORDO: That's just the adult care.

21           CHAIR KEELS: Yes, acute care.

22           MS. EMRICH: And I'll need to look at  
23 their particular test plan as well.

24           Then, of course, we give the  
25 accountability and responsibility of APRN-CNPs, which

1 is what everyone should be doing anyway. And then we  
2 give all the references or citations to current  
3 statute and rule.

4 Then we get to the general visual chart,  
5 and we really -- this is actually two other  
6 iterations of the chart, and we all looked at it and  
7 thought that this was the easiest. This was the most  
8 eye-friendly, but if you want to look at the other  
9 two, we have them available on PowerPoint later, if  
10 needed.

11 So with each certification we went with  
12 the vertical going from usual state of health, and  
13 you notice I didn't say healthy. I said usual state  
14 of health. We thought that would be the most -- to  
15 critical, highly critical. So this went into the two  
16 of them together. And then, of course, we went from  
17 birth to -- notice we didn't say to death. We said  
18 geriatrics. So we went to the end of a usual  
19 lifespan because death can occur and palliative care  
20 and end-of-life care can actually occur at any age of  
21 life development, so that's why we chose to do that,  
22 so up to geriatric.

23 So for the first chart we look at -- the  
24 purple is family across the lifespan. The lifespan  
25 came across, so it is birth throughout the whole

1 geriatric age. It is primary care. And just --  
2 we're looking at the test plan and areas we went --  
3 and this is just a general thought about where, based  
4 upon the test plan and the conditions that may be  
5 managed, treated, and we excluded the actual critical  
6 care from that.

7 Then when you look at psych/mental  
8 health, which is behind the -- it's on the same grid.

9 And, Chris, I may need some information  
10 from you. This is psych/mental health across the  
11 lifespan, but in looking at the test plan, it began  
12 with infants, the test plan. So my thinking is if  
13 you are talking about the parents or a family unit,  
14 then you would get into the young adult/adult as  
15 well, along with the infant. I don't know if we  
16 needed to move that all the way over to birth, or if  
17 it is okay to start with infant.

18 CHAIR KEELS: Unless it's included for  
19 developmental testing.

20 MR. KALINYAK: We don't necessarily do  
21 developmental testing. We ask those questions but  
22 don't necessarily do that.

23 CHAIR KEELS: We certainly have chronic  
24 babies that we do use mental health professionals.

25 MR. KALINYAK: I personally wouldn't want

1 to do that.

2 CHAIR KEELS: They're a special breed.

3 MR. KALINYAK: I mean, usually with the  
4 ages, I overheard some conversations as far as who  
5 actually defines that. Well, the ANCC really defines  
6 it. So prior to the lifespan, lifespan encompasses  
7 everything, so I would imagine unless there's some  
8 caveat to the word for parenting or something like  
9 that, an asterisk of some sort, because really, I  
10 mean, there's two, three, possibly at age four is  
11 when we start treating pediatric mental health.

12 MS. EMRICH: Are you speaking in favor of  
13 moving it over to just the whole lifespan, birth,  
14 parenting?

15 MR. KALINYAK: I would just keep it as is  
16 simply because if you put some sort of asterisk,  
17 something to the effect that birth is more parenting,  
18 those dynamics, I think that's really good.

19 MS. EMRICH: Okay. Then moving over, we  
20 are at neonatal nurse practitioner, and in this case  
21 they care for children from up to age two, actually,  
22 and it can be up to critical care and encompass  
23 primary care as well.

24 Then we have women's health/gender  
25 related. What I did not include is that in women's

1 health, the provision of care to men or males is  
2 specific to STDs, sexual issues, or things of that  
3 nature. So they can treat/involve males at that  
4 point, but that really is it, according to the test  
5 plan, and that begins for women with  
6 puberty/adolescent. That's all.

7           Then coming down to adult gerontology,  
8 acute care, you can see the blue, and it generally  
9 starts -- we'll go from the highest critical care  
10 downward, and you see a great overlap with adult  
11 gerontology primary care. It can. So we thought the  
12 overlap kind of would be important to note that. We  
13 don't know how far down or how far up. That was  
14 really an estimation on our part.

15           Then coming back over for the pediatrics,  
16 the age range -- oh, let me go back to the adult  
17 gerontology and adult acute care and adult  
18 gerontology primary, that concerns the young adult.  
19 That's clearly in the test plan.

20           On the pediatrics again, you're showing  
21 an overlap in both age to young adult. That's how  
22 it's discussed, to young adult.

23           MR. KALINYAK: I just have a really quick  
24 question as far as with the psych/mental health. The  
25 distinctions in age, mental health is a little bit

1 more difficult -- not difficult, but a little bit  
2 more challenging as far as the actual definition of  
3 an age group simply because of mental capacities. I  
4 notice that you have the puberty and adolescents and  
5 you have the young adult.

6           There's been a real -- I did my actual  
7 dissertation work on it, the transitional age youth  
8 and then adult, where you transition from  
9 adolescence. There's a specific age from adolescence  
10 into adulthood, and then from that point forward,  
11 they go adulthood into geriatrics.

12           I'm just wondering if that might be a  
13 little more appropriate as far as the definition  
14 versus -- because, you know, the way I look at  
15 psych/mental health, you have the child adolescent  
16 and then you have that specific population, the  
17 transitional age youth. Then you have the adult.  
18 And a lot of times clinicians or practitioners will  
19 see transitional age youth all the way up to  
20 geriatrics and then more or less specialize in  
21 geriatrics. In the community geriatric is defined as  
22 age 70 or greater. I'm just wondering if that might  
23 be pertinent information relative to defining the  
24 scopes, if you will, not to limit the practice but...

25           MS. EMRICH: To be more informational, of

1 course, we included the age here. You see it is  
2 pretty much the age continuum with each. It wasn't  
3 necessarily meant to restrict. It's more recognizing  
4 that continuum of the age.

5 MR. KALINYAK: Okay.

6 MS. EMRICH: Of growth and development.  
7 But if there is something additional we could  
8 footnote, we can certainly do that somewhere. We  
9 were trying to -- started out being a 12-page white  
10 paper, and we're like, wait a minute. No. No. Then  
11 we just realized we wanted this to be really concise  
12 and very visual.

13 CHAIR KEELS: It's hard to put it into an  
14 algorithm, too.

15 MS. EMRICH: It's specifically not  
16 algorithm friendly. It's not.

17 CHAIR KEELS: To me it's a good starting  
18 point. I was wondering -- I'm sorry, Sandy.

19 MS. WRIGHT-ESBER: No, no.

20 CHAIR KEELS: Under accountability and  
21 responsibility, "The APRN-CNP must apply the Nurse  
22 Practice Act and rules regulating the practice...  
23 Further, the APRN-CNP must utilize good professional  
24 judgment..." Could we refer to professional  
25 organizational standards or statements, physician

1 statement? Like how do we refer back to, for  
2 instance, NAPNAP physician statements or NANN  
3 physician statements or ANCC or ANCP?

4 MS. EMRICH: Okay. I'll check with  
5 others here or reference it out.

6 MS. SCORDO: The scope of practice for  
7 the different groups.

8 CHAIR KEELS: They have policies. Some  
9 of them are quite vague and some of them are quite  
10 specific. Some of them contain age parameters. I  
11 know NAPNAP is working on theirs, revising that,  
12 their age limits.

13 MS. SCORDO: Do you mean the differences  
14 in scope of practice or primary care, acute care? Is  
15 that what you're --

16 CHAIR KEELS: Well, those are more global  
17 ones. But then your actual professional  
18 organizations for CNPs or adult NPs.

19 MS. SCORDO: But we are referring people  
20 back to the scope of practice in this accountability.

21 CHAIR KEELS: Yes. That's true. Could  
22 we put a little --

23 MS. SCORDO: Also because acute care  
24 doesn't really have an organization.

25 CHAIR KEELS: Right.

1 MS. SCORDO: They went to AANP.

2 CHAIR KEELS: I don't think it is. First  
3 of all, when I look at AANP, that's very broad.

4 MS. SCORDO: And their main focus is  
5 primary care.

6 CHAIR KEELS: Right. But some are more  
7 specific, so you want to make sure.

8 MS. SCORDO: I mean, there's no reason  
9 why not.

10 MS. EMRICH: And I think what both of you  
11 are referring to is determining whether or not you  
12 should engage in a particular practice. It's not --  
13 what you're referring to is when you do engage in  
14 that particular standard of practice, but this is  
15 even getting -- this is your decision point.

16 MR. DiPIAZZA: Should you engage in it.

17 MS. EMRICH: Yes, and to begin with in  
18 determining whether or not to engage in it.

19 CHAIR KEELS: You're aware of the  
20 professional standards.

21 MS. EMRICH: Professional standards,  
22 right, exactly.

23 CHAIR KEELS: Tom.

24 MR. DILLING: They clarify -- going back  
25 to statutes and rules and so forth, so when you're

1 talking about good professional judgment, are you  
2 referring to, in your mind, accepted prevailing  
3 standards of care?

4 CHAIR KEELS: Correct. Correct, and what  
5 expectation.

6 MS. EMRICH: And this is consistent --  
7 this phrasing is what has been consistent with the  
8 interpretive guidelines.

9 MR. DILLING: Okay.

10 MS. EMRICH: All within the  
11 accountability and responsibility.

12 MR. DILLING: I think that if you're  
13 going with the graphs, that it's giving way to what  
14 is being done there versus statutes and rules, or  
15 perhaps you can go back and explore alternatives  
16 through that.

17 MS. EMRICH: Will do.

18 MR. DILLING: I just wanted to make that  
19 clear so that when we do go back, we have some idea  
20 in the committee that's what you aren't chasing.

21 CHAIR KEELS: Yes. Because those will  
22 morph over time, right? As evidenced by progression  
23 and when new standards of care are adopted maybe, you  
24 know.

25 MR. DILLING: Right. You know, it's a

1 nebulous standard, to some degree. Where do you go  
2 back to? You go back to the professional  
3 association, but you also go back to individual  
4 practitioners who are in these different settings.  
5 And to be quite frank, when disciplinary action is  
6 initiated just based on not rules themselves and  
7 specifics of those but more on standards of care, we  
8 will see here at the Nursing Board, as you have  
9 already seen on a more regular basis over at the  
10 Medical Board, that there is a reliance upon those --  
11 some type of expert coming in and testifying to what  
12 those standards of care are, without belaboring the  
13 point going into specific examples.

14           That's the nature of what's happening as  
15 you branch out into practice. But I'm not saying  
16 there aren't professional standards out there in the  
17 literature. There are. But it's hard to get your  
18 arms around that all in one and talk about -- how do  
19 you phrase that in shorthand? It's you're using good  
20 professional judgment.

21           CHAIR KEELS: Yes.

22           MR. DILLING: You can file a complaint  
23 with the Board when that is not being done. More  
24 often than not it's coming back, Hey, this person  
25 wasn't using good professional judgment. What does

1 that mean? So being more specific, perhaps we can  
2 get people closer to this.

3 CHAIR KEELS: Thanks. Professional  
4 judgment.

5 Sandy, you have a question?

6 MS. WRIGHT-ESBER: Go first.

7 MR. DiPIAZZA: I have two  
8 recommendations. Is it possible to have the  
9 psychiatric/mental health in a graph of their own  
10 outside of family? And then should we consider  
11 moving the neonatal down to the pediatric graph?  
12 It's just my opinion.

13 MS. SCORDO: What's the second one?

14 MR. DiPIAZZA: Move the neonatal down to  
15 pediatric.

16 CHAIR KEELS: It might be too many  
17 colors.

18 MR. DiPIAZZA: Just my opinion. I think  
19 the reason when I look at the psychiatric/mental  
20 health and families, individuals across the lifespan,  
21 psychiatric/mental health is very specific to psych.  
22 And if I was looking at this as an FNP maybe new to  
23 practice, I might think, Oh, does that mean I can  
24 treat psychiatric patients that require the skills of  
25 a psych CNP?

1 MS. WRIGHT-ESBER: Well, there's a line  
2 where they can't, yeah.

3 MR. DiPIAZZA: But --

4 MS. WRIGHT-ESBER: They do in primary  
5 care. They treat.

6 MS. SCORDO: Yeah.

7 MR. KALINYAK: Yes, absolutely.

8 MS. SCORDO: This tells me if I treat my  
9 basic anxiety and they're not getting better, I  
10 better refer them out.

11 MS. WRIGHT-ESBER: Right.

12 MS. SCORDO: That's how I look at this,  
13 that I should not be doing the complicated cases  
14 because I was trained as such in my primary care  
15 program. I kind of like that.

16 MR. DiPIAZZA: So how do you define a  
17 critical psychiatric?

18 MS. SCORDO: Well, see, that's the  
19 same --

20 MR. DiPIAZZA: I mean, I agree with you,  
21 maintaining stability for depression.

22 MS. SCORDO: To me it just points out I  
23 better do something if nothing's working.

24 MS. EMRICH: While I appreciate the  
25 conversation and the view, just to -- you know, each

1 certification block is unto itself. Obviously, there  
2 is some -- we talked about overlap and so forth.  
3 But, you know, this doesn't mean that the family  
4 nurse practitioner will be engaging in practice  
5 beyond what -- as far as psych/mental health, I mean,  
6 they cover that in their nurse practitioner practice.  
7 To me they are separate.

8 CHAIR KEELS: It would be interesting to  
9 have them all on one graph to see where they all  
10 intersect.

11 MS. EMRICH: We have one if you want to  
12 see it.

13 MS. SCORDO: Oh, my word.

14 CHAIR KEELS: It's a little nutty.

15 MS. EMRICH: It is.

16 CHAIR KEELS: Sandy.

17 MS. WRIGHT-ESBER: I have a couple of  
18 things. I like that we are using the CMS definition  
19 because I think it gives us enough leeway, you know,  
20 I'm going to say we don't want to have too strict of  
21 a guideline. So I like the critical, you know,  
22 pushes into the life-threatening, deteriorating  
23 condition. I like the visuals. I think, you know,  
24 the lines, it looks nice and clean, but it is really  
25 a blurry line.

1 MS. SCORDO: Oh, yes, definitely.

2 MS. WRIGHT-ESBER: And the definition  
3 stays big enough that I don't know if we want to blur  
4 the line. I don't know. And what is the point of  
5 not making a rule? What is the point? I think that  
6 comes to training, clinical judgment.

7 CHAIR KEELS: Right.

8 MS. WRIGHT-ESBER: Certifying bodies, all  
9 those things factor into what is that line.

10 MS. SCORDO: Right.

11 MS. WRIGHT-ESBER: And we should know it  
12 when you're getting into it.

13 CHAIR KEELS: It's hard to define it.  
14 You know it when you're presented with it. I  
15 understand.

16 MS. WRIGHT-ESBER: Yeah. I know it when  
17 I see it, but, you know, I think of a new RN. And I  
18 really appreciate the effort that went into trying to  
19 graph it out --

20 MS. SCORDO: Oh, yeah, absolutely.

21 MS. WRIGHT-ESBER: -- in a usable way. A  
22 couple of minor points. So I think Lisa already  
23 brought up the CNS issue and so many more CNSs are  
24 practicing out there, not in a traditional role  
25 they're more -- they're functioning like NPs, if you

1 will. Back in my day that isn't how they functioned,  
2 but now I have several of them.

3           You know, they can't find that  
4 traditional CNS role, so they're practicing. We have  
5 to acknowledge that. You're going to get this  
6 question, I guess. I'm anticipating that question  
7 coming of CNSs who are doing that work, where do they  
8 fall in this mix, so I think you have to look at  
9 that.

10           Remember, there are some -- as an  
11 old-timer myself, there are still some of those  
12 noncertified CNSs out there before 2000 who are still  
13 able to practice.

14           Then also in letter C, as an old-timer,  
15 you know, practice is consistent with a master's or a  
16 doctoral degree. I have very few left, but I still  
17 have some certified who did not get their master's or  
18 doctoral degree. So I think the language needs to  
19 reflect, maybe for the next 30 years, before they're  
20 all dead.

21           MS. EMRICH: Grandfathered.

22           MS. SCORDO: Grandfathered should be  
23 added.

24           CHAIR KEELS: I have some of them, a few.

25           MS. EMRICH: With CNSs, we do not get

1 certification questions from CNSs. We are not -- not  
2 yet. There are very few CNSs.

3 MS. WRIGHT-ESBER: I have about five or  
4 six that practice in primary care and maybe one or  
5 two in specialties. In mental health, of course,  
6 there's a lot of them because historically there was  
7 a lot of CNSs in mental health.

8 MS. EMRICH: They're usually disease  
9 process oriented. They manage specific diseases.

10 MS. WRIGHT-ESBER: Right. But they are  
11 practicing, so I think once it comes out, I think  
12 you're going to get more questions.

13 MS. EMRICH: We can adapt to that. I  
14 just want to make it clear they have a separate scope  
15 than what CNPs do.

16 MR. KALINYAK: And historically CNSs were  
17 not supposed to even prescribe.

18 MS. EMRICH: But they had prescriptive  
19 authority as long as the CNPs did.

20 MR. KALINYAK: I know. I know. But in  
21 the traditional sense of CNSs in mental health was  
22 primarily counseling.

23 MS. EMRICH: Thank you for your input.  
24 We'll take it back, and if you have further, just  
25 e-mail me, and we will continue to look at this.

1 It's a good start.

2 MS. SCORDO: It's a great start.

3 CHAIR KEELS: I think we got input from  
4 folks on how to best be used, and it will help guide  
5 some of those questions that APRNs are asking.

6 MS. WRIGHT-ESBER: What I like about it  
7 is that it's not a rule. It's a guideline, so I  
8 think it gives enough leeway, I'm hopeful. In  
9 looking at this quickly, it does seem like it gives,  
10 again, that line, and where that line is, you can't  
11 really say where that is.

12 MS. EMRICH: Yes.

13 MS. WRIGHT-ESBER: It's hard to say.

14 MS. EMRICH: But it gives a person a  
15 visual. If you are too far up or too far down, you  
16 should be thinking about it. That's the challenge.

17 MS. SCORDO: Since this is going to end  
18 up going public, I wonder if we shouldn't add on  
19 these references to the different scope and standards  
20 of practice for acute and primary and --

21 CHAIR KEELS: From?

22 MS. SCORDO: The ones from the  
23 organizations, the nationals.

24 CHAIR KEELS: The national professional  
25 organizations.

1 MS. SCORDO: Scope and standards of  
2 practices.

3 CHAIR KEELS: I can send mine.

4 MS. SCORDO: For primary, acute.

5 CHAIR KEELS: I like that there's this  
6 little -- kind of a disclaimer. In this interpretive  
7 guideline the Board does not announce any policy.  
8 Maybe that can be put at the beginning so people  
9 aren't like this is --

10 MR. DiPIAZZA: Right.

11 MS. EMRICH: This is not creating  
12 anything new. All we are doing is applying.

13 MS. SCORDO: Just interpreting it. It's  
14 really good.

15 MS. EMRICH: One other thing, if I might  
16 point out, it does not mention the Consensus Model.  
17 The Consensus Model is congruent with statute and  
18 rules, so, therefore, there was no reason to even  
19 refer to it so much here because it is.

20 CHAIR KEELS: Okay. People can think on  
21 it, and the next time we will bring the scopes.

22 MS. EMRICH: We meet again in April,  
23 which is pretty quickly, and then again before  
24 anything is published or goes to the Board, we will  
25 need to review it a lot further here with the AG's

1 Office.

2 MR. DiPIAZZA: Uh-huh.

3 MR. KALINYAK: Thank you for that.

4 CHAIR KEELS: Better than a 12-page white  
5 paper.

6 MS. EMRICH: It is.

7 CHAIR KEELS: Stop writing. Stop  
8 writing.

9 - - -

10 OTHER BUSINESS

11 CHAIR KEELS: Next is Lisa. Do you want  
12 to talk a little bit about the annual interested  
13 party meeting?

14 MS. EMRICH: Sure. Every year the Board  
15 begins its five-year rule review process. There's  
16 certain chapters of the administrative rules that are  
17 up for a five-year review that's required by law.

18 There are also some various rules that  
19 may need some technical revisions, you know, to bring  
20 them up to law changes and so forth. So every year  
21 the Board always calls what is called an interested  
22 party meeting. So we send out a date to  
23 organizations and persons who are very interested in  
24 what the Board does with its rules to look at any --  
25 get input on any potential rule revisions.

1 I think we did this last year, and it  
2 worked out well. We are going to hold the interested  
3 party meeting on the same day as the June APRN  
4 Advisory Committee meeting, and the plan is that the  
5 Advisory Committee will meet and have a prolonged  
6 lunch break where we will convene the interested  
7 party meeting, probably in a different room, and  
8 anyone who is interested can participate in that.  
9 Then we will reconvene the APRN meeting. We figured  
10 there are persons interested in both that will be  
11 here for the APRN meeting as well.

12 CHAIR KEELS: And are those rules posted  
13 to be --

14 MS. EMRICH: It's too early yet, but we  
15 will be providing them. We just had our initial  
16 staff meeting a couple weeks ago.

17 CHAIR KEELS: Okay. So the rules to be  
18 reviewed are not posted yet.

19 MS. EMRICH: Yes, those aren't.

20 CHAIR KEELS: Okay. So now we find  
21 ourselves at 10 till noon.

22 MS. EMRICH: We have to have a lunch  
23 break.

24 CHAIR KEELS: I don't think we have to  
25 have a lunch break. We can ask if there's any

1 further public comments. Sign in. Come on up.

2 MR. McCLAIN: I got to sign in again?

3 MS. EMRICH: No, he doesn't.

4 MR. McCLAIN: Put times two on there.

5 So, I mean, I appreciate the document.

6 It's nice to see. I scribbled on it. It's a lot  
7 digest.

8 CHAIR KEELS: Absolutely

9 - - -

10 PUBLIC COMMENT{FLUSH}

11 MR. McCLAIN: Just one concern I have off  
12 the top of my head. In looking at it, is the line --  
13 and I think Sandy already addressed that line. My  
14 fear, just moving forward, is that you guys working  
15 on this document, you would literally have to go  
16 through each disease state and define what that line  
17 is, because though we may be answering some  
18 questions, I fear a lot of people are going to create  
19 more questions about, I work in neurology. When is a  
20 stroke no longer a critical care thing? I mean, the  
21 brain dies after four minutes if you're not given  
22 TPA. Is that the minute that you're no longer in an  
23 acute-care condition? Or like DKA, one, are you just  
24 dealing with chronic diabetes, or DKA that has an  
25 anion gap of 11 diabetes, 13, DKA? I mean, like, I

1 fear that this gray window may create some more  
2 questions than helpful, you know.

3 Then I think you also brought up the  
4 educational experience, master's or doctorate  
5 program. I mean, that's great. There are some  
6 bachelor's still out there, if that.

7 MS. WRIGHT-ESBER: If that.

8 MR. McCLAIN: Yes, if that.

9 MS. WRIGHT-ESBER: Associate degree.

10 MR. McCLAIN: I am a CNS. I'd be happy  
11 to answer any CNS practice questions. But, I mean, I  
12 do have some concerns like there isn't much emphasis  
13 in this document with clinical experience. You could  
14 have FNPs, and I realize the Board of Nursing  
15 historically does a lot of grandfathering as things  
16 change.

17 But people that have been practicing in a  
18 certain setting -- and I'm not talking the ICU  
19 setting. I'm talking like a specialty cardiology or  
20 specialty nephrology or urology and, like, this  
21 document comes out and it's, Oh, my gosh, what is our  
22 practice manager going to do with the staff we have  
23 in place, whether it be FNPs, CNSs.

24 And I think it's going to create a lot of  
25 questions, especially with those boxes, and everybody

1 is going to know it's gray, everybody is going to  
2 want to know what box they fit in. So that just -- I  
3 have concerns about that, just off the top of my  
4 head, because, you know, all this education,  
5 master's, doctorate, it's all entry level, you know.

6 And, again, and I've testified before or  
7 spoke, or whatever it's called, you know, if I was  
8 limited to what I learned when I was in APRN school  
9 in 2003, you know, because the university I went to  
10 didn't have that program, it had a CNS, you know, I  
11 would be doing my patients a huge disservice because  
12 none of the drugs I use today existed in 2003, almost  
13 none of them, you know. So there has to be some  
14 leeway for clinical experience as an APRN. I mean,  
15 obviously, if you worked in the ICU as an RN, I  
16 completely get that. It's different. But as an APRN  
17 there should be some caveat for that.

18 MS. WRIGHT-ESBER: And I think we all  
19 need more time to digest just this. So you're  
20 talking more about the visual, if that went away and  
21 just had the definition?

22 MR. McCLAIN: Possibly. Again, I have to  
23 digest the words, look at the ORC and look at the  
24 references. Obviously, I can't do it on my phone  
25 here. I'm quick but not that quick.

1           But, like, everybody loves a visual, and  
2 that's why Lisa and your team probably made a visual.  
3 Everybody loves them. Everybody loves another  
4 stepwise prescribing and that decision-making model  
5 we have. You know, everybody is going to want to  
6 know what box they fit in, and there's a ceiling and  
7 there's a floor for each one of these boxes, and  
8 that's not practice.

9           You know, you may be a family FNP in your  
10 office, and all of the sudden someone has an MI on  
11 your table, and you're going to run to see if this  
12 fits in your box? I mean, that's a problem. You  
13 know, there has to be some leeway because I fear that  
14 this may create more liability than what we're  
15 already dealing with now and letting the hospital  
16 systems define where our scope is and what our scope  
17 is based on their credentialing.

18           CHAIR KEELS: You make a really good  
19 point because I work with a lot of people that are  
20 very detail oriented. I wonder, the visual is  
21 helpful for our discussion and what we've really been  
22 talking about is that overlap and where do you really  
23 just -- where is that critical piece where acute care  
24 certified, you know, are taking care of the  
25 critically ill patient, which I think -- and with

1 psych/mental health, the very complex morbid psych  
2 mental health patient or the acutely ill pediatric  
3 patient. I wonder -- so in that gray area is where  
4 you have to use your good professional judgment,  
5 right, and refer back to your professional -- your  
6 national organization standards of practice, which  
7 may or may not be helpful.

8 MR. McCLAIN: Well, I agree with that,  
9 but then I would argue on the other side of that is  
10 this even necessary, because we're all doing it  
11 anyway. You know, I mean, if we're going to say, Oh,  
12 do this yet use your professional judgment, we are  
13 doing it anyway.

14 MS. SCORDO: I know.

15 MS. WRIGHT-ESBER: What I like is the  
16 definition from CMS because in all our -- I don't  
17 know how long we have been discussing this issue,  
18 this gives a much better definition of about when  
19 somebody is really sick.

20 MR. DiPIAZZA: Yeah.

21 MS. WRIGHT-ESBER: And we were having  
22 side conversations, too, about mental health, and if  
23 you're a primary care NP taking care of your patient  
24 and prescribing meds for their depression and  
25 anxiety, where does that kick in on the diagram?

1 MR. McCLAIN: And that also -- and I  
2 agree with you, but that creates maybe another level  
3 of liability because, I mean, if you are a primary  
4 care and you have a patient that is depressed, you  
5 know, heaven forbid homicidal or suicidal, you can't  
6 pink slip that as a primary care APRN. We can only  
7 get through agreement for psych CNSs or mental health  
8 NPs.

9 So, like, if you're in your office  
10 dealing with a failing system, whether it be mental  
11 health or cardiac or what have you, there's no leeway  
12 because now we've put it in black and white  
13 definition, we could be creating more of a liability  
14 for the CNPs than you realize, rather than saying  
15 using your own professional judgment.

16 CHAIR KEELS: Thank you. We appreciate  
17 your input.

18 Any further business? Questions?

19 Let's think a lot on this. Get some  
20 input, and hopefully come back.

21 We have another yellow sheet.

22 MS. DEETER: I'm Kellie Deeter, president  
23 of OSANA, Ohio State Association of Nurse  
24 Anesthetists.

25 I'm here to discuss the importance of an

1 appropriate legislative remedy that addresses Ohio's  
2 CRNAs inability to write orders that relate to the  
3 anesthesia and clinical functions that we provide.  
4 For clarity, a clinical function would be such things  
5 as the intubation when done outside of the OR or a  
6 labor epidural, which is considered analgesia rather  
7 than anesthesia and takes place outside of the  
8 perioperative area. There are several others as  
9 well.

10           Sorry, I'm nervous. I didn't plan on  
11 doing this today.

12           The inability to order perioperatively or  
13 order succinylcholine for intubations or ephedrine or  
14 the local anesthetic necessary for epidurals is quite  
15 an obstruction to safely fulfilling the practice that  
16 they are trained, educated, certified, and consulted  
17 by physicians to provide.

18           This is not a small-scale problem, as the  
19 OSANA testified to, while opposing our last four  
20 bills. CRNAs from all over the state have reported  
21 being expected to order routinely by both their  
22 physicians and their facilities, with the only two  
23 exceptions being the CRNAs at OSU and Cleveland  
24 Clinic, main campus only.

25           The reason for those expectations are

1 that CRNAs did order throughout the history of our  
2 practice until 2013 when the Attorney General  
3 rendered a strict interpretation of the statute.  
4 Over the last five years making dramatic cultural  
5 changes in practice have not seemed to happen in this  
6 regard. In the majority of those cases, it isn't  
7 upon the attempts made by the CRNA themselves. We  
8 have several reports of bullying and retaliation  
9 against CRNAs for making attempts to not write orders  
10 by the very physicians that continue to oppose the  
11 legislative remedy.

12           Imagine going to work and literally not  
13 being allowed to practice within the law and the  
14 ramifications for complying with and practicing  
15 within the law is not being able -- not being put on  
16 the schedule by the physicians who make it because  
17 you were considered disruptive. Worse yet, imagine  
18 patients and nurses who are in conflict between the  
19 needed care, sometimes which is critical, and the  
20 current statute.

21           We plan to once again introduce  
22 legislation that addresses this issue. It will only  
23 focus on the ordering aspect rather than  
24 contemplating any removal of a physician's  
25 supervision.

1           It is noteworthy for you to be aware that  
2 there is a Senate bill that is being reintroduced  
3 this General Assembly that claims to address these  
4 issues. Last General Assembly it was Senate Bill  
5 275. This bill did not address issues that relate to  
6 ordering as part of the CRNA's scope of practice but,  
7 quote, specifically prohibits CRNAs from ordering or  
8 personally selecting or administering controlled  
9 substances.

10           CRNAs offer techniques that minimize the  
11 use of opioids; however, controlled substances are an  
12 integral part of anesthesia. For a CRNA not to be  
13 able to personally select and administer controlled  
14 substances removes 2,200 Ohio CRNA jobs in the event  
15 that would pass, if that should happen.

16           I have no doubt that this is the goal,  
17 unfortunately, of our opposition. Additionally, the  
18 bill only addresses the immediate post-op period and  
19 not the preop period where we may be performing nerve  
20 blocks or epidurals. It does not include  
21 preoperative antiemetics or others we would perform  
22 as a clinical function that is currently within our  
23 scope.

24           So I would like you to please watch out  
25 for out legislation to be introduced and understand

1 the inherent flaws that are in the other bill I  
 2 mentioned. It simply is not a starting point for our  
 3 CRNA legislation but rather further restricts are  
 4 clinical practice.

5 CHAIR KEELS: Thank you very much.

6 MS. WRIGHT-ESBER: Would you repeat the  
 7 bill?

8 MS. DEETER: The last General Assembly?

9 MS. WRIGHT-ESBER: Which one are you  
 10 concerned about?

11 MS. DEETER: 275 last General Assembly.  
 12 This General Assembly it is not numbered.

13 MS. WRIGHT-ESBER: Okay.

14 MS. DEETER: But it is coming.

15 MS. WRIGHT-ESBER: Thank you.

16 CHAIR KEELS: Good job. Thank you very  
 17 much. We look forward to hearing more.

18 - - -

19 ADJOURNMENT

20 CHAIR KEELS: With that, I think we are  
 21 adjourned. We will see everybody back on April --

22 MS. EMRICH: The 29th.

23 CHAIR KEELS: April 29.

24 (The meeting concluded at 11:59 a.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, February 25, 2019, and carefully compared with my original stenographic notes.

*Rosemary Foster Anderson*  
Rosemary Foster Anderson,  
Professional Reporter and Notary  
Public in and for the State of  
Ohio.

My commission expires April 5, 2019.

(rfa-89183)

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