

BEFORE THE OHIO BOARD OF NURSING

- - -

Meeting of the Advisory Committee on Advanced  
Practice Registered Nursing

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PROCEEDINGS

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

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1     ADVISORY COMMITTEE MEMBERS PRESENT:

- 2       Erin Keels, APRN-CNP, Chairwoman
- 3       Pamela Bolton, APRN-ACNP, APRN-CNS, Member
- 4       Peter DiPiazza, APRN-CNP, Member
- 5       Brian Garrett, APRN-CRNA, Member
- 6       Jody Miniard, APRN-CNP, Member
- 7       Sherri Sievers, APRN-CNP, Member
- 8       Michelle Zamudio, APRN-CNM, Member

9     BOARD STAFF PRESENT:

- 10       Lisa Emrich, RN, Program Manager: Practice,  
11       Education, and Licensure
- 12       Anita DiPasquale, Staff Attorney
- 13       Chantelle Sunderman, Administrative Professional

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1 Monday Morning Session,  
2 June 17, 2019.

3 - - -

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

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

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

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

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

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

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

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

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

25 MEMBER MINIARD: I'm Jody Miniard. I'm a

1 Nurse Practitioner and I'm one of the faculty members  
2 representing faculty.

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

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

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

10 CHAIRWOMAN KEELS: Oh, sure.

11 MS. EMRICH: -- to her.

12 CHAIRWOMAN KEELS: Sure.

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

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

21 MEMBER DIPIAZZA: Thank you.

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

25 And let's say hi to the folks in the

1 gallery. Good morning. Would you like to introduce  
2 yourself and who you are representing? We'll start  
3 with the front.

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

7 CHAIRWOMAN KEELS: Thank you.

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

10 MS. NEWELL: Erica Newell with OAAPN.

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

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

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

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

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

22 MS. SINGLETON: Jeana Singleton. I'm an  
23 attorney with Brennan, Manna & Diamond. We serve as  
24 counsel for the Ohio Association of Advanced Practice  
25 Nurses.

1 MS. DAVIS: Jessica Davis, also with  
2 Brennan, Manna & Diamond.

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

5 MR. McCLAIN: Jesse McClain, Clinical  
6 Nurse Specialist, representing OAAPN.

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

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

11 CHAIRWOMAN KEELS: Good morning and  
12 welcome.

13 A reminder to silence the things that  
14 make noise, like your phones and your pagers, please.

15 We are being live-streamed and videotaped  
16 by a third party as an FYI. So good morning to all  
17 of you who are joining us remotely.

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

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

25 CHAIRWOMAN KEELS: Okay. The Public

1 Participation Guideline is on the handout or  
2 available for you to take a look at. Essentially  
3 we'll hold comments until during the open forum.

4 And the Committee Charge is as follows:  
5 This Committee shall advise the Board regarding the  
6 practice and regulation of Advanced Practice  
7 Registered Nurses and may make recommendations to the  
8 Committee on prescriptive governance.

9 And for our agenda today, we have a  
10 pretty packed agenda.

11 Next up, I want to provide some comments  
12 to kind of bring us all up-to-speed on where we've  
13 been over the last two years and longer.

14 Those who are new to our Committee  
15 received quite thick packets to review, so I hope to  
16 summarize that for you.

17 We'll have public comments after that.

18 We do have a guest who will be live on  
19 the phone at 11:00 a.m., Carolyn Buppert, and then we  
20 will have some general information and updates.

21 We will break for lunch and then we have  
22 an Interested Party Meeting that starts at 1:00 p.m.  
23 on the 4th floor.

24 Depending on who attends that meeting and  
25 the number of comments, that may or may not be heard,

1 will determine how long that meeting lasts. If it's  
2 shorter, we'll come back up and start earlier.

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

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

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

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

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

20 Okay? Make sense? All right, great.

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

25 So we'll start back in 1996 which

1 concluded the APRN Pilot Program. At that time, the  
2 Board began issuing certificates of authority to  
3 CNPs, CNSs, CRNAs, and CNMs.

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

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

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

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

20 It addresses structure and congruence of  
21 graduate education with resulting national  
22 certification in one or more population foci which  
23 are the neonatal, the pediatric, adult-gero, family  
24 across the lifespan, psych-mental health, women's  
25 health/gender-related.

1           Adult and pediatrics are subdivided into  
2 two separate graduate education certifications which  
3 are the primary care and acute care certifications.

4           The model defines APRN scope of practice  
5 as the culmination of formal graduate or higher  
6 degree education which includes content from the  
7 three P's: advanced physical assessment,  
8 pharmacology and physiology, and results in a  
9 national certification exam in the role and  
10 population.

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

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

20           As a member of the NCSBN, or the National  
21 Council of State Boards of Nursing, the Ohio Board of  
22 Nursing was involved in the review of the Consensus  
23 Model and found that it was consistent with existing  
24 Ohio rule and law relative to APRNs. So the rule was  
25 -- we did not need to do anything with those rules.

1           The Ohio Board of Nursing receives many  
2 questions from practicing APRNs in the state and you  
3 all received a sample of questions in your packet.

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

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

14           Shortly thereafter, in 2017, House Bill  
15 216 was passed and enacted -- and enacted. It  
16 established this APRN Advisory Committee, and our  
17 first meeting was held two years ago on June 12,  
18 2017. As I read before, the purpose of this  
19 Committee is to advise the Board of Nursing on issues  
20 related to APRN practice.

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

1 legislative process.

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

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

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

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

24           The issue becomes at what point does the  
25 patient with the acute condition, that is high risk

1 to become or does become critical and/or  
2 life-threatening, necessitate management that is  
3 outside of the scope of practice of primary care and  
4 within the scope of practice of acute care.

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

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

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

23 So, for clarification and guidance only,  
24 the Committee proposed to use the CMS definition of  
25 "critical care" and that is "That which involves

1 high-complexity decision-making to assess,  
2 manipulate, and support vital system functions to  
3 treat single to multiple organ system failure and/or  
4 to prevent further life-threatening deterioration of  
5 the patient's condition.

6           Although this care occurs within --  
7 excuse me.

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

11           Like this definition -- excuse me again.

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

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

22           A definition of "acute care" by the World  
23 Health Organization was mentioned in previous  
24 meetings, but we can't seem to find that through  
25 research.

1                   Perhaps -- excuse me.

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

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

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

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

24                   The Interpretive Guideline pulls all  
25 existing rule and law about the scope of practice of

1 NPs into one document, similar to what has been  
2 previously drafted for RN Interpretive Guidelines.

3 It includes the CMS definition of  
4 "critical care" as a reference, but this is subject  
5 to change, as we previously discussed.

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

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

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

21 The Interpretive Guidelines is a  
22 guideline that explains the application of current  
23 law and rule. It is not, itself, enforceable by the  
24 Board. Rather, it is the applicable state law and  
25 rule that is enforceable. So we were not creating

1 any new rule or any new laws; simply describing what  
2 currently exists.

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

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

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

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

23 We reviewed the IG with them and the  
24 committees agreed that the IG was a good idea. They  
25 asked us to consider developing some FAQs and case

1 examples to accompany the IG. They also provided  
2 feedback to ensure that the graphs are consistent  
3 with national certification statements.

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

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

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

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

24 Any questions or comments from the  
25 Committee?

1 (No response.)

2 CHAIRWOMAN KEELS: No? Okay, great.

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

5 Are there any other public comments?

6 I have Jeana and Jesse.

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

9 MEMBER DIPIAZZA: There's one more.

10 CHAIRWOMAN KEELS: Oh, there's one more.

11 Sorry, I was trying to get that.

12 Thank you very much.

13 All right. Jesse representing OAAPN.

14 Would you like to come on down?

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

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

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

21 CHAIRWOMAN KEELS: Okay.

22 MR. McCLAIN: I promise.

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

25 MR. McCLAIN: No problem. I think I'm at

1 4:30, so I think we're okay.

2 CHAIRWOMAN KEELS: Thank you.

3 MR. McCLAIN: All right, guys.

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

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

10 I presume you're all here to advance and  
11 protect your profession as APRNs. With the  
12 introduction of Representative Brinkman's House Bill  
13 177, we too strive to advance our profession but,  
14 unfortunately, we have been dealing with an issue  
15 that seems to be hindering our practice because  
16 nurses are once again attacking nurses.

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

21 (Pause.)

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

25 Scare tactics have been used to motivate

1 APRNs to return to school or find other places of  
2 employment which is unnecessary.

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

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

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

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

1 practice."

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

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

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

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

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

25           Third, the hospital's ongoing practice

1 assessments required by The Joint Commission;

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

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

7 Why add a sixth later of restriction?

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

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

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

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

23 Some organizations have justified their  
24 support for state regulations to limit NP scope of  
25 practice on the grounds that they are necessary to

1 protect the public from low-quality healthcare, but  
2 Peter's research found no evidence of this.

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

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

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

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

24 Why are we trying to reinvent the wheel?

25 Our predecessors already defined APRN

1 practice. In fact, Ohio Administrative Code  
2 4723-8-01, Section (F), states: "Practice of nursing,  
3 as an Advanced Practice Nurse, means providing, to  
4 individuals and groups, nursing care that requires  
5 knowledge and skill obtained from advanced formal  
6 education, training, and clinical experience."

7 CHAIRWOMAN KEELS: Thank you. Thank you  
8 very much.

9 Does the Committee have any questions for  
10 Jesse?

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

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

17 CHAIRWOMAN KEELS: Unfortunately.

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

20 CHAIRWOMAN KEELS: I appreciate it.

21 May I ask you a question? So when you  
22 were talking about further restrictions to scope of  
23 practice, were you referring to the Interpretive  
24 Guideline or are you talking in general terms about  
25 the Standard Care Arrangement and --

1           MR. McCLAIN: The Interpretive Guideline.  
2 I mean, the Standard Care Arrangement is already in  
3 place, we are trying to get rid of that to improve  
4 access to care, but I was referring to the  
5 Interpretive Guideline.

6           CHAIRWOMAN KEELS: Can you tell me how  
7 you see that as being more restrictive to scope of  
8 practice when it seeks to simply clarify existing  
9 rules?

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

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

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

1 identify Ohio Administrative Code.

2 CHAIRWOMAN KEELS: Thank you.

3 Questions?

4 MEMBER ZAMUDIO: So when I was reading  
5 the IG, it does mention a Master's or  
6 Doctoral-prepared degree program. Can you, like from  
7 an OAAPN perspective, educate me about how many NPs  
8 are still in practice in Ohio that maybe have a  
9 Bachelor's?

10 MR. McCLAIN: I mean --

11 MEMBER ZAMUDIO: Are there some?

12 MR. McCLAIN: -- there's a few. I mean  
13 obviously that's -- I think it was '95 or '96. I'm  
14 not entirely sure --

15 MEMBER ZAMUDIO: So there are some.

16 MR. McCLAIN: -- when it was required,  
17 but yeah, there are some. I mean 1995 or '96, when I  
18 think you had to have a Master's. I'm not sure. I  
19 know some may know the exact date, but that was 23  
20 years ago. So I mean, theoretically, those will be  
21 retiring over the next few years, I think, but I'm  
22 not really --

23 CHAIRWOMAN KEELS: And we had a  
24 recommendation to acknowledge the grandfather.

25 MEMBER ZAMUDIO: Okay, great. So will

1 the grandfather, though, apply only to their  
 2 educational preparation or to their current job  
 3 function?

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

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

10 MEMBER ZAMUDIO: Okay.

11 CHAIRWOMAN KEELS: -- it would not  
 12 require that.

13 Yes, Lisa.

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

21 MEMBER ZAMUDIO: Great.

22 CHAIRWOMAN KEELS: Thanks so much.

23 MR. McCLAIN: Sorry I ran long.

24 CHAIRWOMAN KEELS: No worries.

25 Next up we have Jeana Singleton

1 representing OAAPN.

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

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

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

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

24 The only other thing is, Chairwoman  
25 Keels, you had mentioned meeting with OAAPN or

1 including them in discussions about reviewing the  
2 revised version of the IG. OAAPN is absolutely  
3 interested in meeting on that topic, so thank you.

4 CHAIRWOMAN KEELS: Thank you.

5 MEMBER DIPIAZZA: I do have a question  
6 for you.

7 MS. SINGLETON: Sure.

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

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

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

20 MEMBER DIPIAZZA: Right.

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

24 Second, it's my understanding there's a  
25 LACE document that's out there also that does talk

1 about clinical experience. I think it's important to  
2 remember that.

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

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

9 MS. SINGLETON: Right.

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

12 MS. SINGLETON: Correct.

13 MEMBER ZAMUDIO: -- everyone agreed with  
14 the terminology.

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

18 MEMBER ZAMUDIO: Right.

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

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

25 MS. SINGLETON: Absolutely, yes. Ohio

1 law and regulations are what govern Ohio.

2 MEMBER ZAMUDIO: Thank you.

3 MS. SINGLETON: Thank you.

4 CHAIRWOMAN KEELS: Next up we have  
5 Jessica Davis who is also representing OAAPN.

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

10 CHAIRWOMAN KEELS: Okay, that's fine.  
11 I'll keep you right here in this stack.

12 MS. DAVIS: Thank you.

13 CHAIRWOMAN KEELS: Dr. Margaret Graham  
14 from the Ohio State University College of Nursing.  
15 Good morning.

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

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

24 CHAIRWOMAN KEELS: Yes.

25 DR. GRAHAM: Do the new people have that?

1 CHAIRWOMAN KEELS: It was included in the  
2 packet, I believe. I have some. If not, we can pass  
3 it around.

4 MEMBER MINIARD: Jeana just distributed  
5 it.

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

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

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

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

23 And I think that we have to think about  
24 when we started Acute Care Nurse Practitioner care  
25 programs in this state. So we have people in their

1 late 40s, early 50s, who completed Family Nurse  
2 Practitioner programs or Adult Nurse Practitioner  
3 programs who are working as hospitalists, who have  
4 been doing that for many, many years; and expecting  
5 them to come back and to start brand new, I think  
6 would be -- it wouldn't be beneficial to the people  
7 of Ohio, and I think Ohio Hospital Association has  
8 made that very clear.

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

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

21 You know, I think that we start -- and I  
22 see Erin shaking her head "no," but I think once you  
23 start separating the hairs, the way I feel like that  
24 we're explaining this at the Advisory Board, I think  
25 we have to be so careful because I think we'll put

1 very well-educated Advanced Practice Nurses, who are  
2 practicing and have been practicing to their scope,  
3 at a great peril. And I think that will put the  
4 citizens of Ohio at great peril as far as losing  
5 many, many providers. I think we'll have people  
6 leaving the State, who can; those who can't, I think  
7 they will be very concerned about their practice.

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

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

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

22 The best example I can give of that is a  
23 Family Nurse Practitioner who is doing colposcopies.  
24 We don't teach colposcopies in an FNP program but  
25 there are many formal education programs that teach

1 Advanced Practice Nurses colposcopies that make them  
2 very, very well educated, and it's very safe for them  
3 to do that. That's just one of many examples.

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

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

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

22 CHAIRWOMAN KEELS: Michelle and than Pam.

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

1 DR. GRAHAM: Exactly.

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

6 DR. GRAHAM: Right.

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

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

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

22 DR. GRAHAM: Thank you.

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

25 So I think back to certification and what

1 happened in the certification process with the  
2 practice analysis, it's done every five years, that  
3 psychometrically-sound process that all certification  
4 organizations go through that's constantly repeated.

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

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

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

22           And, second, I think that the Board of  
23 Nursing and that educators of Advanced Practice  
24 Nurses and professional organizations for Advanced  
25 Practice Nurses have to work to make sure that

1 hospitals and other agencies, who are hiring Advanced  
2 Practice Nurses, recognize the importance of  
3 credentialing and recognize the importance of scope  
4 and credentialing.

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

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

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

24           MEMBER BOLTON: Being on a credentialing  
25 committee and watching that happen, the one -- what I

1 noticed is that, you know, before an APRN was  
2 represented on that committee there was -- it was  
3 really blind by the committee to decide whether or  
4 not that person was competent.

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

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

18           And you're exactly right, we have to have  
19 Advanced Practice Nurses on the credentialing  
20 committees. I mean those are things we need to  
21 advocate for, but I think that those have been  
22 designed well in some of the large institutions  
23 across the state in order to make sure there is  
24 safety, I mean, because safety is the bottom line, I  
25 think.

1                   MEMBER BOLTON:  Would you see the  
2 competency documents as one of those documents that  
3 would be used to --

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

11                   MEMBER BOLTON:  Absolutely.

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

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

22                   MEMBER BOLTON:  Thank you.

23                   CHAIRWOMAN KEELS:  Sherri is next.

24                   MEMBER SIEVERS:  Just a couple comments.

25                   I also recently was the Chair of the

1 Content Expert Panel that rewrote the FNP exam which  
2 just came out May 22nd, and so just to give you an  
3 example --

4 DR. GRAHAM: And it's a big job.

5 MEMBER SIEVERS: It was a big job. It  
6 was lots of trips to Washington, D.C.

7 And as part of that, our instructions, as  
8 we were building the ANCC exam for FNPs, was to  
9 remember it was entry-level.

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

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

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

25 So yes, clinical practice and those exams

1 are updated, but they cannot possibly represent every  
2 knowledge point that is within the scope for those  
3 certifications.

4 The other thing --

5 MEMBER BOLTON: Can I just clarify that?

6 MEMBER SIEVERS: Yeah, sure.

7 MEMBER BOLTON: So I was using that as  
8 the entry level.

9 MEMBER SIEVERS: Right.

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

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

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

25 DR. GRAHAM: Right.

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

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

12                  CHAIRWOMAN KEELS:  Thank you.

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

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

22                  So, for instance, I think we all  
23                  acknowledge that certification exams validate  
24                  entry-level knowledge competency, but then in many  
25                  places you need to have transition-to-practice

1 programs or continuing education, CME, skills, you  
2 know, procedure labs, so on and so forth, to maintain  
3 your competency to gain and build upon that  
4 expertise.

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

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

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

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

25           The other thing that I don't think that

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

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

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

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

1 can't happen.

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

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

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

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

24 And I think based on some of our -- some  
25 of the feedback from especially OHA and OONE that an

1 FAQ may be a way to help clarify what the terms  
2 "clinical experience" and "education" mean relative  
3 to staying within your scope but continuing to build  
4 upon your expertise.

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

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

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

20 One is I think some of the questions have  
21 centered around nurses who are working in hospitals.  
22 And so I think we can take the responsibility to make  
23 sure that we educate the administration, and some of  
24 that could be through the nurse execs. You know,  
25 most nurse execs aren't Advanced Practice Nurses,

1 they are leaders and executives working in that  
2 organization. I think working more with the Hospital  
3 Association.

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

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

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

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

25 We can't stop them from taking the path,

1 but I think that's where working with hospitals and  
2 other executives to help them understand this is what  
3 your position description is, you are really looking  
4 for this type of APN versus this type of APN.

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

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

12 Thank you so much.

13 DR. GRAHAM: Thank you.

14 CHAIRWOMAN KEELS: We really appreciate  
15 your time.

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

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

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

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

1 MS. WILLIAMS: Okay.

2 CHAIRWOMAN KEELS: Sorry about that.

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

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

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

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

11 Good morning, Chris.

12 MS. WILLIAMS: Good morning.

13 Good morning, everybody.

14 MEMBER BOLTON: Good morning.

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

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

22 I'm -- I actually am the person who went  
23 to the Board, six or seven years ago, to ask the  
24 Board of Nursing to implement an AA -- no -- APRN  
25 Advisory Committee, and we went with OSANA, ONA, and

1 OAAPN, and it was the first time in history those  
2 three groups linked arms. We approached the Board,  
3 we petitioned them.

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

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

17 So I wanted to tell you that legislation  
18 is a very expensive process, it took a number of  
19 years, but we did get it in House Bill 216 because  
20 for us it was very important. There was only one  
21 seat on the Board held by an APRN, with 16,000 APRNs  
22 or more in the State of Ohio, that really the issues  
23 that we face day-to-day are not understood in  
24 general, certainly by LPNs and sometimes not by our  
25 fellow RNs, although we are RNs also.

1           So we felt it was very important in order  
2 to move ahead in Ohio professionally, this was the  
3 first step so that we weren't always on the back end,  
4 begging to be heard, begging to be able to speak,  
5 begging to show you what we know and share documents.  
6 So you came from that beginning.

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

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

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

25           I mean collaborating with Margaret Graham

1 and the group at OSU is of benefit to all of us. I  
2 listened to Margaret speak, and I come back and I  
3 leave renewed, I've learned something.

4 That's a collaborative process.

5 Not just meeting with OONE or -- a  
6 collaborative process, if you want to talk about  
7 consensus, if you want to talk about exchange of  
8 ideas, then foster an exchange of ideas. Bring these  
9 groups together. We have a lot to say about this.  
10 How would this look, how would that look, does this  
11 work here, is it your purview or the Board's purview  
12 to regulate specialty practice.

13 And I'll remind you of something else.  
14 I'm an old person. I am. I was going to say old  
15 lady, but I'll just say old person. I've been  
16 practicing for over 40 years. I remember when family  
17 medicine was attacked by internal medicine and  
18 specialty practice and I remember it well, and the  
19 reason I remember it so well is I am in family  
20 practice and I'm still working, but my husband was in  
21 family medicine, and it was quite something, and a  
22 lot of the things that were said then are said now  
23 when it comes to APRNs.

24 And I will tell you that the executives  
25 and the directors of these health facilities look at

1 us like we're crazy. You're what? You can't do  
2 what? The Board said what? More and more we hear  
3 the move towards PAs, so I just -- and APRNs are  
4 light years above in terms of taking care of people  
5 and understanding and being compassionate. So  
6 there's my reminder.

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

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

14 MEMBER ZAMUDIO: Thanks, Chris.

15 MEMBER BOLTON: Thanks, Chris.

16 MS. WILLIAMS: Thank you.

17 CHAIRWOMAN KEELS: Next up we are going  
18 to dial in Carolyn Buppert. You have her extensive  
19 CV in front of you. Carolyn is an Adult Primary Care  
20 NP, certified back in 1985.

21 Carolyn?

22 MS. BUPPERT: Hi. Can you hear me?

23 CHAIRWOMAN KEELS: Good morning. You're  
24 a little bit low.

25 MS. EMRICH: Let's turn the volume up

1 here a little bit.

2 CHAIRWOMAN KEELS: That's better.

3 MS. BUPPERT: How's that?

4 MS. EMRICH: That's better.

5 CHAIRWOMAN KEELS: That's better.

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

8 MS. BUPPERT: Hi, Lisa.

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

11 MS. BUPPERT: Hi, Erin.

12 CHAIRWOMAN KEELS: Hi. Good morning.  
13 Thank you so much for joining us. We really  
14 appreciate your time. I was just calling out your  
15 extensive CV to the Committee, they have that in  
16 front of them, and was noting that you are an Adult  
17 Primary Care Certified Nurse Practitioner since 1985,  
18 but also --

19 MS. BUPPERT: I was.

20 CHAIRWOMAN KEELS: -- a lawyer who  
21 specializes in legal issues related to the  
22 administration of and delivery of healthcare. Your  
23 clients include hospitals, medical practices, nursing  
24 homes, agencies, individual healthcare practitioners,  
25 and you have an extensive listing of presentations

1 and publications related to APRN practice issues; so  
2 your expertise is invaluable.

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

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

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

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

1 clinical requirements, so I let it go.

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

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

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

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

24 And I say well, it doesn't matter what I  
25 think, I think you should contact your Board of

1 Nursing. And they often will say well, they didn't  
2 call me back or I did get a response but it was  
3 vague, so I don't know what to do with that.

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

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

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

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

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

25 The third being -- that's really a

1 worrisome situation but, again, you know, I don't  
2 give them advice. I tell them to contact the Board  
3 of Nursing which, of course, brings it back to you  
4 all.

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

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

20           Another concern is those who are doing  
21 the hiring, whether it be a private practice  
22 physician group or a hospital, they don't know how  
23 nurse practitioners are educated and they tend to  
24 often think one size fits all, and so it's really on  
25 the nurse practitioner, himself or herself, to

1 safeguard his or her own career and practice.

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

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

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

16 And given that the NCSBN already has this  
17 tool, it seems to me to be a reasonable thing to  
18 offer nurse practitioners and say, well, I'm not  
19 going to go through every nurse practitioner's job  
20 situation and give them an opinion on whether to take  
21 the job or not, but if you can get through this  
22 algorithm with yes answers all the way to the end,  
23 after the first one which is "Is there any legal  
24 prohibition of this," the answer should be no, but  
25 all the other questions the answers should be yes.

1 If you can get to the end of this algorithm with yes  
2 answers, then you probably can feel somewhat  
3 comforted; and if you can't, I wouldn't take the  
4 position or perform that role.

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

8 CHAIRWOMAN KEELS: Thank you.

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

14 Anybody else have some questions yet?

15 Sherri.

16 MEMBER SIEVERS: Hi. Sherri Sievers.

17 I'm an FNP representing practice.

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

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

1 Children's through the lifespan, right, your cystic  
2 fibrosis.

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

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

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

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

16 MEMBER SIEVERS: Okay.

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

23 I'm quite impressed with the algorithm,  
24 so, I mean, not that it -- I mean I don't know,  
25 you're the ones who will need to implement it, you

1 know, if someone comes with a complaint.

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

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

19 CHAIRWOMAN KEELS: Brian.

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

22 I just have a question about your  
23 experience from '85 to '93. I have one question and,  
24 based on that answer, I'll have a couple of follow-up  
25 questions.

1                   What did you do as a Nurse Practitioner  
2 in the Department of Anesthesiology at John Hopkins?

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

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

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

14                  MEMBER GARRETT: Just the H&Ps, okay.

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

17                  MEMBER GARRETT: Okay.

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

21                  MEMBER GARRETT: Okay.

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

25                  MEMBER GARRETT: Gotcha, okay. Thank you

1 very much.

2 CHAIRWOMAN KEELS: Pete.

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

5 MS. BUPPERT: Hi.

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

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

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

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

24 MS. BUPPERT: No.

25 MEMBER DIPIAZZA: No?

1 MS. BUPPERT: No, I don't, uh-uh.

2 MEMBER DIPIAZZA: Okay.

3 CHAIRWOMAN KEELS: Sherri.

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

9 MS. BUPPERT: Right.

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

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

25 MEMBER DIPIAZZA: I would think, like,

1 successful proctoring has been met.

2 MS. BUPPERT: Yeah.

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

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

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

16 MEMBER SIEVERS: Thank you.

17 CHAIRWOMAN KEELS: Any other questions?

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

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

25 CHAIRWOMAN KEELS: Putting clarity around

1 the terms "formal education" and "clinical  
2 experience" as it relates to APRN scope of practice  
3 within the population focus.

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

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

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

19 CHAIRWOMAN KEELS: Okay, great. Thank  
20 you.

21 Do you have any questions?

22 MS. EMRICH: No.

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

25 Okay. Well, it looks like we're out of

1 -- I can't believe it, but we're actually out of  
2 questions. That almost never happens.

3 MS. BUPPERT: Okay.

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

7 MS. BUPPERT: My pleasure.

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

10 MS. BUPPERT: Uh-huh.

11 MS. EMRICH: Bye-bye.

12 MS. BUPPERT: Bye-bye.

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

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

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

1 training, so they can't do it, right?

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

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

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

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

18           I'm actually asked to train attending and  
19 primary care physicians on procedures, and I know  
20 there's procedures, you know, there's population foci  
21 on procedures such as intubating and, you know,  
22 they'll tell me, "I didn't get any of this in my  
23 residency," so I have to sign them off. Now, our  
24 Medical Director comes in and just makes a slash and  
25 writes his names. So they're getting that as their

1 practice evolves and I've heard about the family  
2 medicine intervention specialist.

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

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

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

25 So, I don't know, that's my outside

1 looking in. I'm the new person to the group, but I  
2 just want to give you my thoughts and experience.

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

5 MEMBER GARRETT: Yeah.

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

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

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

24 So, by example, I wasn't here last time  
25 but there was some questions or comments around the

1 NNP role and we are certified to take care of  
2 patients up to the age of 2. If you query most NNPs,  
3 they will say uh-uh, I'm not trained to do that.

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

11 If I wanted to leave what I'm doing right  
12 now and go take a job in a neonatal follow-up clinic  
13 or even a well baby care area to see patients up to  
14 2, I would need more education and training within my  
15 population focus so that I could develop competency  
16 and expertise to do that job. I think that's what  
17 we're saying.

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

23 MEMBER DIPIAZZA: Right --

24 MEMBER GARRETT: -- and I wouldn't try to  
25 go to --

1 CHAIRWOMAN KEELS: Yeah.

2 MEMBER GARRETT: -- an outpatient  
3 facility and manage that same asthma attack.

4 CHAIRWOMAN KEELS: So I think we are  
5 splitting hairs and I think an FAQ might be helpful  
6 to sort of put maybe some guidance around the  
7 guidance document.

8 Sherri.

9 MEMBER SIEVERS: I think it depends on  
10 what we put in there.

11 CHAIRWOMAN KEELS: Yeah.

12 MEMBER SIEVERS: I think, again, going  
13 back to the references that our certifying bodies  
14 have put in place.

15 CHAIRWOMAN KEELS: Yes.

16 MEMBER SIEVERS: I know a lot of them  
17 have great white papers.

18 And I think that's a very good  
19 observation that you made, Brian, because the  
20 difference between anesthesiology and primary care,  
21 we get 600 hours. 600 goes like that, right? And it  
22 was in a wide variety of settings. You might have  
23 only had 60, 120, 240 in different areas.

24 Where, anesthesia, you probably had way  
25 more than that and it was all in anesthesia or all in

1 neonatology, right?

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

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

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

16           MEMBER SIEVERS: Yes.

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

19           MEMBER SIEVERS: Right.

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

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

1 it.

2 CHAIRWOMAN KEELS: But we keep talking  
3 about it.

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

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

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

15 MEMBER MINIARD: Right.

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

18 CHAIRWOMAN KEELS: We can still talk  
19 about it.

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

24 MEMBER MINIARD: Right, right, that's  
25 what I thought.

1 MEMBER SIEVERS: Which are great  
2 resources.

3 CHAIRWOMAN KEELS: Yeah.

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

7 CHAIRWOMAN KEELS: And those are your  
8 living documents.

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

11 CHAIRWOMAN KEELS: Yeah.  
12 Michelle.

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

18 CHAIRWOMAN KEELS: Right.

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

21 CHAIRWOMAN KEELS: Yeah.

22 MEMBER ZAMUDIO: So would it perhaps be  
23 better to have either something that's more global  
24 and addresses us referencing white papers and  
25 referencing our national guidelines, or to just use

1 our current decision-making tool which is on the  
2 Board of Nursing website which does address all of  
3 these things?

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

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

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

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

24 CHAIRWOMAN KEELS: So -- I'm sorry. I  
25 didn't see your hand up, Jody.

1 MEMBER MINIARD: That's okay.

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

10 Jody, I'm sorry.

11 MEMBER MINIARD: That's okay.

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

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

1 we have to practice within that.

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

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

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

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

25           And I don't think anyone is saying that

1 there isn't something valuable in clinical expertise  
2 or clinical practice that you gain, but I think it's  
3 important to remember that that clinical expertise  
4 does not therefore eliminate the fact or allow you to  
5 practice outside of your population focus.

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

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

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

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

1 very specific.

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

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

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

16 MEMBER ZAMUDIO: I can address that.

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

23 And then I went back to the Ohio Revised  
24 Code, and I keep going back to this specific passage  
25 of 4723-8-01 paragraph (F), and it says the practice

1 of nursing as an APRN in your definition means  
2 "providing to individuals and groups nursing care  
3 that requires knowledge and skill obtained from  
4 advanced formal education, training and clinical  
5 experience."

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

8 So when we struggle with those three  
9 areas, it says, you know, this care is described in  
10 4723.43.

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

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

23 MEMBER MINIARD: Right.

24 MEMBER ZAMUDIO: So those were the --  
25 when I said "restriction" --

1 MEMBER MINIARD: Right.

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

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

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

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

23 I don't think anyone's training and  
24 clinical expertise matter, but they only matter when  
25 you're working within your scope. And I think that

1 that's what this whole purpose and conversation  
2 should be focused on, not on acute versus primary  
3 care.

4 MEMBER ZAMUDIO: Right.

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

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

12 CHAIRWOMAN KEELS: Sherri.

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

15 MEMBER MINIARD: Right.

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

1 MEMBER BOLTON: H&Ps.

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

8 MEMBER MINIARD: It is.

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

13 MEMBER MINIARD: I kind of was too.

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

19 MEMBER MINIARD: Is it orange or red.

20 MEMBER SIEVERS: -- or is that here?  
21 What is the definition?

22 So I think having things that, to what  
23 you were saying, make us too focused and too narrow  
24 were not helpful. This would stem a lot more  
25 questions in my opinion.

1           So I think it's just being broad enough  
2 where we can help people ask themselves those  
3 questions.

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

8           CHAIRWOMAN KEELS: I think you're spot  
9 on.

10          MEMBER SIEVERS: Yeah.

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

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

17          CHAIRWOMAN KEELS: Yes.

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

20          CHAIRWOMAN KEELS: It's publicly posted.

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

23          CHAIRWOMAN KEELS: Vet away.

24          MEMBER SIEVERS: I think the overlap is  
25 good. It's the continuum of care or the critical

1 illness continuum is very hard.

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

6 Pam, you had your hand up.

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

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

21 My other comment, and I haven't had time  
22 to kind of digest the NCSBN algorithm, the one thing  
23 that I want to hear from the Committee if you feel  
24 the same way, the one thing that is a little  
25 concerning to me is in a couple of these questions

1 they have "setting," "practice setting," and I feel  
2 like that is counter to the Consensus Model, and so  
3 as we evaluate that I would just ask that we consider  
4 that.

5 CHAIRWOMAN KEELS: That's a good point --

6 MEMBER ZAMUDIO: Great point.

7 MEMBER MINIARD: It's a very good point.

8 CHAIRWOMAN KEELS: -- because we have  
9 been trying very hard to say it's about the patient's  
10 needs and severity of illness, not the setting.

11 MEMBER BOLTON: Yes.

12 MEMBER DIPIAZZA: Right.

13 MEMBER BOLTON: Age.

14 CHAIRWOMAN KEELS: That has caused many  
15 more questions.

16 MEMBER SIEVERS: Which, going back to  
17 referring people back to their certifying bodies, I  
18 think would take care of that.

19 MEMBER MINIARD: One just completely  
20 sidenote. I've heard the term thrown around a lot,  
21 and I just want to be very clear that we're really  
22 not talking about credentialing. We're really  
23 talking about privileging, okay?

24 MEMBER DIPIAZZA: Right.

25 MEMBER MINIARD: Credentialing is not the

1 same thing as privileging.

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

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

12 MEMBER SIEVERS: Yes, you're right.

13 MEMBER BOLTON: Medical staff.

14 MEMBER MINIARD: Right. Completely two  
15 different things.

16 CHAIRWOMAN KEELS: That's a really good  
17 point.

18 MEMBER ZAMUDIO: Right. And that's what  
19 I liked about the OSU, I forget who the author was of  
20 this, but on the OSU suggestions it said clinical  
21 scope of practice may be further delineated by the  
22 employing organization. I took that to mean their  
23 DOPs. Right? That's their delineation of their  
24 privileges. So it could be more restrictive, it  
25 can't expand on your scope, but it could be that

1 individual person being privileged to do that  
2 particular function.

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

13 CHAIRWOMAN KEELS: Yeah.

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

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

25 I also think there's an opportunity to

1 continue to work with the educator side as well so  
2 that we do have graduates who understand their scope.

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

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

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

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

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

1 developing those?

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

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

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

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

17 Is there something further you want to  
18 address with that?

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

22 MEMBER ZAMUDIO: Okay.

23 MS. EMRICH: And so we really wanted to  
24 give, you know, us, staff, simply because we had an  
25 extra Board meeting in between the short time period

1 between last meeting and this meeting and we got  
2 additional input, we chose not to keep sending out  
3 little tweaks.

4 MEMBER ZAMUDIO: Right, right.

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

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

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

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

19 MEMBER ZAMUDIO: Got it.

20 MS. EMRICH: And at that time --

21 CHAIRWOMAN KEELS: Brian --

22 MS. EMRICH: I'm sorry.

23 At that time, once it's disseminated, if  
24 there's, you know, anyone can proffer any revision  
25 back to us that they mark it up, you know, whatever

1 is believed to be appropriate by any individual and  
2 we'll look at those.

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

5 MEMBER ZAMUDIO: Right.

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

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

16 MEMBER ZAMUDIO: I don't know.

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

1 MEMBER MINIARD: Authority.

2 MEMBER GARRETT: Authority or law, right?

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

4 Can we just call it "Guidelines and FAQs"?

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

7 MEMBER GARRETT: Okay.

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

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

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

18 MEMBER GARRETT: Right.

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

22 MEMBER GARRETT: Sure.

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

25 In this particular case it was determined

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

5 MEMBER GARRETT: Okay.

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

9 MEMBER GARRETT: Right.

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

13 People felt --

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

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

21 MS. EMRICH: Correct.

22 And just to clarify too, for purposes of  
23 this Committee, it really wouldn't necessarily take a  
24 law change. It's really just an administrative rule  
25 change is what could be done. And the Board could

1 certainly go that route if it chose to, or with  
2 recommendation from this Committee as well, because  
3 an administrative rule could be changed through the  
4 rulemaking process but that's not a direction that  
5 this Committee, that I've heard from this Committee  
6 that they want to go at this point.

7 CHAIRWOMAN KEELS: At this point, yeah.  
8 Sherri.

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

14 MS. EMRICH: Get rid of the chart.

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

22 Because I think it's a slippery slope  
23 once you -- even though it's an Interpretive  
24 Guideline, I think this is what you're getting at, it  
25 could be interpreted, even though it's not in rule in

1 legislation -- in litigation it's going to be looked  
2 at. So I think we --

3 MEMBER GARRETT: The optics.

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

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

11 MEMBER SIEVERS: Right.

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

17 MEMBER SIEVERS: Simple.

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

21 MEMBER SIEVERS: Right.

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

25 MEMBER SIEVERS: Right.

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

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

14           So, Pete had his hand up.

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

20           MEMBER MINIARD: Up.

21           MEMBER DIPIAZZA: -- because we have  
22 rules pending to advance Advanced Practice in the  
23 State of Ohio. I think it would be really hard for  
24 people to support those rules or that pending  
25 legislation when we, as a group, can't even decide

1 what the heck we're doing, and I think that's really  
2 unfortunate because it's coming down to more of egos  
3 and what can we do and what can't we do, and we  
4 really are here to protect the public --

5 MEMBER MINIARD: Right.

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

9 MEMBER MINIARD: Yes.

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

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

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

23 CHAIRWOMAN KEELS: I thought it did.

24 MEMBER ZAMUDIO: At the very top it will  
25 have to saying something specific about that or my

1 recommendation would be to use the Decision-Making  
2 Tool, because -- you referenced an employer. If you  
3 called and said look, I'm going to hire this person,  
4 can they do this? "Look at our Decision-Making  
5 Tool."

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

8 MEMBER ZAMUDIO: The Ohio.

9 MEMBER SIEVERS: The Ohio.

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

12 MEMBER SIEVERS: Right.

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

15 MEMBER ZAMUDIO: Right.

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

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

20 CHAIRWOMAN KEELS: I don't know that -- I  
21 don't -- I don't know the answer to that question but  
22 I believe, and I don't have that guideline in front  
23 of me, that it is labeled for CNPs only and it tries  
24 to clarify that this is not new rules, just simply  
25 trying to clarify existing rule and law. And maybe

1 it's not at the top. Maybe we can go ahead and put  
2 it up at the top.

3 MS. EMRICH: Make it more prominent.

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

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

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

10 MEMBER ZAMUDIO: Right.

11 MEMBER MINIARD: Yeah.

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

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

18 Yes, Sherri.

19 MEMBER SIEVERS: Maybe we could come up  
20 with something like this but it's just very generic.

21 "Is it within the Ohio law and rule?"

22 And then we reference those numbers.

23 "Is it within your scope of practice?"

24 Kind of like a tool and then have the  
25 resources for the certifying bodies. So like a

1 series of questions that if they work through every  
2 single one of those --

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

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

14 MEMBER SIEVERS: Right.

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

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

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

25 MEMBER MINIARD: And I think the purpose

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

6 CHAIRWOMAN KEELS: Yeah.

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

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

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

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

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

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

1 I think we --

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

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

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

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

13 Pete, did you have a question?

14 MEMBER DIPIAZZA: No.

15 CHAIRWOMAN KEELS: Lisa?

16 MS. EMRICH: No.

17 CHAIRWOMAN KEELS: Anybody else have  
18 their hand up?

19 Thank you. This was a great discussion.

20 For those of you who are just joining us,  
21 thanks for just jumping right in. It's apparent that  
22 you guys have been staying current and updated on  
23 where we are and what we're trying to accomplish, so  
24 thank you for that.

25 Next up we have General Information and

1 Updates. First, after the "a," is Legislative Report  
2 to the Board which is Mr. Dilling who is over there  
3 deep in thought.

4 MR. DILLING: Yeah, very interesting  
5 discussion.

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

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

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

22 CHAIRWOMAN KEELS: A good thing.

23 MR. DILLING: I think they've gotten away  
24 from a formalized protocol within an institution  
25 and, you know, fall back on the privileging and

1 what's being done normally in every hospital today,  
2 right, really, and there's no reason to change the  
3 way that happens.

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

13           House Bill 177, after listening to the  
14 opponent testimony, there are a lot of questions that  
15 were raised. I thought both sides did a good job in  
16 presenting their testimony and I think that there  
17 will be interested party meetings and we'll see what  
18 can be worked out. I don't know where you go in  
19 terms of the middle ground. I'm not there on the  
20 inside. As with 216, it's mostly the associations  
21 talking with one another. You know, you'll hear  
22 things here, but I don't know what that tells you as  
23 to is this all-in, get rid of the Written Standard  
24 Care Arrangement, or is there some possible middle  
25 ground.

1           Certainly the physicians, both nationally  
2 and here in Ohio, echo the refrain of team-based care  
3 and somebody has got to be in charge of the team,  
4 right? There's always a captain. And who do you  
5 think wants to be the captain? Everybody wants to be  
6 the captain, right? Who is going to vote in the  
7 captain? It's going to be an institution? Well,  
8 it's not all institutional practice.

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

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

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

23           MEMBER ZAMUDIO: Sorry, actually, I do  
24 have a question about the military license as a  
25 retired military officer.

1 MR. DILLING: Great. I don't mean to --  
2 that's not a comment on it.

3 MEMBER ZAMUDIO: No, no.

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

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

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

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

1 know. Pretty much you put a military stamp on it.

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

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

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

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

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

25 MEMBER ZAMUDIO: Nice.

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

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

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

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

24 One, we're going to have to report back  
25 statistics. And some day if, in fact, it does work

1 out that way for some people and they start calling,  
2 then somebody is going to say oh, maybe he was right,  
3 you know, but also I think that we could probably  
4 maneuver our rules in such a way, even though  
5 somebody could make an argument about it, no one is  
6 going to make an argument about it if we go in  
7 through the rule process and say hey, this is the way  
8 it works and will you just let us do this.

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

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

22           MEMBER ZAMUDIO: Okay. Thank you.

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

25           CHAIRWOMAN KEELS: Thanks, Tom.

1 Certainly we've really appreciated hearing from OSANA  
2 and OAAPN on the status of their bills.

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

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

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

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

24 CHAIRWOMAN KEELS: Great. Thank you.

25 Anything else?

1 All right. Thank you.

2 MR. DILLING: Thank you.

3 MEMBER ZAMUDIO: Thanks, Tom.

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

6 MS. EMRICH: Yes.

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

12 A reminder that all current APRN licenses  
13 and RN licenses expire after October the  
14 31st of 2019. The late fee will go into effect on  
15 September the 16th.

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

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

24 The data graph goes from July 1st and  
25 it's sort of up and down and up and down. Then it

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

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

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

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

25 They are required, obviously, to maintain

1 their CE needed to maintain your national  
2 certification.

3 CHAIRWOMAN KEELS: Michelle.

4 MEMBER ZAMUDIO: Only because I know I'm  
5 going to get this question. With renewal, the late  
6 fee beginning on 9/16, is that after midnight on the  
7 15th, until midnight on the 16th, or is it --

8 MS. EMRICH: As of midnight September  
9 15th.

10 MEMBER ZAMUDIO: Got it.

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

14 MEMBER ZAMUDIO: Okay. Got it.

15 MEMBER MINIARD: September 16th.

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

18 MEMBER DIPIAZZA: At 12:01.

19 CHAIRWOMAN KEELS: Yes.

20 MS. EMRICH: At 12:00:01.

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

23 MS. EMRICH: So what's key is, and we're  
24 working with the system administrators on this, your  
25 renewal application cannot just be started on

1 September -- it has to be completed. You would be  
2 surprised, you'd be surprised. We are recommending  
3 that you renew early.

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

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

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

24 So if you -- if that happens, just please  
25 look back at the public verification website, look

1 back into your portal, you will see that your license  
2 has been renewed and that it expires in, you know,  
3 2021; so that's what you should see. So please just  
4 be aware of that. We're trying to be very proactive  
5 and get the information out there.

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

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

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

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

22 CHAIRWOMAN KEELS: Some of them are, you  
23 know, like where do I find something, but some of  
24 them are also around scope of practice, can I do  
25 this, is this within my scope, so it sort of

1 underscores the need for something to help people  
2 answer these questions in the least-restrictive way  
3 possible but still consistent with current rule and  
4 law.

5 Comments or questions about that?

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

13 CHAIRWOMAN KEELS: Michelle.

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

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

24 CHAIRWOMAN KEELS: Many times that falls  
25 back to the individual hospital --

1 MEMBER ZAMUDIO: Right.

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

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

8 CHAIRWOMAN KEELS: Right.

9 Great.

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

12 MS. EMRICH: Sure. The Board --

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

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

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

25 And there is a plan for there to be sort

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

5 MEMBER ZAMUDIO: That's good.

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

8 CHAIRWOMAN KEELS: Okay. So now we've  
9 come to lunch, yay. So we will break for lunch until  
10 1:00. We will start, at 1:00 sharp, the Interested  
11 Party Meeting on the 4th floor.

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

16 May I --

17 CHAIRWOMAN KEELS: Of course.

18 MS. EMRICH: -- just for logistics?

19 Okay, thank you.

20 So the Interested Party Meeting is for  
21 anyone who would like to attend. It's actually being  
22 convened by our Chief General Counsel who will be  
23 going over all of the draft revised rules that will  
24 be considered by the Board or would be going to  
25 public hearing later this year, usually in November,

1 so this is an opportunity to provide input to those.

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

5 As Erin mentioned, that begins at  
6 1:00 p.m., so please just go directly to the 4th  
7 floor meeting room.

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

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

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

22 - - -

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

25 Next up on our agenda is to review the

1 proposed rules on detoxification.

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

5 MS. EMRICH: Page 10.

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

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

16 So you've had this, hopefully you've had  
17 a chance to review this. Like I said, on page 10 and  
18 11 are essentially definitions.

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

21 CHAIRWOMAN KEELS: Yes.

22 MS. EMRICH: That's the change.

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

25 MS. EMRICH: Uh-huh.

1 CHAIRWOMAN KEELS: So take a look at that  
2 and see if you have any questions around that.

3 Questions? Concerns?

4 And my understanding, from the Board  
5 retreat, was that in correctional facilities they  
6 were going to draft their own rules.

7 MS. EMRICH: I think so.

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

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

15 MEMBER ZAMUDIO: Erin?

16 CHAIRWOMAN KEELS: Yes, ma'am.

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

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

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

1 CHAIRWOMAN KEELS: Oh, "Third Edition."  
2 You know, I always wonder about being really specific  
3 with these criteria.

4 MEMBER ZAMUDIO: I know.

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

8 MEMBER GARRETT: Maybe say "most recent."

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

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

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

23 CHAIRWOMAN KEELS: So the rule or the  
24 statute is in place, but the process wasn't  
25 implemented yet.

1 MS. EMRICH: Yeah, by the feds.

2 MR. McCLAIN: I can speak on that.

3 CHAIRWOMAN KEELS: Can we have Jesse?

4 MS. EMRICH: No.

5 CHAIRWOMAN KEELS: Wait until the public  
6 comments.

7 MR. McCLAIN: That's fine.

8 CHAIRWOMAN KEELS: Page 14, evaluations.

9 For those in the audience, I just want to  
10 make it clear these are posted for comment and any  
11 comment can be received by the Board, okay?

12 MS. EMRICH: Anything on these? I don't  
13 know that these are actually -- these were in the  
14 Interested Party materials that Holly sent out, so  
15 any comments regarding these, they should be sent to  
16 Holly, and the sooner the better.

17 CHAIRWOMAN KEELS: Sooner rather than  
18 later.

19 MEMBER SIEVERS: She said July 24th.

20 MS. EMRICH: Yeah.

21 CHAIRWOMAN KEELS: July 24th to Holly.

22 MS. EMRICH: That's right before the  
23 Board's July meeting, and then she will file these  
24 with JCARR after that.

25 MEMBER MINIARD: End of August you said?

1 MS. EMRICH: Uh-huh.

2 CHAIRWOMAN KEELS: Any other comments or  
3 questions?

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

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

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

11 MS. EMRICH: A collective --

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

15 MS. EMRICH: Or just to give a comment.

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

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

22 MEMBER ZAMUDIO: Yes.

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

25 CHAIRWOMAN KEELS: Advanced Practice

1 Registered Nurse, yes.

2 MEMBER SIEVERS: Okay, great.

3 CHAIRWOMAN KEELS: Do I need a vote?

4 MS. EMRICH: Consensus is fine.

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

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

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

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

22 We also, Lisa and her team -- I say "we"  
23 very loosely because Lisa and her team do a yeomen's  
24 job pulling these together -- we were hoping to use  
25 the CMS definition of "critical care" as sort of the

1 point of which primary care scope of practice ends  
2 and it becomes the scope of practice for the acute  
3 care certified practitioner, and it really speaks to  
4 that critical nature of the patient and that  
5 multi-system organ failure, imminent death, you know,  
6 acute dysfunction of body systems.

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

14           MEMBER ZAMUDIO: I found it.

15           CHAIRWOMAN KEELS: Do you have it?

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

1 MEMBER DIPIAZZA: It's in there, it's  
2 just --

3 MEMBER MINIARD: Buried.

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

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

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

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

16 MEMBER ZAMUDIO: Okay.

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

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

23 But that certainly resonated with me that  
24 that's what we're trying to say, right? It's that  
25 immediate jeopardy of life.

1 CHAIRWOMAN KEELS: Yeah, immediate  
2 jeopardy, yeah.

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

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

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

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

24 CHAIRWOMAN KEELS: I know. I think I  
25 still like talking about a point of reference, but I

1 understand your concern.

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

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

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

11 CHAIRWOMAN KEELS: Okay.

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

16 CHAIRWOMAN KEELS: Maybe, yeah.

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

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

25 It was kind of a great -- it was a great

1 meeting and I saw some aha moments, so I thought that  
2 was really good.

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

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

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

18 CHAIRWOMAN KEELS: Yeah.

19 MEMBER SIEVERS: It could go either way,  
20 right?

21 CHAIRWOMAN KEELS: Sure.

22 MEMBER GARRETT: Well, the reason I said  
23 that is we keep saying it's Interpretive Guidelines  
24 but it's really clarification. I've heard several  
25 people refer to "clarification." What we are really

1 meaning is this, right, a clarification?

2 CHAIRWOMAN KEELS: Yeah, I'm not sure.  
3 I'll have to defer to Lisa on how limited we are  
4 through Board processes.

5 MEMBER GARRETT: Gotcha.

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

11 MEMBER GARRETT: Yeah.

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

15 MEMBER GARRETT: Yeah.

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

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

1 with it, and then it would go and be looked at by the  
2 Board itself.

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

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

11           MEMBER MINIARD: "Momentum."

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

15           MEMBER MINIARD: It made it --

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

21           MEMBER GARRETT: Yeah.

22           CHAIRWOMAN KEELS: -- more inflammatory.

23           We really do want to help people  
24 understand so that we can, you know, make everything  
25 greater, that's all.

1 MEMBER GARRETT: Optics through  
2 advertising.

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

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

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

15 MEMBER ZAMUDIO: Yes, absolutely.

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

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

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

24 MS. EMRICH: We could do an FAQ. I would  
25 have to, you know, we could certainly develop an FAQ

1 for review and see how --

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

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

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

11 MEMBER ZAMUDIO: I agree.

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

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

22 MEMBER SIEVERS: And by -- oh, sorry.

23 CHAIRWOMAN KEELS: Yes, ma'am.

24 MEMBER SIEVERS: By "FAQ" not really -- I  
25 don't mean what Carolyn Buppert said about, like,

1 people give her examples of scenarios and weigh in,  
2 right?

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

9           CHAIRWOMAN KEELS: It can simply refer to  
10 the NCSBN.

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

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

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

25           Again, I think almost -- well, I don't

1 know if an FAQ would need to go through the Attorney  
2 General's Office or not.

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

5 CHAIRWOMAN KEELS: Okay.

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

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

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

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

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

25 Answer No. 2 is this answer.

1           "How do I know what my certifying body  
2 says?"

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

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

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

14           MEMBER SIEVERS: Right.

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

17           So if it was an FAQ, taking out that --  
18 changing the definition that's in there, striking the  
19 part about "may occur in an ICU," leaving this here,  
20 it would be specific to an FAQ specific to CNPs so  
21 other people wouldn't misinterpret that to be "Oh,  
22 you're an NP instead of an CNM," so, you know, we  
23 could put that on there, and then to be sure we  
24 included education, training, and clinical  
25 experience, like, to match the statute.

1 CHAIRWOMAN KEELS: I'll take those  
2 recommendations.

3 Jody.

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

6 MEMBER ZAMUDIO: It's robust.

7 MEMBER MINIARD: A robust conversation.  
8 I truly, truly feel, after only sitting  
9 at this table for a year, that we are well beyond the  
10 need of an FAQ.

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

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

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

1 document.

2 CHAIRWOMAN KEELS: Lisa.

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

7 MEMBER MINIARD: Correct.

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

14 CHAIRWOMAN KEELS: Pete's turn.

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

21 CHAIRWOMAN KEELS: Thank you.

22 Sherri.

23 MEMBER SIEVERS: Yes, and only if it  
24 helps. If it makes things muddier, then it doesn't  
25 help if they come away more confused.

1           Do you have an idea of what it looks like  
2 for you? I'm trying to envision what -- if you could  
3 design something, what would that look like for you?  
4 Like, what would help, what do you think would make  
5 it clear?

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

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

19           So I would have to defer, you know,  
20 that's not my area of expertise by any stretch of the  
21 imagination to come up with an Interpretive Guideline  
22 or write rules and statute, but I do think we need  
23 something that's more formalized in a way than when  
24 you get on the Board's website and you pull up a FAQ  
25 that just has various questions that are very vague.

1           We've been asking those questions and so  
2 has our fellow nurse practitioners across the State  
3 since -- for years, for two or three years, and we  
4 haven't -- I think we need something that's more  
5 formalized that really gives APRNs, particularly CNPs  
6 because that's what we're talking about, a more  
7 definitive answer in a way. And then if there are  
8 questions that come aside from that, then those can  
9 be answered in the FAQ.

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

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

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

24           MEMBER MINIARD: Closer.

25           MEMBER SIEVERS: -- close to agreement

1 with the critical care definition, adding in the  
2 clinical practice. I think that's the big things  
3 right now.

4 MEMBER ZAMUDIO: And the word "training."

5 MEMBER GARRETT: You said earlier,  
6 something between Interpretive Guideline and FAQ. I  
7 think FAQ is a little too informal. I think  
8 Interpretive Guideline locks us into some processes,  
9 right? Am I interpreting that correctly?

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

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

20 MEMBER ZAMUDIO: What are the options?

21 MEMBER GARRETT: -- where you can take  
22 what you've done --

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

25 MEMBER GARRETT: Right, right.

1           MEMBER MINIARD: That was my comment.  
2 Why does it matter what we call it. If it's not rule  
3 or statute, it's not rule or statute.

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

6           MEMBER MINIARD: Right.

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

9           CHAIRWOMAN KEELS: Pete had his hand up.

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

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

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

1 MEMBER MINIARD: Right.

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

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

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

10 MEMBER SIEVERS: Okay.

11 MEMBER DIPIAZZA: -- for all, though.

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

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

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

24 MEMBER DIPIAZZA: That's what we're  
25 talking about.

1 MEMBER ZAMUDIO: No, no, but she's saying  
2 it's just for us to decide our own scope of practice.  
3 I'm cautioning that this document will be used for  
4 other purposes as well.

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

7 MEMBER ZAMUDIO: But this specific one.

8 MEMBER DIPIAZZA: -- an inappropriate  
9 purpose, though.

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

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

24 So if it's not clear it could be good or  
25 bad. I'm just raising that it might add more

1 confusion and not be as helpful.

2 MEMBER ZAMUDIO: Right.

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

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

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

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

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

19 MS. EMRICH: Same content but maybe  
20 configured differently.

21 CHAIRWOMAN KEELS: A helpful tool.

22 MEMBER ZAMUDIO: Can we formally state  
23 our recommendations then? So if someone is looking  
24 at it, like, Lisa would know, like, what were the  
25 recommendations, can we just kind of either poll each

1 person or state what our recommendations are? That  
2 would give the groundwork, I think, to a document  
3 that reflects kind of what everybody is thinking.

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

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

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

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

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

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

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

25 CHAIRWOMAN KEELS: The grandfathering.

1 MEMBER ZAMUDIO: Yeah, the  
2 grandfathering.

3 CHAIRWOMAN KEELS: Yes.

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

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

15 MEMBER ZAMUDIO: Okay.

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

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

24 MEMBER ZAMUDIO: Okay. So by putting  
25 clinical experience in there, in my mind that's going

1 to grandfather -- to use a different -- I can't come  
2 up with another word. Is that a protection issue for  
3 those people who, like, I read some of these articles  
4 saying it would be egregious to take someone out of a  
5 25-year job position and say you need to go back to  
6 school.

7 CHAIRWOMAN KEELS: The Board is not  
8 saying that.

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

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

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

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

21 MEMBER ZAMUDIO: Yes, absolutely.

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

1 MEMBER ZAMUDIO: Right.

2 CHAIRWOMAN KEELS: So --

3 MEMBER ZAMUDIO: That's great.

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

6 MEMBER ZAMUDIO: Right.

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

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

13 CHAIRWOMAN KEELS: Okay.

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

16 MEMBER SIEVERS: Yeah.

17 CHAIRWOMAN KEELS: Pete, anything  
18 further?

19 MEMBER DIPIAZZA: No.

20 CHAIRWOMAN KEELS: Brian, anything  
21 further?

22 MEMBER GARRETT: No.

23 CHAIRWOMAN KEELS: Jody?

24 MEMBER MINIARD: No.

25 CHAIRWOMAN KEELS: Pam?

1           MEMBER BOLTON: And you said clinical  
2 practice within your scope, right?

3           CHAIRWOMAN KEELS: (Nods.)

4           MEMBER BOLTON: Okay. I just wondered on  
5 that.

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

17           MEMBER MINIARD: No.

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

20                   But will any amount, say you're an  
21 individual, you've been through a graduate program  
22 and you've qualified to take the Women's Health Nurse  
23 Practitioner Exam and you're out there as a Nurse  
24 Practitioner, will any amount of training and  
25 clinical experience, outside of a graduate program,

1 prepare you to manage acute psychiatric patients?

2 MEMBER MINIARD: No.

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

5 MEMBER MINIARD: Yes.

6 MEMBER SIEVERS: Yes.

7 MEMBER ZAMUDIO: Right.

8 MEMBER BOLTON: Yes.

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

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

14 MS. EMRICH: Exactly.

15 MEMBER MINIARD: -- focus.

16 MEMBER ZAMUDIO: Right.

17 MEMBER SIEVERS: Right.

18 MS. EMRICH: Exactly.

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

25 MEMBER SIEVERS: Babies are in my scope

1 as an FNP, but I shouldn't be a Neonatal Nurse  
2 Practitioner.

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

5 MEMBER SIEVERS: Exactly.

6 CHAIRWOMAN KEELS: -- on an oscillator.

7 MEMBER ZAMUDIO: Right.

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

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

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

17 CHAIRWOMAN KEELS: Managing the care.

18 MEMBER SIEVERS: Right.

19 MEMBER ZAMUDIO: That's a great  
20 distinction.

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

23 CHAIRWOMAN KEELS: And maybe we can  
24 somehow clarify that.

25 MS. EMRICH: So I'm happy that that's all

1 of our thoughts.

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

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

6 MEMBER BOLTON: Thank you for that  
7 clarification.

8 CHAIRWOMAN KEELS: Okay. Okay.

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

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

14 CHAIRWOMAN KEELS: Does she have to --

15 MS. EMRICH: No.

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

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

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

22 MS. DAVIS: Good afternoon.

23 By way of a brief introduction, my name  
24 is Jessica Davis, and I'm a partner at Brennan, Manna  
25 & Diamond.

1 I specialize in the defense of medical  
2 malpractice claims, those brought against Advanced  
3 Practice Nurses, physicians, hospitals employing  
4 those folks, skilled nursing facilities employing  
5 those folks, and home healthcare agencies, just to  
6 name a few.

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

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

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

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

25 So a certification, education, training

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

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

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

13 In defending these claims over the last  
14 15-plus years, I will tell you that we consider the  
15 details of every aspect of that qualification.

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

21 Similarly with training, all those  
22 details are considered. Where the training occurred,  
23 the length of the training, whether the training was  
24 repeated, whether a clinician had to take a year off,  
25 what they saw and experienced in that training for

1 example, the length of the training, the orientation,  
2 the preceptorship or the lack thereof of  
3 preceptorship, the proctor, who was the proctor, how  
4 long the proctorship lasted. All of that is  
5 considered.

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

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

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

23 And then, of course, we talk about CMEs,  
24 conferences that the clinician may have attended,  
25 presentations, lectures. In fact, I just had a

1 physician be asked to provide the data that was given  
2 to him during a lecture that he attended, over the  
3 course of a weekend, relative to acute care for a  
4 fetus in lifesaving efforts.

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

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

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

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

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

25 The inquiry never stops there and it will

1 not protect a clinician or establish the  
2 qualification in a specific area because you have to  
3 remember that overall marking umbrella, excuse me, of  
4 what the standard of care is.

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

8 Rather, this Committee, in my opinion,  
9 should consider what detailed guidelines will do in  
10 providing context for your clinicians.

11 And I would respectfully suggest to you,  
12 as you're looking at this, you consider what type of  
13 fodder you're providing for patients' counsel to use  
14 against the clinicians. That won't always be the  
15 case, sometimes it will create a very bright line  
16 that I could advocate for on behalf of your  
17 practitioners, but it will undoubtedly create fodder  
18 as well.

19 Let me give you --

20 CHAIRWOMAN KEELS: I'm sorry, you'll have  
21 to stop. Thank you so much. Your five minutes is  
22 up. Thank you.

23 Does anybody have any questions?

24 Yes, Michelle.

25 MEMBER ZAMUDIO: What were you going to

1 say as an example for us?

2 MS. DAVIS: Sure.

3 So the first example that comes to mind  
4 is the ACOG guidelines, for example. So clinicians  
5 that deliver babies are always asked about ACOG and  
6 whether ACOG sets the standard of care, and the  
7 answer to that question is no, it doesn't set the  
8 standard of care. It provides a guideline by which  
9 that clinician then uses their independent education,  
10 training, and experience in that particular setting,  
11 that same or similar circumstances to answer that  
12 question.

13 Hospital policies and procedures are a  
14 similar example of that.

15 MEMBER ZAMUDIO: So a guideline, similar  
16 to the ACOG Technical Bulletins or Practice Bulletins  
17 including some type of not just a regular disclaimer  
18 but then including "This is not meant to be a legal  
19 guideline, this is for clinical guidance," et cetera,  
20 et cetera, is that a recommendation that we put  
21 something like that in here?

22 MS. DAVIS: Absolutely. It's a best  
23 practice. It's never a substitute for clinical  
24 judgment and experience; using your experience,  
25 education, and training.

1 CHAIRWOMAN KEELS: Any other questions?  
 2 Great. Thank you so much.

3 MS. DAVIS: Thank you.

4 CHAIRWOMAN KEELS: We appreciate your  
 5 time.

6 MEMBER MINIARD: Thank you.

7 MEMBER BOLTON: Thank you.

8 CHAIRWOMAN KEELS: Okay. Next up we have  
 9 Maria Kiesling.

10 MS. KIESLING: "Marcia."

11 CHAIRWOMAN KEELS: Oh, "Marcia." I'm  
 12 sorry. Hi, Marcia.

13 MS. KIESLING: It was probably my  
 14 handwriting.

15 CHAIRWOMAN KEELS: She is with Aultman  
 16 Hospital in Canton.

17 MS. KIESLING: I am a practicing Family  
 18 Nurse Practitioner. I work four days a week actually  
 19 seeing patients. Another day of the week I have an  
 20 administrative role. I'm the Lead Nurse Practitioner  
 21 for our organization, actually APP, I have PAs as  
 22 well, but I also am Chair of our Allied Credentialing  
 23 and Privileging Committee at Aultman Hospital.

24 And I know we're unique. There are a lot  
 25 of hospitals out there that do it, but we have our

1 own Allied Health, so we credential our CNAs, all our  
2 APRNS, our PAs. We actually have physical therapists  
3 we're credentialing, an optometrist, so, you know,  
4 it's a broad range. Anything that's not a doctor, we  
5 credential.

6 And I just want to -- I've been here  
7 before and I know there's new members now and I know  
8 most of you understand it, but if you're in the  
9 outpatient world sometimes you don't have to go  
10 through the actual privileging and credentialing  
11 process; it's pretty stringent.

12 So we all sit up here and talk about what  
13 we're allowed to do as FNPs and what we're allowed to  
14 do as Acute Care but, in the end, you're doing it in  
15 a facility hopefully that's credentialing and  
16 privileging you and, you know, we have very strict  
17 guidelines through JCAHO and our medical staff  
18 office. It's peer-reviewed, it's confidential, and  
19 we take it very seriously.

20 So yes, you are credentialed as far as  
21 checking all those boxes, do you have your DEA, we  
22 did your background check, we did everything we  
23 needed to do that way, but then you're also checking  
24 the box of what procedures do you want to do on our  
25 hospital premises.

1           And those of us on the committee don't  
2 just check the box saying go do what you want to do.  
3 We look at your education, we look at your background  
4 and we decide, "Hey, yeah, go ahead, but you've got  
5 three months of supervision" and we check that box  
6 and you can do nothing unless that doctor is standing  
7 right beside you.

8           And you can only be proctored by a  
9 physician, not a nurse practitioner or a PA. We do  
10 not allow our APPs to proctor even paps. In the  
11 outpatient world, you're being proctored to do a pap,  
12 it has to be with a physician.

13           So we take that very seriously and I  
14 think most of the institutions in the State of Ohio  
15 do as well. I know there's some outliers, there  
16 always will be, unfortunately, but I think that's a  
17 legislative issue. I think that should be dealt with  
18 on the legislative part of the realm with the Joint  
19 Commission and how is everybody credentialed and  
20 privileged throughout the State so we are equal  
21 because right now, you're right, we aren't completely  
22 equal.

23           Do you have a question, Pam?

24           MEMBER BOLTON: No. I'm sorry.

25           MS. KIESLING: So, you know, like I said,

1 process, procedure, we follow it very seriously and  
2 there are many times we have APPs come by asking for  
3 privileges and we'll say no. We look at your  
4 education, we look at your background, you came from  
5 another facility and you haven't done this procedure  
6 in five years, no, you have to go out and proctor it  
7 and bring me the documents to make sure it's done  
8 correctly and we're staying safe and we're keeping  
9 the patients safe. So there is a very strict process  
10 that I think most of the people in the State of Ohio  
11 follow.

12 CHAIRWOMAN KEELS: Questions for Marcia?

13 MS. KIESLING: Thank you.

14 CHAIRWOMAN KEELS: Thank you. We  
15 appreciate your time.

16 MS. KIESLING: You're welcome.

17 CHAIRWOMAN KEELS: Chris Williams with  
18 OAAPN.

19 MS. WILLIAMS: Thank you.

20 I just want to say I was surprised to  
21 hear, at the end of the discussion, about acute care.  
22 It's just a constant "square peg, round hole," you  
23 guys. You've been here three years doing this, it's  
24 time to let it go. It doesn't fit. You just heard  
25 about liability. It doesn't fit there either.

1           Acute care, from my perspective and what  
2 I've read, is not a population, so once you start  
3 talking like that, I know exactly where the  
4 conversation is going and what's going to show up  
5 next and I think it's sad that that was shoved in at  
6 the very end of the day.

7           I think you need to look really hard at  
8 that and I think you need to let it go. This is not  
9 good process. There's not going to be good outcomes  
10 here. This is not in the purview, from my  
11 perspective and OAAPN's perspective, of the Board of  
12 Nursing. It's licensure.

13           Everyone gets in trouble. A bad  
14 practitioner, physician or otherwise, will eventually  
15 be caught or at least we hope they're caught. And  
16 when they are, this is a vigorous, rigorous Board of  
17 Nursing. I don't think they mess around and I think  
18 they go after bad practitioners as quick as they can  
19 so people meet their final outcome pretty quickly  
20 here.

21           So I would ask you to reconsider whether  
22 it's time to let this go. Nothing fits here. I know  
23 it's on some people's agenda. I know it's on some  
24 national agenda. I know it happened in Wyoming and  
25 it's happened in a couple other states. And the

1 reason why you have so many questions and so many  
2 people showing up here is we think it's wrong, and  
3 it's wrong for practice, and it's wrong for patients,  
4 and it's wrong for healthcare.

5 CHAIRWOMAN KEELS: So, Chris, I have a  
6 question for you.

7 MS. WILLIAMS: I'm sorry, pardon?

8 CHAIRWOMAN KEELS: If you don't mind.

9 MS. WILLIAMS: No.

10 CHAIRWOMAN KEELS: So there are distinct  
11 certifications exams in acute care and primary care  
12 for adults and for peds, right, so do you not  
13 consider those distinct populations?

14 MS. WILLIAMS: No, I don't. I don't. I  
15 think that's a continuum. Just like life is on  
16 continuum, healthcare is on a continuum. And if  
17 someone is here and someone is there, can you tell  
18 the difference? Probably yes. Yes, you can.

19 A well-child 3-year-old is not someone  
20 who has been in the ICU for a month and is on  
21 lifesaving machines. I hate going to ICUs. I'm  
22 primary care, needless to say. Yes, that's easy, but  
23 anything in between is a mixture of everything.

24 And I don't think -- the reason why  
25 there's so much trouble with this is because you

1 can't draw the line and you shouldn't draw the line  
2 and medicine doesn't do it. Medicine didn't do it to  
3 family medicine. The profession regulated itself.  
4 The Board of Medicine didn't regulate family  
5 medicine. And they went through these struggles.

6 So I think this is one profession or one  
7 APRN type and I think it's a turf struggle or a job  
8 struggle. There's economics involved here. I don't  
9 have it mapped out, I'm not an economist, but  
10 somewhere there is always economics.

11 So I think you should let it go. I think  
12 it's "square peg, round hole," really.

13 CHAIRWOMAN KEELS: So I think our  
14 challenge has been that we get so many questions --

15 MS. WILLIAMS: Right.

16 CHAIRWOMAN KEELS: -- from NPs on where  
17 -- and I agree I think the prudent person would  
18 acknowledge where I'm a primary care certified person  
19 and this is critical care management --

20 MS. WILLIAMS: Right.

21 CHAIRWOMAN KEELS: -- and I shouldn't be  
22 doing this.

23 MS. WILLIAMS: Right.

24 CHAIRWOMAN KEELS: Unfortunately we're  
25 still getting questions. So I'm still -- we're

1 struggling on --

2 MS. WILLIAMS: How do you answer those?

3 CHAIRWOMAN KEELS: -- how to provide the  
4 answers to those.

5 MS. WILLIAMS: I'm going to give you a  
6 perfect guide, a perfect guide, and that's OAAPN's  
7 legal answers. They have come from the years we  
8 spent researching every statute, every rule, to give  
9 the right answer and quote the right statute and  
10 rule. We have legal expertise now. When I read the  
11 answers, I think they're so right on, they're so  
12 succinct and they take it back to that individual.

13 They quote where it comes from. It's  
14 right here, it's here and here. And if you fit in  
15 here, here, and here, then you should be okay, or  
16 however they say it. And it's not heavy-duty  
17 legalese. It's very understandable. I think they do  
18 a great job and I think they're a guide for answering  
19 anything in terms of practice. It's better than it's  
20 ever been.

21 CHAIRWOMAN KEELS: Lisa, you had your  
22 hand up.

23 MS. WILLIAMS: And that was not an ad.

24 MS. EMRICH: You talked about the Board's  
25 actions when something bad occurs. I think the Board

1 is always concerned and always wants to make sure  
2 information is available to all of its licensees --

3 MS. WILLIAMS: Yes.

4 MS. EMRICH: -- so to forewarn as to what  
5 may cause disciplinary action.

6 So if information needs to be provided  
7 regarding national certifications and what those  
8 mean, I think that's important to provide  
9 because, you know, it's not a catch-ya kind of  
10 situation. It has to be --

11 MS. WILLIAMS: But I think what you've  
12 also heard, though, is it's not just the national  
13 certification.

14 So if you're a family medicine doc and,  
15 when you first entered, you did deliveries, let's say  
16 10 years of deliveries and then you didn't like  
17 getting up in the middle of night so you quit for 15,  
18 20 years. You cannot -- well, if you do you're a  
19 fool -- walk out your door and start delivering  
20 babies again.

21 If you get before a Court, I'm sure you  
22 would be in big trouble, big trouble. When was the  
23 last time you did this? How many have you done in  
24 the -- I mean, that's where it stops and it's too bad  
25 it stops there after there's been a problem.

1           But regulating, getting specific and  
2           regulating it beforehand, that's where I think you  
3           meet trouble. It's going to happen. And I think the  
4           legal discussion about what's asked for in court,  
5           it's the standard of care, did you meet it and are  
6           you competent.

7           CHAIRWOMAN KEELS: I think that sort of  
8           circles back to the discussion we had on clinical  
9           experience and formal education as you build upon  
10          your levels of expertise within your population.

11          Michelle, did you have your hand up or  
12          was it Jody?

13          MEMBER ZAMUDIO: Actually I did not this  
14          time.

15          CHAIRWOMAN KEELS: I'm sorry.

16          MEMBER MINIARD: You said exactly what I  
17          was going to say.

18          CHAIRWOMAN KEELS: I'm sorry. Did  
19          anybody else have their hands up for Chris?

20          MS. WILLIAMS: Okay. Thanks.

21          CHAIRWOMAN KEELS: Thanks so much.

22          MS. WILLIAMS: Thanks for allowing this  
23          input.

24          CHAIRWOMAN KEELS: Sure, absolutely.

25          I see Jesse. Are you coming down here to

1 talk?

2 MR. McCLAIN: Yeah, I just want to  
3 address the CNS thing.

4 CHAIRWOMAN KEELS: Okay. Oh, yeah, yeah,  
5 I know that you are -- have been involved in the --

6 MS. EMRICH: MAT.

7 MR. McCLAIN: In the waiver.

8 CHAIRWOMAN KEELS: Yes, please and thank  
9 you.

10 MR. McCLAIN: So I am a CNS, I have my  
11 waiver, so you can take the waiver program. You  
12 cannot, on SAMHSA's website, click a button to allow  
13 a CNS or a CNM to apply for that X DEA waiver.

14 CHAIRWOMAN KEELS: It's at the SAMHSA  
15 level.

16 MR. McCLAIN: It's at the SAMHSA level.

17 CHAIRWOMAN KEELS: Okay.

18 MR. McCLAIN: The problem with SAMHSA is  
19 it falls under the Executive Branch which is Trump's  
20 branch, okay?

21 So I've been working with Senator Portman  
22 and his team on trying to update SAMHSA's website.  
23 The problem is that Portman has no pull under there  
24 because he's the legislative Branch.

25 So when they reached out to SAMHSA, they

1 said, well, we have to give a report in two years on  
2 how well the program is working, so that's the answer  
3 we have, so I mean --

4 CHAIRWOMAN KEELS: Which won't be working  
5 very well if --

6 MR. McCLAIN: Well, it could be next  
7 month, it could be in 22 months, because in 24 months  
8 from October of '18 they have to give a report. So  
9 honestly like every day or every other day, because I  
10 have it saved on our Favorites, I always go in to see  
11 if they updated it.

12 Now, when I met with Senator Portman's  
13 Aide about this, like, we walked through the website  
14 together and I showed him, like, I can click the NP  
15 and go to the next level, and I showed him that, but  
16 then there's two attestation statements that I have  
17 to attest that I'm NP with a collaborator. Well, I'm  
18 not, you know, so I don't want to continue that  
19 process even though he's like, well, you function  
20 similar, just continue that process.

21 I'm like listen, there's already enough  
22 scrutiny with this, with waivers and all this stuff,  
23 like, I don't want to, even though my intentions may  
24 be good, I am not clicking that button, they need to  
25 update their first page.

1           So I think that's where the problem is.  
2           So, I mean, I'm glad the rule is going to change  
3           because it could be tomorrow that their website is  
4           updated.

5           CHAIRWOMAN KEELS: Okay. Thank you very  
6           much. It all came back to me now.

7           MR. McCLAIN: Okay.

8           CHAIRWOMAN KEELS: Appreciate it. Thank  
9           you.

10          Okay. That brings us to the end of the  
11          meeting, I think.

12          MS. EMRICH: Yup, 3:01.

13          CHAIRWOMAN KEELS: We don't have any  
14          other requests and so I heard a couple requests for  
15          our next meeting. I'm pulling up my agenda.

16          We'll take the Interpretive Guideline  
17          input on both the graph as well as the document, and  
18          Lisa and her team will work on it, and as soon as  
19          they can get it out to everyone to review, it will be  
20          posted for comment and then we'll talk about it at  
21          our next meeting which is in September.

22          MS. EMRICH: October.

23          CHAIRWOMAN KEELS: October. October  
24          meeting.

25          MEMBER MINIARD: October 28.

1 CHAIRWOMAN KEELS: October 28?

2 MEMBER MINIARD: I'm pretty sure.

3 CHAIRWOMAN KEELS: Okay.

4 MEMBER MINIARD: Is that correct?

5 CHAIRWOMAN KEELS: I don't know.

6 MEMBER MINIARD: It's what's on my  
7 calendar.

8 MS. EMRICH: October the 28th.

9 MEMBER MINIARD: Yay.

10 CHAIRWOMAN KEELS: Were those the only  
11 requests I heard really around the IG?

12 MEMBER MINIARD: Is OAPN speaking?

13 CHAIRWOMAN KEELS: Yes, yes. President  
14 Greaves will be here and she will be speaking, yes.

15 And hopefully we'll have some updates on  
16 the CNRA as well as the Standard Care Arrangement  
17 Bills.

18 MEMBER MINIARD: Okay.

19 CHAIRWOMAN KEELS: And we should have  
20 some feedback on the detox rules if there was any  
21 feedback at all.

22 Okay. Then we are adjourned.

23 (Thereupon, the proceedings concluded at  
24 3:05 p.m.)

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CERTIFICATE

I do hereby certify that the foregoing is a true and correct transcript of the proceedings taken by me in this matter on Monday, June 17, 2019, and carefully compared with my original stenographic notes.

  
\_\_\_\_\_  
Carolyn M. Burke, Registered Professional Reporter, and Notary Public in and for the State of Ohio.

My commission expires July 17, 2023.

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