

ADVISORY COMMITTEE ON  
ADVANCED PRACTICE REGISTERED NURSING

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MEETING

before the Advisory Committee on Advanced Practice Registered Nursing, at the Ohio Board of Nursing, 17 South High Street, Suite 600, Columbus, Ohio, called at 10:00 a.m. on Monday, October 28, 2019.

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Advisory Committee on Advanced Practice Registered Nursing:

Erin Keels, APRN-CNP, Chair

Peter DiPiazza, APRN-CNP, Member

Sherri Sievers, APRN-CNP, Member

Michelle Zamudio, APRN-CNM, Member

Brian Garrett, APRN-CRNA, Member

Jody Miniard, APRN-CNP, Member

Angela Gager, APRN-FNP, Member

Pamela Bolton, APRN-ACNP, APRN-CNS, Member

Also Present:

Lisa Emrich

Chantelle Sunderman

Anita DiPasquale

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1 Monday Morning Session,

2 October 28, 2019.

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4 CHAIRWOMAN KEELS: It's 10:00 o'clock.

5 Good morning, everyone. All right. I want to  
6 welcome everyone to the Advisory Committee on  
7 Advanced Practice Registered Nursing.

8 I'm Erin Keels. I am the Chair. I am  
9 with the Board brought to this Committee. I am a  
10 nurse practitioner from Columbus, Ohio, and I'd like  
11 to go around the table with introductions to start us  
12 out.

13 MS. EMRICH: Lisa Emrich, Board Staff.

14 MS. DIPASQUALE: I'm Anita DiPasquale,  
15 also Board Staff.

16 MEMBER DIPIAZZA: I'm Pete DiPiazza. I  
17 am an FNP representing primary care.

18 MEMBER SIEVERS: Sherri Sievers, FNP.

19 MEMBER ZAMUDIO: Michelle Zamudio,  
20 Certified Nurse Midwife.

21 BOARD MEMBER KLENKE: Lisa Klenke, Board  
22 Member.

23 MEMBER BOLTON: Pam Bolton, acute care  
24 and CNS.

25 MEMBER MINIARD: Jody Miniard. I'm an

1 acute care nurse practitioner representing faculty.

2 MEMBER GARRETT: And Brian Garrett  
3 representing the CRNAs.

4 CHAIRWOMAN KEELS: And we have a court  
5 reporter joining us today to report the meeting  
6 proceedings, so please, Committee and everyone, raise  
7 your hands when you want to speak and speak clearly  
8 and succinctly so we can record your comments.

9 Now let's see who's joining us in the  
10 gallery, if you'd like to introduce yourself and say  
11 who you're with.

12 MEREDITH: Meredith from OAAPN.

13 JENNIFER: Jennifer, OAAPN.

14 MR. DILLING: Tom Dilling, Board Staff.

15 MS. ROSSELET: Robin Rosselet, APRN.

16 MR. HOLLABAUGH: Joe Hollabaugh, I  
17 represent the Ohio State Association of Nurse  
18 Anesthetists.

19 MR. MCCLAIN: Justin McClain, CNS from  
20 Youngstown representing OAAPN.

21 MS. DZUBAK: Jessica Dzubak, Director of  
22 Nursing Practice representing ONA.

23 MS. KEEBLING: Marsha Keebling, Nurse  
24 Practitioner, Canton, Ohio, Aultman Hospital.

25 MS. ELMORE: Kelly Elmore, CRNA with UC

1 in Cincinnati.

2 CHAIRWOMAN KEELS: Thank you. Welcome.

3 I'd like for everybody to take a second  
4 to silence your pagers and phones. I just have to do  
5 that myself. The Public Participation Guideline is  
6 available on the table for those who wish to review  
7 that.

8 If you plan to address the Committee  
9 during the public comments portion, please make sure  
10 you sign in on the yellow paper and leave it for us  
11 so that we can call you. The charge of this  
12 Committee is to advise the Board of Nursing regarding  
13 the practice and regulation of Advanced Practice  
14 Registered Nurses and may make recommendations to the  
15 Committee on prescriptive governance.

16 So for today, our agenda is in front of  
17 you. We'll have some comment around some articles  
18 that were sent for review, and we'll have public  
19 comments. We'll have comments from OAAPN. We will  
20 plan to break for lunch around 11:30'ish.

21 We'll come back and have general  
22 information and updates. And then we'll tackle the  
23 draft of the Interpretive Guidelines. Then we'll  
24 have some more public comments. And then we will  
25 have some discussion around APRN-CRNA title and

1 schedule our 2020 meetings.

2           So I'd like to make a few remarks and  
3 comments to help frame today's meeting and  
4 discussions. As I review the transcript from our  
5 last meeting, I had some thoughts and I wanted to  
6 share those with you.

7           One was around the bucket of scope of  
8 practice decisions. And within this Committee, we've  
9 had ongoing discussions aimed at understanding and  
10 clarifying APRN scope of practice. Ohio APRNs e-mail  
11 and contact the Board in fair numbers with lots of  
12 different questions.

13           And what we've really been trying to do  
14 with the interpretive guidelines is to provide  
15 guidance so that we can place on the website for  
16 APRNs to be able to pull that up and help answer at  
17 least more of their common questions.

18           The Interpretive Guidelines, once we get  
19 to that discussion, and the accompanying FAQs, once  
20 those are developed, are not meant to serve as any  
21 new role making or restrict practice. They really  
22 are meant to simply pull the existing statute and  
23 rule into one place and then to provide some  
24 clarifying comments around those.

25           An Interpretive Guideline is a formal

1 process, so once we do have a draft that we are  
2 satisfied with, it needs to go to the Attorney  
3 General as well as the full Board for review and for  
4 approval. The FAQ is a more informal process and is  
5 something that we can develop here and then run by  
6 the Board for approval and then post it on the  
7 website.

8           Neither the IG or the FAQ will ever  
9 address 100 percent of the scenarios. If we can get  
10 it to address maybe 75 percent of common questions, I  
11 think that would be a success.

12           We've heard some discussion over the past  
13 couple years that perhaps the IG is not necessary  
14 because hospital credentialing processes help ensure  
15 that APRNs practice within their scope, but I thought  
16 that -- I was thinking to myself not all APRNs work  
17 in hospitals, not all APRNs go through a  
18 credentialing process, especially those that don't  
19 work in hospitals, and not all APRNs report to APRN  
20 leaders who might be able to answer their questions  
21 as they come up.

22           So I feel that the IG and FAQ will be  
23 valuable and help answer some routine questions and  
24 to demonstrate to chief stakeholders that APRNs are  
25 well positioned to move forward with full practice

1 authority which will still be based on our population  
2 focus.

3 My other thought when I reviewed the  
4 transcript was there were phrases that were being  
5 used such as nurses attacking nurses, scare tactics  
6 and fear mongering. I don't feel that those comments  
7 serve us well to move forward in collaborative  
8 discussions and in a team based approach. So I would  
9 ask that people are kind of mindful when we have  
10 those discussions and just try to be thoughtful about  
11 that.

12 My other thought was the word -- the use  
13 of the word specialty and acute care are really  
14 challenging. The word specialty is used in statute  
15 and rule to describe the population focus, but the  
16 Consensus Model uses the word specialty to describe a  
17 specialty certification within a population focus. I  
18 think that's very confusing and something that we  
19 could potentially put in the FAQ to help clarify  
20 that.

21 The acute condition is a condition that  
22 changes quickly and deviates from the patient's  
23 norms. And all APRNs are well equipped to handle  
24 acute illnesses and situations.

25 In fact, the Attorney General opinion

1 stated clearly that nothing requires a nurse  
2 practitioner to be certified in acute care in order  
3 to provide services to patients because we all  
4 provide acute care services, but at some point, the  
5 acute issue may become so critical and life  
6 threatening, that those with acute care certification  
7 are the ones that are qualified to care for that  
8 patient.

9           And I think that's where we've really  
10 been trying to dig in which is important, but I know  
11 that we have other issues happening in the  
12 communities with perhaps behavioral health and  
13 women's health where at one point the other type of  
14 provider becomes the most appropriate one to either  
15 consult or manage that condition.

16           And I think that's what we're really  
17 trying to provide guidance around. And, again, it's  
18 not gonna -- we're not going to be able to answer  
19 every question. So I'm asking that we use really  
20 clear verbiage when we are talking about all of this.

21           For instance, there was a statement made  
22 that no other state regulates specialty practice. So  
23 if we're talking that specialty practice describes a  
24 specialty certification that an APRN gains expertise  
25 in within the population focus, this is true. States

1 do not regulate that specialty certification within a  
2 population focus like oncology or cardiology or  
3 urology if those certifications exist, right.

4 But if the word specialty practice is  
5 describing the population focus board-certification,  
6 the statement is inaccurate because many states  
7 including Ohio regulate the role of the APRN, as well  
8 as the population focus, and it's on our licensure on  
9 the verification site.

10 In fact, some states go so far as to  
11 regulate that population focus with its own license,  
12 and they're very strict on that. And we're sort of  
13 in the middle where your population focus is on that  
14 license.

15 So then I noticed that we've also had --  
16 heard some statements that I don't really know that  
17 there's evidence for such as PAs are being hired in  
18 more numbers than APRNs. So if there are numbers or  
19 statistics that could be used to help clarify or  
20 frame that, those type of comments, that would be  
21 very helpful because I actually don't know of that  
22 being accurate, at least in the community that I work  
23 in.

24 So those were some comments that I  
25 reflected on the transcript and I'm hoping that that

1 helps sort of frame our discussion as we move forward  
2 because I have a feeling a lot of it is going to be  
3 on the IG as it tends to be.

4           So we'll move on to the next -- thank you  
5 for enduring that with me, I appreciate that. The  
6 next is the discussion about the Journal of Nurse  
7 Practitioner articles. I see that you guys -- you  
8 have them in your packet, I know you've read them,  
9 and who wants to spend some time -- or if you wanted  
10 to spend some time reflecting on those articles or  
11 not.

12           MEMBER BOLTON: I'll just say one thing.  
13 I was very confused following the statement where  
14 Dr. Miller talks about the Consensus Model and then  
15 he goes on to provide an example. There's some  
16 interpretation that I've heard that -- that saying  
17 that we, acute care nurse practitioner, can see  
18 anyone in the primary care setting forward and that  
19 it limits the role of the primary care NP.

20           I did e-mail him directly and I asked him  
21 about that. And his response was that it is simply  
22 an example showing the differentiation that the  
23 confusion can cause. It was in no way highlighting  
24 what an acute care NP versus a primary care NP can do  
25 in a practice.

1 CHAIRWOMAN KEELS: Thank you for  
2 clarifying that. I appreciate that.

3 Any other discussion?

4 MEMBER ZAMUDIO: I found a few  
5 interesting things when I was looking through it. I  
6 actually thought the definition that he put forth  
7 about scope of practice was important because it  
8 recognized experience, so I was like I like his  
9 definition there. And he also validated all the  
10 inconsistency which is what we're all in this  
11 quagmire about.

12 He did state that the patient care needs  
13 defined the best NP to take care of that patient.  
14 That was a perspective we hadn't really hit on very  
15 much. I do disagree with the statement that  
16 Credentialing Committees rarely have an APRN member.  
17 And I tried to get some information on that.

18 I've worked at five facilities in the  
19 State of Ohio and every single one of them had an  
20 APRN and all that. So I don't know how it is in  
21 Texas, but I think it's a little different in Ohio.

22 And then I did notice that he recommended  
23 a Decision-Making Model as well for four different  
24 states. So I think he did point out we're one of 16  
25 -- Ohio's one of 16 that have a required

1 collaborative agreement for this period in time.

2 So I think he had some good points, but  
3 the idea that Credentialing Committees aren't doing  
4 their job or that we're not on those Credentialing  
5 Committees I disagreed with.

6 CHAIRWOMAN KEELS: Yeah, I think there's  
7 a wide variability, right. I know that in my  
8 organization, we have an APRN Quality and  
9 Credentialing Committee that then sends a  
10 recommendation to the med staff and the Board, but  
11 there's not an actual APRN that sits on that. We  
12 send our recommendation. But then I know some  
13 organizations that there's an APRN on the actual med  
14 staff.

15 MEMBER BOLTON: And I think it depends on  
16 whether or not you're a voting member. We have a  
17 member on there, but we are not a part of the medical  
18 staff, therefore, we cannot vote. So I think there's  
19 a lot of quagmires and different confusion.

20 MEMBER SIEVERS: I just noticed that in  
21 these recommendations on what we should do going  
22 forward, that it wasn't explicit that he was saying  
23 that the Board should further define. It was more  
24 based on some mitigation strategies with education  
25 and working with the institutions. It did say that

1 review the state's scope of practice, not that there  
2 should be anything really specifically that he  
3 recommended coming out of there.

4 MEMBER ZAMUDIO: He said something about  
5 the Decision-Making Model being important which we  
6 have, but he said he did recommend to try to tease  
7 out some of this, but I think 90 percent of what the  
8 patient needs, are you the best person to take care  
9 of that patient's needs and still within your scope.

10 CHAIRWOMAN KEELS: Okay, great. Anymore  
11 comments? No? All right. Great.

12 Then we'll move on to our next agenda  
13 item and I know that --

14 MEMBER ZAMUDIO: Are we going to talk  
15 about the other article? Sorry.

16 CHAIRWOMAN KEELS: Oh, I'm sorry.

17 MEMBER ZAMUDIO: I thought we were  
18 talking just about the Miller article. I wanted to  
19 talk about the attorney's article, Balestra. I guess  
20 she runs the law offices of Melanie Balestra in  
21 California. She's a malpractice attorney.

22 I wasn't sure what we were supposed to  
23 get out of it. I read the thing, I did a little  
24 research on her. And I think her takeaway was that  
25 there's threats to the license for FNPs in mental

1 illness treatment which we were touching on a bit. I  
2 wasn't sure what we were supposed to take out of  
3 that.

4 I read her recommendations to have  
5 additional individual malpractice insurance. That's  
6 a surprise coming from a malpractice attorney. And  
7 then that the closed and paid claims that she quoted  
8 in her article going from 9 percent to 22 actually  
9 were quoted from the Nurses Services Organization  
10 which again is a malpractice coverage.

11 So I went to their site and contacted  
12 them, tried to get some information. I couldn't find  
13 those statistics except the one thing I could confirm  
14 was that the average payout for the nurse  
15 practitioner claims was \$6,000. So I'm just going to  
16 say that's at the level of what they call nuisance  
17 lawsuits, et cetera.

18 So \$6,687 was the average payout. I  
19 couldn't find the other statistics, but I wasn't sure  
20 if that was encouraging us to have more malpractice  
21 insurance was what that article was supposed to do.

22 MEMBER SIEVERS: Yeah, and I agree. And  
23 one thing it brought to my attention was that this --  
24 what we've been discussing really doesn't address  
25 going across different certifications. It doesn't

1 address the NP family practice and what is their  
2 ability to care for mental health or women's health  
3 or -- so I wasn't sure if that was something we were  
4 going to go down and that's why this was brought up  
5 or -- you see what I'm saying?

6 CHAIRWOMAN KEELS: We don't have any  
7 ulterior motives in providing these to you.

8 MEMBER ZAMUDIO: Oh, I thought we were  
9 going to discuss malpractice or something.

10 CHAIRWOMAN KEELS: No, no, no. It's just  
11 an FYI. Sorry.

12 MEMBER SIEVERS: It may come up later,  
13 but it is a role here and they are a big issue as far  
14 as we know, and that might be questions that we get  
15 as well from somebody how this gets -- how to focus.

16 CHAIRWOMAN KEELS: I think in our past  
17 conversations, we've sort of gone back to what are  
18 your NONPF competencies for nurse practitioners or  
19 what are your -- sort of the basic content that  
20 covers within your national certification. There's  
21 behavioral health elements in all of those areas.

22 Other comments you want to share? All  
23 right. Very good. All right, ready to move on? All  
24 right, thank you.

25 Next up, I think Jesse, are you

1 representing OAAPN?

2 MR. MCCLAIN: I think that's the plan.

3 CHAIRWOMAN KEELS: And Josecelyn is...  
4 all right. Come on up.

5 MEMBER GAGER: Excuse me, I'm Angela  
6 Gager. I was a few minutes late.

7 CHAIRWOMAN KEELS: Oh, Angela, please  
8 come up.

9 MEMBER GAGER: I didn't want to  
10 interrupt, so sorry. I'm a country girl and the  
11 parking got the best of me this morning. My  
12 apologies.

13 MR. MCCLAIN: Don't mind me. I have  
14 stuff written all over the place. My mind is like a  
15 steel trap: Rusty, illegal and lost in the woods.

16 Thank you, Chairwoman, for allowing us  
17 the opportunity to speak today. I guess there's a  
18 number of topics, and I could start with kind of  
19 where OAAPN is at with legislatively and things that  
20 are going on and I could move into maybe some brief  
21 comments on the articles as well.

22 As you know in October of 2018, Senator  
23 Portman passed a bill for allowing CNSs and CNMs to  
24 be able to be part of the MAT treatment across the  
25 nation if the states would allow it. The issue we

1 got into was not actually with Ohio Revised Code or  
2 rule, I should say, was the federal SAMHSA agency did  
3 not open up their website to allow CNSs and CNMs.

4 I think it was mid September, beginning  
5 of September I had e-mailed Lisa that finally the  
6 website updated and now it says APRN. So CNSs and  
7 CNMs can now legally apply for the MAT waiver. So,  
8 however, again, just be mindful of the SCA laws in  
9 Ohio. If you have the X and your collaborator does  
10 not have the X, you cannot use your X.

11 So you still could only practice if your  
12 collaborator does. So it helps, but it also may not  
13 help with the same notion because I know there are a  
14 few APRNs that have the X but their collaborator  
15 doesn't, so they still cannot prescribe MATs, so it's  
16 kind of a quagmire we have too.

17 CHAIRWOMAN KEELS: Did you get yours?

18 MR. MCCLAIN: I did. My collaborator  
19 doesn't have theirs.

20 CHAIRWOMAN KEELS: Oh, no. You went  
21 through all that.

22 MR. MCCLAIN: Yeah. Well, it's okay.  
23 The education was free and nobody could pass on  
24 further education even though it's not formal  
25 education technically in a school setting. But you

1 can't pass up free education, so it was nice to learn  
2 and I'm stilling trying to talk my collaborator into  
3 getting it because in northeast Ohio, we have a big  
4 problem.

5 CHAIRWOMAN KEELS: How long is it valid  
6 for?

7 MR. MCCLAIN: That's a good question. I  
8 think it's two years but don't quote me on that. I  
9 know after a year, you can't -- if you have certain  
10 number of treatments, you could apply for more, but I  
11 don't think lack of use will expire after a year, but  
12 I'm not really sure, to be honest with you.

13 CHAIRWOMAN KEELS: Okay.

14 MR. MCCLAIN: Go ahead.

15 MEMBER DIPIAZZA: I was just going to  
16 clarify. So you renew your TEX every time you get  
17 your DEA, but then there's some educational  
18 requirement to maintain it. And SAMHSA is good about  
19 sending that out. I'm the same as Jess, I have an X,  
20 but I don't have a collaborating agreement.

21 MR. MCCLAIN: So, again, there are a few  
22 sitting at this table that have the X, you know,  
23 which is why we need to remove the standard of care  
24 arrangement, but I'll get there in a little bit.

25 On October 8th, we had APRN day at the

1 Statehouse where we invited Ohio APRNs to come down.  
2 In the morning, they got a little educational  
3 seminar. And then in the afternoon, we kind of  
4 stormed the Riffe Center and the Statehouse to talk  
5 about how great APRNs are. We had about a hundred  
6 people come to that event, and we probably touched on  
7 60 to 80 legislators. I don't know the exact count  
8 of that.

9 We had a little reception afterwards  
10 where many of them that we couldn't meet with met  
11 with us at that facility, so that was really nice. A  
12 lot of positive feedback from both APRNs as well as  
13 legislators on that.

14 The primary discussion was House Bill 177  
15 which removes the standard of care arrangement. Had  
16 one main purpose, is to remove the SCA.  
17 Unfortunately, opposition really does not want to  
18 negotiate. Opposition wouldn't care if you removed  
19 it or if you removed it after 60 years, they're still  
20 going to be opposed to removal of the SCA.

21 So the plan was then to start basically  
22 asking legislators what are you comfortable with,  
23 what do you think, you know. So right now we have a  
24 sub bill that we got back on Wednesday or Thursday  
25 that we're kind of reediting and drafting. It's not

1 technically a transition to practice, but the idea is  
2 to have the SCA for maybe 2,000 hours, and then after  
3 2,000 hours, the SCA is retired.

4 We do have some language for the GMXO  
5 operators for those in primary care or urgent care.  
6 What we found out over the summer -- well, in the  
7 spring I should say, was there were general medical  
8 x-ray operators, I believe is the phrase. They have  
9 to be supervised by a physician on-site. And the  
10 problem with many of these urgent cares is there's  
11 not a physician on-site.

12 So we wanted to update the language to be  
13 more in the current times where they could be on-site  
14 or via telecommunications. So it's just more cleanup  
15 language. It's not increasing scope for anybody.  
16 It's just so the x-ray operators can do the x-ray if  
17 they have a physician via telecommunications, cell  
18 phone basically.

19 Right now by their law, they cannot do  
20 the x-rays at certain centers because there's not a  
21 physician on-site. And we had a few members, APRNs  
22 in rural Ohio where they were having trouble getting  
23 x-rays. They had reached out to their Senator. I  
24 think it was a Senator who was going to try and put  
25 it in the budget bill as just cleanup language, but

1 that never actually got completed.

2 As we all know, the budget kind of ran  
3 over to the three weeks, so that kind of halted a lot  
4 of those changes. So we're hopeful to just have an  
5 easy fix for them on that. Other than that, the  
6 bill's pretty clean. It is not a scope bill. It  
7 doesn't change your scope. What you do today you  
8 will still do tomorrow. So that does take a lot of  
9 the controversy and argument out of the sales of  
10 opposition, so I don't know if there's any questions  
11 regarding the bill or anything....

12 CHAIRWOMAN KEELS: So the substitute bill  
13 will then go back into the House?

14 MR. MCCLAIN: Yes.

15 CHAIRWOMAN KEELS: Is that right?

16 MR. MCCLAIN: So, yeah. So we've had  
17 four hearings in the House Health Committee which had  
18 a lot of changes over the past couple weeks. So the  
19 Health Committee looks different now than it did in  
20 September even.

21 So, yeah, so the substitute bill when  
22 it's finally correct will get dropped by  
23 Representative Brinkman and go back into the Health  
24 Committee hopefully for more hearings and then  
25 hopefully a vote and move on. That's the plan.

1           MEMBER ZAMUDIO: I have a question. So a  
2 lot of the opposition that I have heard revolved  
3 around supposition, well, this could happen and the  
4 sky could fall and we could have all these kinds of  
5 things happen. When talking to the supposition more  
6 at the state level, have they looked at the  
7 information from the overwhelming number of states  
8 who already have removed that and looked at those  
9 outcomes?

10           MR. MCCLAIN: So that's a great question.  
11 What we learned a couple of General Assemblies ago  
12 with 216 is you could have all the data, 50 years of  
13 data that shows APRNs are safe, providing high  
14 quality, effective care on par, if not superior in  
15 certain areas than the counterparts. That data  
16 seemed to fall on deaf ears.

17           It's still more of the sky is falling,  
18 are you sure you want them out there without this,  
19 that or the other; however, when you educate that  
20 there is not someone on your shoulder making sure you  
21 do X, Y or Z, then they seem to be more comfortable  
22 with what the word collaboration means.

23           Again, we're not getting rid of  
24 collaboration. We're getting rid of the written  
25 mandate that you have to have someone. We're still

1 expecting and there isn't anyone at this table or in  
2 the state that's still not going to professionally  
3 collaborate every day.

4 I work in neurology. When I have an MS  
5 question, I'm not calling my signed contracted  
6 collaborator, I'm calling the MS specialist who I'm  
7 friends with in Pittsburgh. When I have a durum  
8 question, I'm not calling my collaborator, the person  
9 that signs my -- I'm calling the people I collaborate  
10 with in Toledo.

11 So, like, professional collaboration will  
12 still be there. You know, this basically gets rid of  
13 the mandated paper we sign every two years and that  
14 you have to report to the Board of Nursing who your  
15 collaborator is and this, that and the other.

16 MEMBER ZAMUDIO: Thank you.

17 MR. MCCLAIN: And it is permissive. So  
18 in hospital systems, those who work in hospital  
19 systems choose to have some type of Employment  
20 Agreement, they're more than welcome to have that.  
21 We're not saying it has to go away we're getting rid  
22 of this contract. And if a hospital wants to  
23 implement their own little employment agreement, have  
24 at it. We're just not going to call it SCA.

25 MEMBER ZAMUDIO: Thanks.

1 MR. MCCLAIN: So hopefully we'll have  
2 that introduced again here shortly. I do want to  
3 comment on some of the articles, if that's okay.  
4 I'll find my article comments. I did notice that  
5 both of the articles referenced Decision-Making  
6 Models, you know, but, again, I'd be remiss if I  
7 didn't mention that both of the articles referenced  
8 Decision-Making Models for all nurses, you know.

9 And I just think we're doing our degrees  
10 and our service an injustice by just lumping us again  
11 was RN and LPN Decision-Making Models. They're two  
12 vastly different scopes of practices and you can't  
13 just lump us all into one.

14 I have no issue with a Decision-Making  
15 Model. I'm sure most of APRNs in Ohio, no matter how  
16 clean and crisp it is -- and Erin and I appreciate  
17 your comment that, you know, your goal is to answer  
18 75 percent of questions -- you could have the best  
19 answer, the sky is blue, here's the evidence, and  
20 you're going to get 75 questions: Are you sure?  
21 Well, what if it's foggy? It was really foggy  
22 driving down to Columbus today. You're going to  
23 generate more questions.

24 So I appreciate the intent. I just don't  
25 think the goal's going to be there. But lumping us

1 in with RNs, you know, it's just not ideal. And I  
2 think it's, again, an evidence of a juris doctorate  
3 from Long Beach, California not understanding or  
4 someone in Texas, and I think it was Michelle who  
5 brought up that -- how it works in Texas. That's a  
6 restricted state. I'm not too comfortable with Texas  
7 law, but according to AANP's website, they're a  
8 restrictive, supervised state. So I'm not shocked  
9 that they don't have APRNs on committees deciding  
10 scope of practice, you know.

11 To go back to the Med Exec comment,  
12 though, yeah, Ohio is behind the times on getting  
13 members to Med Exec, but Med Exec is not determining  
14 your scope of practice when you walk in there.  
15 They're determining your scope of practice when you  
16 get in trouble, you know. So, I mean, that's two  
17 vastly different committees there.

18 Miller did comment the NONPF white paper  
19 about primary care is not limited to preventive  
20 maintenance care of the well person but includes  
21 continuous care for patients with stable, acute or  
22 chronic conditions. And I think we get into this,  
23 all right, what kind of patient it is; where I think  
24 we need to start thinking about what it is that APRN  
25 is treating in that patient.

1           Again, working in neurology, I may be  
2 consulted to adjust the patient's seizure medicines  
3 when they're in the ICU for ARDS but I would be the  
4 first one to tell you you don't want me touching a  
5 patient with ARDS, but I'm not handling anything to  
6 deal with that.

7           I'm adjusting their Trileptal because it  
8 doesn't come in an IV and I need to put them on  
9 something that comes in an IV. So I think it's more  
10 of the condition the patient is dealing with and what  
11 you're assigned to treat them which I feel the graphs  
12 or even the Oregon chart or any other chart doesn't  
13 pick up because it's here's what the patient has,  
14 deal with it, where I think it's a little more  
15 intricate than that.

16           We have many safeguards already in place.  
17 The Momentum article that basically started this  
18 whole issue states another resource available on the  
19 Board's website is a Decision-Making Model for  
20 determining the APRN scope of practice,  
21 quote/unquote.

22           So we admitted we have a scope of  
23 practice Decision-Making Model three years ago almost  
24 to the date. I feel like we're using it. In the  
25 three years you guys have been arguing this -- well,

1 many of you, some of you have changed -- have been  
2 arguing this point -- the sky -- not to use a cliché  
3 again -- the sky has not fallen. You know, patients  
4 are not being harmed. APRNs may or may not be  
5 reported, but like the world is not coming to an end  
6 in Ohio. If there were safety issues, rest assured  
7 we would hear about it, the Board would hear about  
8 it. That's just not happening.

9 I feel like there isn't one RN or LPN or  
10 APRN that is not good stewards with their license.  
11 We don't take that too lightly that we're giving a  
12 license. When I worked in the ICU, I'd be the first  
13 one to tell you you don't want me putting an IV in  
14 you. Let me go get so-and-so or so-and-so, they're  
15 better at IVs. ABGs, I'm your guy, but I knew where  
16 my scope and where my area of expertise lay.

17 I feel like APRNs still do that which is  
18 why the sky is not falling. We have a  
19 Decision-Making Model already. We just need to  
20 utilize it. Hospital systems for the most part have  
21 APRNs on Credentialing Committees. I really don't  
22 know one that doesn't other than the one just  
23 mentioned.

24 You said not all APRNs go through a  
25 credentialing process, but I would argue the ACNP-FNP

1 issue isn't an issue outside of those hospital  
2 systems. And even in rural hospitals, we have APRNs  
3 that are chief medical officers in some of these  
4 rural hospitals. They're running the show. Trinity  
5 over in Dennison, Ohio, Eric is the CMO of that  
6 hospital.

7           So I mean, like, we know what we're  
8 doing, we know our scope, and we're -- we're  
9 educating these hospitals. Miller said in his  
10 article that there were like five issues he wanted to  
11 correct. Every single one of them was in your APRN  
12 schools. It wasn't a problem with state laws, it  
13 wasn't a problem with state licensure.

14           It was you need to teach them at schools.  
15 You need to teach them in the graduate programs.  
16 Faculty should be educating this. Courses need to  
17 incorporate scope. So he was advertising the issues  
18 in the schools, not with state law, you know. He  
19 went through and listed five things to correct:  
20 School, school, school, school.

21           And I just feel like more regulation  
22 isn't the answer. Answering the questions, sure, we  
23 all have to do that. We hired a lawyer just to  
24 answer FAQs at OAAPN. The Board of Nursing, that's  
25 gonna be what it is, and I don't think this

1 Decision-Making Model or this Interpretive Guideline  
2 is going to prevent questions from still being  
3 flooded in. So that's my comments, take it or leave  
4 it.

5 CHAIRWOMAN KEELS: So Jesse, thank you  
6 for that. Are you then saying that you don't feel  
7 that we need to have Interpretive Guidelines, and  
8 that the Board shouldn't move to do more to help  
9 answer questions for people who come in to Ohio or  
10 who are working in Ohio and have questions?

11 MR. MCCLAIN: So, I mean, the whole  
12 purpose of Interpretive Guidelines -- and Lisa, you  
13 can correct me if I'm wrong -- is part of the  
14 customer service standards for the Board of Nursing.  
15 They're okay to create Interpretive Guidelines based  
16 on the number of FAQs that come in.

17 So I feel we already have an  
18 Interpretive Guideline. It's called the  
19 Decision-Making Model. It was written years ago.  
20 Three years ago the Board of Nursing advertised that  
21 you should be using the Decision-Making Model for  
22 scope of practice.

23 I feel it's working. It's not that I'm  
24 against it. I just don't feel like this is needed.  
25 We have something that's working. It's not going to

1 answer the questions. They're still going to e-mail  
2 the questions. I feel what we have is working and  
3 it's okay to walk away.

4 MEMBER ZAMUDIO: So you commented that  
5 it's been there for years and that we started  
6 addressing it about three years ago. Do you feel  
7 like the current situation that requires just an  
8 update of our Decision-Making Model that we currently  
9 have, does that need to be shored up?

10 MR. MCCLAIN: I don't know that it needs  
11 updated or if it needs shored up. It's working, you  
12 know. I mean, yeah, it probably just needs to be  
13 looked at again but maybe stamped with a new date to  
14 show that it was looked at again, but I mean it's  
15 been working for years.

16 Just because an article came out and told  
17 you to even use it, now it felt like the sky's fallen  
18 and we all need to do something and we need to move  
19 around. And we've talked about it for three years  
20 and nothing has changed in our practice.

21 Hospital systems maybe got scared and  
22 became a little more restrictive, you know, and  
23 changed their hiring policies which is okay, they  
24 have every right to do that. And I'm not saying  
25 hospitals can't do that. I'm not saying employers

1 can't do that. I just don't feel the Board of  
2 Nursing should be doing that. That should be a  
3 hospital system to be worried about it. I don't  
4 think the Board should restrict it when we're not  
5 really sure what the APRNs are -- you know, their  
6 intent is.

7           And I gave the example of me with seizure  
8 medicines. You know, from the outside looking in,  
9 oh, my gosh, Jesse went in there and I'm not a CNP,  
10 so -- but Jesse went in there and is taking care of  
11 an ARDS patient. Yeah, but I'm not really handling  
12 that ARDS. I'm handling the changing the Trileptal  
13 to Keppra or whatever that would be just to make  
14 their job for caring for the patient a little  
15 simpler, one less worry for them.

16           So I feel like what we have is working.  
17 It just needs reference. And the Board of Nursing  
18 answers questions all the time referencing the  
19 decision-making, referencing this Ohio Revised Code,  
20 referencing this Ohio Administrative Code.

21           You know, doing something just because  
22 we've been talking about it for three years isn't  
23 ideal either. Oh, we have to do something, we talked  
24 about this. No, it's okay to say, you know what, we  
25 need to move on, we have bigger issues in Ohio.

1 Yeah, they're going to send in questions anyway,  
2 we're moving on. That's wisdom to know when to move  
3 on. I think it's time to move on.

4 CHAIRWOMAN KEELS: Pam.

5 MEMBER BOLTON: Jesse, I'm looking at one  
6 of the these Frequently Asked Questions and it's a  
7 newly Certified Family Nurse Practitioner who said  
8 she's interviewed for an adult CNP position with  
9 surgical trauma and she talks about what kind of  
10 patients she would be taking care of, and she asked  
11 the Board -- or the Staff of the Board is this a type  
12 of position allowed within my scope of practice with  
13 national certification in family. She also notes  
14 that she's taken the coursework for pediatric acute  
15 care but is not an adult acute care certification.

16 I'm looking at that question and I'm  
17 looking at the Decision Model, I'll be honest, I  
18 struggle with that because I feel like the Decision  
19 Model is very broad. And I feel like you can  
20 determine -- you know, if you believe you have that  
21 scope, you can say that, if you have the skill and  
22 the clinical competence. Can you work me through  
23 that scenario with this Decision Model?

24 MR. MCCLAIN: But I mean, that nurse knew  
25 enough to ask whether or not that was in their scope,

1 and I think that's where -- I mean, they sent out the  
2 questions but they didn't send out their answers or  
3 when the questions came in or when the answers went  
4 out.

5 MEMBER BOLTON: Right.

6 MR. MCCLAIN: I feel to be transparent,  
7 when did that question come in and what was the  
8 answer that went out would be nice to see also, you  
9 know. But I feel like they sent the question, the  
10 employer can then determine the hiring practice. I  
11 don't feel that that's the Board of Nursing's job to  
12 delineate that. That's the Credentialing Committee  
13 that can do that.

14 MEMBER BOLTON: But I'm a little confused  
15 because what you shared was that the Decision-Making  
16 Model should help that individual answer that  
17 question, right?

18 MR. MCCLAIN: Uh-huh.

19 MEMBER BOLTON: So can you work me  
20 through that and help me understand how because I'm  
21 struggling with that. I'm struggling to -- because I  
22 think there's a lot of subjectivity in this and --

23 MR. MCCLAIN: I think that's how it was  
24 originally written, as to be broad and to give that  
25 empowerment to the hospital systems and employers. I

1 agree, but I don't think that question is going to be  
2 any better answered with those colorful graphs is my  
3 argument.

4 MEMBER BOLTON: Okay.

5 CHAIRWOMAN KEELS: Jody.

6 MEMBER MINIARD: So I want to go back to  
7 something. I would agree that no matter what kind of  
8 Interpretive Guideline Decision-Making Model you  
9 have, there are going to be people who fall outside  
10 or in that gray zone. And I would agree that I think  
11 that it is the APRNs', in my opinion, responsibility  
12 to know their scope of practice.

13 And I go back to something in the article  
14 that Dr. Miller said on the second page towards the  
15 end where he gives his proposed solution to the  
16 problem of the misunderstanding, and he gives five  
17 things basically.

18 And most of those five things fall on the  
19 role of APRN faculty to educate their students what a  
20 scope of practice is, not all of them, but if you  
21 kind of read the paragraph, they kind of fall in the  
22 education piece which I think is huge.

23 And I think that as faculty, that is my  
24 responsibility, and I solely see that, but I can  
25 speak from my institution and my students, that I

1 talk about this a lot. I meet with students before  
2 they come in, are you sure this is what you want to  
3 do because if you want to be in this, you want to do  
4 this when you're done. If you think you want to do  
5 this, you're in the wrong program, you need to switch  
6 programs.

7 But that doesn't happen all the time,  
8 so -- in every institution. I can't speak for every  
9 institution that educates APRNs. And particularly in  
10 the distance learning environment, we're educating  
11 APRNs that are outside the state. People are getting  
12 their education outside of the state and then coming  
13 to Ohio to practice.

14 So I agree that there's a gray. And I  
15 want to comment on something that was sort of taken  
16 out of context. I'm going to circle around for a  
17 second. Follow me. At our last meeting, there was a  
18 lot of discussion by OAAPN after the meeting on their  
19 kind of summary of our meeting. And one of the  
20 things that really troubled me was there was a  
21 comment that was said that specifically over and over  
22 during that summary about regulation and the Board  
23 regulating and the Board making laws.

24 And during that meeting, we had said over  
25 and over that this is simply an Interpretive

1 Guideline. It's not law or rule. It is still the  
2 APRNs' responsibility to understand their scope.  
3 It's just to help them, right. So I think that was  
4 kind of taken out of context.

5 And I would be really curious how this  
6 model -- I would agree with Pam, this current  
7 decision-making tool, I guess is the right word, is  
8 there a lot of questions. And it may have been  
9 sparked by one particular article, but being in  
10 education, prior to that article coming out, there  
11 were many, many questions preceding that article. So  
12 I think blaming the entire conversation on one  
13 article is a little much, I guess.

14 And I think there -- I think there are a  
15 lot of students and current APRNs who still have a  
16 lot of questions about where their scope lies. And I  
17 would be interested to see -- We had mentioned at the  
18 last meeting as well if OAAPN had sent out -- if they  
19 had surveyed their members.

20 Because OAAPN is talking a lot about what  
21 APRNs in the State of Ohio are saying, but I've never  
22 seen a true -- like have they ever surveyed their  
23 members about what they feel about maybe not this  
24 attachment A, but what do they feel their  
25 understanding of scope of practice is?

1           Because I've never -- I'm an OAAPN member  
2 and have been for years, probably going on 15 or 16  
3 years, but I've never received anything about that.  
4 So speaking for everyone, I'm just a little bit  
5 confused as to how -- what the -- kind of what Pam  
6 said, what is a better thing because I'm not sure  
7 that this is really working as well as people are  
8 saying it is.

9           MR. MCCLAIN: Where's the evidence it's  
10 not working?

11           MEMBER MINIARD: Well, because there are  
12 questions -- I can tell you in education, I still get  
13 lots of questions about this. At the University of  
14 Cincinnati where I teach, we have the largest  
15 distance learning program in the country, and I teach  
16 both on-site and in the DL program, and there's just  
17 tons of questions about this all the time.

18           MR. MCCLAIN: But they're students,  
19 they're supposed to have those questions.

20           MEMBER MINIARD: Right, but it's not just  
21 from students. It's from graduates, it's from  
22 students who have passed certification who then come  
23 back to you later asking for your advice and  
24 questions.

25           And I think that they're getting

1 misleading information from many different sources,  
2 and I think we have to have one spot that everybody  
3 says go here, this is what you should do, go here,  
4 and that's why I think an Interpretive Guideline  
5 would be more helpful than going to piecemealing it,  
6 going to multiple different organizations to try to  
7 find the answers.

8 I think we have to provide our APRNs a  
9 better guideline of scope of practice. Those of us  
10 like you and I who have been practicing in our roles  
11 for years, that's very different. We understand our  
12 scope of practice, but those people who are writing  
13 questions like No. 6 working in a trauma ICU licensed  
14 as a Family Nurse Practitioner is interviewing for an  
15 adult CNP position but is getting a pediatric acute  
16 NP degree as well as her FNP, like that's all over  
17 the place.

18 Like this person -- this is just one  
19 person, but I think it is representative of some  
20 questions that other people would have too because I  
21 know from personal experience, I get a lot of  
22 questions about that.

23 CHAIRWOMAN KEELS: Brian, did you have a  
24 question?

25 MEMBER GARRETT: Yeah. Just on the

1 outside looking in as an educator, and so correct me  
2 if I'm wrong, but for undergraduate education, it's  
3 very prescriptive -- it's more prescriptive on what  
4 the education would be, but for graduate education,  
5 they defer to the accrediting bodies.

6 So accrediting bodies set minimum  
7 standards for what a program should teach. And I  
8 taught NPs in certain classes, and obviously I  
9 specialize in anesthesia, but whenever there's gaps  
10 in education or in understanding of the education,  
11 that something has to fill in the gap, right.

12 So obviously we have accrediting bodies.  
13 We're not -- if we had a minimum standard for what  
14 should be taught in a program and it cleared this up,  
15 then we wouldn't have this type of diverse gap. So  
16 whenever there's a gap, we have a minimum standard  
17 for professional aspects, we call it. We have to go  
18 through each one of our accrediting bodies and get  
19 the scope of practice down to the.... For whatever  
20 reason, an acknowledgment of the accrediting bodies,  
21 there's still a gap. So the question is how do we  
22 fill that gap.

23 And there's several ways to do it. They  
24 can either have Interpretive Guideline and FAQ or  
25 like the other guy said, get their prescriptives and

1 making sure that they have done certain things or a  
2 continuing education credit thing or something like  
3 that.

4 But for me looking at it, we have a gap  
5 between the minimum standards by the accrediting body  
6 and what we need in Ohio. So we have to fill that  
7 hole somehow. The question is how do we do it, and  
8 that's what we're all trying to talk about, right,  
9 the Interpretive Guideline, FAQ, whatever.

10 But I agree with you on the education.  
11 The problem is the education -- the schools don't  
12 drive the education. The national accrediting body  
13 decides that. If they came to me and said you need  
14 to do this tomorrow, it would change tomorrow.

15 So we either need to get NONPF or all  
16 those accrediting bodies to change, which is not  
17 going to happen, we're just Ohio, right. What we  
18 have is what we have. And that's -- and that's what  
19 we're talking about.

20 So it's not necessarily that the schools  
21 are the issue. It's the accrediting body. And we  
22 have a specific gap here and we have to fill that.  
23 So, again, I'm just a process person on the outside  
24 looking in, and we have to get that filled because I  
25 teach professional aspects courses for anesthesia

1 education, but it is very prescriptive. It's down to  
2 what....

3 So being familiar with NONPF and things  
4 like that, it's not as prescriptive on those areas,  
5 so for me outside looking in, just saying we have the  
6 Decision-Making Model and we still have some  
7 questions, is there a better way to fill the gap is  
8 what I'm saying. I don't have an answer.

9 MR. MCCLAIN: And I agree there may be a  
10 gap in teaching laws in Ohio at the school level, you  
11 know, because I try and teach -- Youngstown State  
12 University, I go and teach their acute care. They  
13 have me come as guest lecturer on APRN law and Ohio  
14 Revised Code and Ohio Administrative Code, so I  
15 realize you need someone who understands, you know,  
16 4723, but I then steer back to just because you got  
17 bizarre questions does not mean that there's a gap in  
18 care.

19 In three years, there have been no data.  
20 I think, Erin, you asked for data about PAs being  
21 hired more than NPs. From my understanding, that is  
22 anecdotal, but I will see if we can get that for you,  
23 but there's no data that show what we have in place  
24 already isn't working. It's not, you know....

25 MEMBER GARRETT: I can do the argument on

1 the other side on data. I'm not trying to push back,  
2 but what I'm saying is I have to do a law requirement  
3 every year for my RN license for me to make sure that  
4 I understand the law. And I'm not practicing -- I'm  
5 a practicing RN, but I'm practicing as an advanced  
6 practice, right?

7 MR. MCCLAIN: Right.

8 MEMBER GARRETT: Why wouldn't I have an  
9 APRN mandatory law CEU which would be beneficial to  
10 me which can do less and just substitute that for the  
11 RN licensure and then help clear that up and then  
12 that's the gap we're looking for between the  
13 accrediting body and you substitute one for the  
14 other? I don't know if that would be done by the  
15 Board or by statute, I don't know. That would make  
16 more sense to me.

17 That was my whole point of what I was  
18 trying to say is why do I do this RN thing every  
19 year, it talks about passing meds, and I'm not doing  
20 that and actually give me an APRN license law -- this  
21 gap, one or two hours, whatever it is, every couple  
22 of years and that would be more beneficial to me.

23 And then maybe it would decrease the  
24 questions. And it would be more beneficial, I get  
25 CEU credits for it, and then I don't have to do the

1 one on nursing that I -- my wife and I go, "Why are  
2 we doing this?" My wife is a nurse practitioner, by  
3 the way. "Why are we doing this?" I would like to  
4 have one that's to me. How cool would that be,  
5 right? That's where I was going with that. Sorry.

6 MR. MCCLAIN: Hey, and if we want to, I  
7 mean, the five-year rule review is up, if we want to  
8 write a rule that says, you know, instead of RN law  
9 you've got to do APRN law to end this discussion, I'm  
10 not sure there's one APRN in Ohio that probably  
11 wouldn't be like okay, you know, because....

12 MS. EMRICH: Just out of step one, that  
13 one-hour law requirement, it doesn't prohibit an APRN  
14 from looking at the law and rules specific to APRNs  
15 specific to --

16 MR. MCCLAIN: No, no, no. I --

17 MEMBER GARRETT: No, the books are always  
18 RN based and the --

19 (Multiple people talking at once.)

20 MR. MCCLAIN: And I would also argue that  
21 many APRNs are actually doing like a prescribing law  
22 course which satisfies the law requirement.

23 MEMBER GARRETT: Yeah, if the Board of  
24 Nursing could get it somehow --

25 MR. MCCLAIN: But to fix this problem,

1 all right.

2 CHAIRWOMAN KEELS: Actually... Sherri.

3 MEMBER SIEVERS: So just on No. 6, I  
4 think there's a big responsibility here by this  
5 employer. And I think that if you -- you don't want  
6 to miss the rest of the Decision-Making Model which  
7 it goes back to the Code and the law which says that  
8 it's education, training and certification.

9 So I think you could quickly shut this  
10 person down because they probably did not -- were not  
11 tested on ICU principles, nor did they probably do  
12 clinical in an ICU setting. So I think a simple FAQ  
13 with this scenario with the answer being if you do  
14 not have the education, training and certain national  
15 certification done, it's easily answered. And  
16 there's probably four or five questions that you  
17 could cover most of the big issues that we're talking  
18 about here in an FAQ which would not be to the extent  
19 that this is.

20 I think that the flip side of that, you  
21 know, I have many of your students, and they still do  
22 come out confused. I had an acute care student that  
23 applied for an outpatient clinical job, and we just  
24 don't put our acute care folks there because they're  
25 not in that scope at all.

1           And so I think it's the employer  
2 responsibility to have clear job descriptions and  
3 postings that require the -- I would never allow a  
4 Family Nurse Practitioner to be in a surgical trauma  
5 or ICU at our institution.

6           But what you don't want the employer to  
7 be is so pigeonholed that they can't find coverage.  
8 We know our patient population best and we use many  
9 in-patient areas which are predominantly medical  
10 which may have some orange patients, but our red  
11 patients, in my opinion, are in our ICU which we  
12 don't puts folks there.

13           So the debate is now going to become  
14 which I have for later, is the question you're going  
15 to get is what is a red patient, define a red patient  
16 for me. So it's still going to be unclear for folks.  
17 The questions are just going to be different.

18           So how can we come up with something to  
19 address that the most frequent things that we feel  
20 are the biggest issues in an FAQ that may be some  
21 scenarios like you suggested or led to, Pam, walk  
22 through how would this be answered and come up with  
23 those, those FAQs.

24           And here's an example that you're still  
25 going to get questions, I just love No. 5. I had a

1 certificate to prescribe and where do I do that. So  
2 clearly you're going to have people who are just not  
3 understanding, right?

4 And there's -- we can't have an FAQ for  
5 every single question, but if we can land on that we  
6 think that red is probably critical care or something  
7 and have a few questions that just push back and ask  
8 the person, education, training, certification, I  
9 think the answer for themselves is, well, no.

10 CHAIRWOMAN KEELS: Can I... this is  
11 Jesse's time --

12 MEMBER SIEVERS: Sorry.

13 CHAIRWOMAN KEELS: -- or OAAPN time. Any  
14 other comment from OAAPN?

15 MR. MCCLAIN: I'll just comment on the  
16 graph real quick since we're talking about it.

17 CHAIRWOMAN KEELS: Okay. And you can  
18 finish your section.

19 MR. MCCLAIN: It doesn't cover every  
20 scenario, you know, and there's going to be women's  
21 health where they're going to have to do a  
22 gynecological exam on a younger individual that may  
23 not fall into this graph or, again, the patient is an  
24 acute care individual but you're not handling that  
25 acute care problem. You know, this graph does not

1 account for that.

2           And I just feel and lawyers have also  
3 stated, that this could create a legal issue that may  
4 not -- the broad Decision-Making Model we have now,  
5 you know, does not create because you could get in  
6 there and argue that I'm just handling the seizure  
7 medicines, I'm not handling the ARDS, and that could  
8 be argued.

9           This would then put that FNP into a legal  
10 argument where they were practicing outside of their  
11 scope when they weren't handling the acute care  
12 problem in that acute care patient but not handling  
13 the acute care issue. So it does create this legal  
14 issue that doesn't need to be there, but the hospital  
15 systems do it.

16           CHAIRWOMAN KEELS: Lisa.

17           BOARD MEMBER KLENKE: I'm not speaking at  
18 all as a Board member. I do have some questions for  
19 you, Jesse, but I'm speaking as a hospital  
20 administrator and somebody that works with the  
21 Credentialing Committees and Medical Executive  
22 Committees.

23           One of my concerns is the lack of  
24 knowledge and education particularly when there's not  
25 an APRN who's very articulate on scope of practice

1 that may be assisting with making some of those  
2 decisions. Some of the I think opposition that you  
3 may hear may be the lack of knowledge.

4 So I think APRNs may be artificially held  
5 back in hospital systems. You said that they can  
6 make their own policies and they can and they do, but  
7 they may be making them based on their lack of  
8 knowledge and understanding.

9 MR. MCCLAIN: Absolutely.

10 BOARD MEMBER KLENKE: And so any type of  
11 common understanding that could be created to  
12 certainly allow the situation that you described,  
13 you're not going to manage a patient in an ICU, but  
14 hospital hears that we've got an acute patient in the  
15 ICU and what is Jesse doing in there? But if the  
16 Credentialing Committee understands those subtle  
17 differences, you would be privileged to do that.

18 So even though the Executive Committee  
19 you said does not make decisions until there's a  
20 problem, they actually do. They determine what your  
21 delineation of privileges and scope is within that  
22 organization.

23 It's very different if you're in the  
24 Cleveland Clinic or you're a small rural hospital  
25 like I am, but in smaller community hospitals, I can

1 tell you they struggle because there's not the  
2 expertise to determine. So they may artificially  
3 narrow the scope of practice just because it's  
4 comfortable for them.

5 And they may not be allowing APRNs to be  
6 practicing to the full scope because of that lack of  
7 knowledge or the fear that what are they going to do  
8 is not really explained to them well because there's  
9 not somebody that's very articulate in what their  
10 scopes are.

11 So even though more -- I side with you  
12 more on some things in terms of the more we write  
13 things down, sometimes it does create a barrier, but  
14 I also think that without common understanding, we  
15 may be hurting the APRN scope at least in certain  
16 parts of the state where there's not really highly  
17 knowledgeable APRNs who understand those differences.  
18 And a lot of that is determined in hospitals at least  
19 by the delineation of privileges that are granted to  
20 an individual.

21 CHAIRWOMAN KEELS: Anything else?

22 MEMBER ZAMUDIO: Just a quick point.

23 Sorry. You mentioned the women's health, and  
24 everyone knows I'm here to represent the nurse  
25 midwives, but there's also a great deal of overlap

1 between the women's health practitioner and nurse  
2 midwifery.

3           And so I'm looking at that and it stops  
4 before the red, I thought what kind of situation  
5 could that be? Well, a patient with abnormal uterine  
6 bleeding comes in, the women's health nurse  
7 practitioner evaluates her, orders labs, does an  
8 endometrial biopsy. That comes back, endometrial  
9 cancer is diagnosed. She refers.

10           So that's what a nurse midwife would do  
11 and that's what a women's health nurse practitioner  
12 would do, but one big thing that we're not  
13 considering here is our Decision-Making Model is  
14 broad but it covers everyone. What we're looking at  
15 is an Interpretive Guideline for nurse practitioners,  
16 for CNPs. That doesn't involve me.

17           So we have the Decision-Making Model for  
18 all four of our roles or specialities according to  
19 the rules, but this isn't going to address me. This  
20 is going to address a women's health nurse  
21 practitioner. We function very much the same.

22           So we have to keep in mind the overall  
23 picture here. You're talking about Interpretive  
24 Guideline for CNPs. The Decision-Making Model is for  
25 all of us. That is a huge distinction.

1           So I think one of the decisions should be  
2 are we going to have these Interpretive Guidelines  
3 for CNPs only which would pigeonhole a lot of us or  
4 do we need a Decision-Making Model like the one we  
5 have last updated in 2017, although we've been doing  
6 this for a while, it was updated in 2017 that  
7 addresses all nurse practitioners and maybe some  
8 education to fill that gap.

9           I didn't get to watch it, but Erin, there  
10 is some video called Staying In Your Lane that you  
11 did, and I really would like to -- or Lisa did, yeah,  
12 yeah, sorry, so something like that to show all of us  
13 and to add to education and then a broader DMM which  
14 is what is recommended by these authors. A  
15 Decision-Making Model would take away an Interpretive  
16 Guideline that's only going to address one of the  
17 four roles.

18           CHAIRWOMAN KEELS: So Pete and Brian,  
19 these are questions for Jesse.

20           MEMBER GARRETT: So just a suggestion for  
21 the group name for Jesse -- my being a solution guy,  
22 so what if OAAPN came up with a specialty specific  
23 CEU that's mandatory that is specific to your  
24 specialty, my specialty. And then OAAPN partners  
25 help write that and then the Board of Nursing, if you

1 have an NP or an CRNA to... or discipline with the  
2 Board, you could say, look, you didn't complete, do  
3 all this, and they say I didn't know, I didn't go to  
4 the website or have the FAQ, so both sides get what  
5 you want.

6 If you can say, listen, you have  
7 something and then you have, A, you have a  
8 disciplinary issue, sorry you did this, right, you  
9 know, you said you stated you knew this and it fills  
10 the gap in education. That's just my suggestion  
11 because I've been hearing the talk, and you can  
12 butcher that suggestion up. It's just a suggestion.

13 MEMBER ZAMUDIO: It's a good one.

14 CHAIRWOMAN KEELS: Pete, did you have a  
15 question?

16 MEMBER DIPIAZZA: No, I just -- I wanted  
17 to thank Lisa because I was going to make that  
18 comment about we need an Interpretive Guideline. I  
19 mean, Jesse, I feel like we need an Interpretive  
20 Guideline, and it's for the very reason that Lisa  
21 talked about where we don't have necessarily well  
22 articulated or expert advanced practice that can help  
23 guide people to decide where they need to be, what's  
24 safe.

25 No one's disagreeing as a neuro CNS that

1 you can't take care of the neurological needs of  
2 someone in the critical care, but would I want you to  
3 intubate me or manage my drips, right? I wouldn't  
4 want to do that.

5 MR. MCCLAIN: I wouldn't want to do that  
6 for you.

7 MEMBER DIPIAZZA: But we could -- we are  
8 maybe the outliers in that thought. Put a new FNP in  
9 that position, would they think along those same  
10 lines? Sometimes you're dangerous when you don't  
11 know what you don't know.

12 MEMBER MINIARD: Or a new FNP that comes  
13 from an NP background. That happens a lot.

14 MEMBER BOLTON: So on the Decision-Making  
15 Model again, Jesse, it says here, "The  
16 Decision-Making Model is a guide for APRNs to use  
17 when determining whether a specific procedure, task  
18 or activity is within the APRN's scope of practice,"  
19 is that really talking globally about the scope of  
20 practice issue or is that talking about a task?

21 And it was your comment, Michelle, that  
22 made me think about this. Are we making an  
23 assumption that everyone who comes to this  
24 Decision-Making Model has a certain set of knowledge.  
25 And with that knowledge that comes forward, it's

1 really going to drive how those questions are  
2 answered.

3           So I'm not really sure because I wasn't a  
4 part of the creation of this, but I'm thinking that  
5 there's -- we're talking about two different things.  
6 We're talking about a much more global thought around  
7 scope of practice, and here we're talking about a  
8 specific procedure, task or activity. Is this really  
9 going to -- is this really meeting the criteria for  
10 assessing whether someone is within their scope?

11           MEMBER ZAMUDIO: I agree.

12           MR. MCCLAIN: So the answer to that, I  
13 mean, I understand it says task or activity or  
14 procedure, task or activity I think I have it in  
15 here, but specific to this discussion, the Board of  
16 Nursing recommended APRNs use the APRN  
17 Decision-Making Model for scope of practice.

18           So I think their definition at that time  
19 in the Momentum article was task and activity to be  
20 functioning -- how you're functioning within the  
21 hospital or outpatient or anything. So that may be  
22 your consideration of misinterpretation, but that is  
23 how the Board advertised it in the Momentum 2016  
24 article.

25           MEMBER BOLTON: Okay. And you may be

1 right, and I don't remember all of how that was  
2 brought forth. In here, its procedure, task or  
3 activity is within the scope of practice. So it's  
4 making in my interpretation, and I would need the  
5 Board to correct this, it's once you've determined  
6 what that scope is, then is this particular  
7 procedure, task or activity appropriate to that  
8 scope.

9 MEMBER MINIARD: Speaking about a task,  
10 not a population of patients.

11 MEMBER BOLTON: Correct.

12 CHAIRWOMAN KEELS: Yeah, to me that's  
13 where the crux of this discussion has gone, right, is  
14 how do you determine your scope of practice  
15 particularly in some of those gray zones. And no,  
16 we're not going to be answering all 100 percent of  
17 the questions, but how do we guide the APRNs.

18 The Board wants to do this to provide a  
19 service to APRNs, and we are charged with  
20 recommending on how best to do that. So to Brian's  
21 point, maybe it takes a couple different forms, I  
22 don't know, but we need to help people understand  
23 scope of practice.

24 MEMBER MINIARD: I just want to make one  
25 comment to Lisa and Pete, that I think that we have

1 to be -- I think that, again, I would second, Pete,  
2 that we do need some sort of Interpretive Guideline  
3 or FAQ or something that's more specific to the scope  
4 of practice of APRNs in the State of Ohio.

5 And I think we have to be very careful  
6 that that responsibility lies on the APRN and not  
7 putting the responsibility on the employers to be  
8 responsible to make sure that the APRN is practicing  
9 within their scope of practice.

10 Scope of practice is the responsibility  
11 of the licensee, the person who is licensed to be  
12 working, and it is not the responsibility of the  
13 employer. It does fall back on the employer, but we  
14 have to make sure that there's something there so  
15 that the APRNs are more -- are more informed of scope  
16 of practice and not put it all on employers because I  
17 think it will be very difficult from some of our  
18 smaller community hospitals, as you said, Lisa, that  
19 don't have experts in law and scope of practice and  
20 that just don't have that. So we have to have  
21 something that gives our APRNs more guidance.

22 MEMBER SIEVERS: One final thing that  
23 does involve Jesse.

24 CHAIRWOMAN KEELS: Doesn't involve?

25 MEMBER SIEVERS: It does.

1 CHAIRWOMAN KEELS: Okay, good.

2 MEMBER SIEVERS: Being a CNS, how would  
3 you see that this applies to you, and even to Lisa as  
4 an employer, what do you do with a CNS and what is  
5 the guideline there? You said all APRNs, and I  
6 agree, but this is not all APRNs. And I have CNSs in  
7 my institution, so now what do I tell them?

8 And so not having something that  
9 addresses all of these issues because it's just going  
10 to switch one problem for another, they're still not  
11 going to understand the red, there's still going to  
12 be the question of the overlapping of the roles.

13 I'm an FNP and I see psychiatric mental  
14 health patients, how far up on the grid can I go?  
15 Because they think they got some training and that's  
16 what one of the articles was and clearly that's an  
17 issue. I'm a CNS, does this apply to me and how do I  
18 determine my scope of practice? Or I'm a nurse  
19 midwife and how do I determine my scope of practice?

20 So we're not addressing the complete  
21 issue of scope of practice for all APRNs, and I think  
22 that is like the top thing in my mind that's falling  
23 short. So being a CNS, I didn't know if you could  
24 speak to that and where you see yourself with this  
25 guideline.

1 MR. MCCLAIN: I mean, I'm an adult CNS  
2 per my national certification, and that certification  
3 no longer exists outside of just renewal, so it does  
4 create a problem. Obviously the top of the page says  
5 for nurse practitioners, so obviously it doesn't  
6 apply.

7 If you go back to the Consensus Model,  
8 and I forget, it's the graph with all the circles, so  
9 Page 18 or Page 19, I've read it so many times, you  
10 can go dizzy, there's a cross at the bottom of it.  
11 Now, whether I agree with it or not because I do  
12 not agree -- the Consensus Model to me is like the  
13 Bible. If you read it, you read it and I read it,  
14 we're going to get three different interpretations of  
15 it.

16 But the cross at the bottom, and I forget  
17 the exact wording, it says Clinical Nurse Specialist  
18 is trained in both acute care and primary care or  
19 goes across -- I forget the exact words, it's like  
20 the last line with that cross. So I'm not sure I  
21 agree with that statement because there's a critical  
22 care CNS certification as well. So there's a lot of  
23 blurred lines.

24 And I agree, I mean, it would be nice to  
25 have the Decision-Making Model that we already have

1 that applies to all APRNs rather than this subset  
2 because it does seem like a target on FNP, you know,  
3 rather than a target on acute care because I have  
4 acute cares that are working in outpatient settings  
5 with stable patients. And then you get into that  
6 whole question of, all right, should they be doing  
7 that; well, what are they treating.

8 So you do go down this like snowball out  
9 of control when I lean back on my argument for three  
10 years there have been no problems. Do I fit into  
11 that graph? To answer your question, no, because I  
12 deal with a certification that is fizzling out  
13 per se.

14 When I went to school 18 years ago or  
15 whenever it was, the university that was access for  
16 me didn't have an NP program, so I went to the CNS.  
17 Now thankfully in the State of Ohio, thanks to the  
18 wonderful rules and laws of the Ohio Board of  
19 Nursing, I'm able to work in my outpatient and  
20 inpatient setting with all my patients. Can I go two  
21 miles across the border and do the same thing?  
22 Absolutely not. I can't walk into PA and do what I'm  
23 doing over there that I'm doing here.

24 But in the three years that -- not so  
25 much this Committee, this Committee was just created

1 in '17, but in the three years this discussion was  
2 going on, you know, every single APRN could get one,  
3 if not two, post grad certificates. Everybody could  
4 have gotten -- Bachelor's-prepared RNs could have  
5 gotten their Master's and started working on their  
6 doctorate by now. You know, like this is a lot of  
7 time dealing with an issue where there's no data to  
8 show that it's a problem.

9 I just feel like, whether Brian's  
10 suggestion, I haven't researched continuing education  
11 or not, or a rule that says APRN law should be -- I'm  
12 not sure what the answer is there, but I just feel  
13 like what we're dealing with this graph targeting  
14 primary care NPs is not the answer.

15 MEMBER DIPIAZZA: This is just my  
16 observation, but I think particularly the reason why  
17 this conversation has turned into an acute care and  
18 FNP is because really that is the only group of  
19 licenses where we have split out acute care in the  
20 title. You don't have acute care CNSs. You have  
21 psych, you have adult gero, you have pediatric....

22 MR. MCCLAIN: There's critical care  
23 scenarios.

24 MEMBER DIPIAZZA: But it's very specific  
25 to critical care, right. So going into that, you

1 know I can manage critical care population. The way  
2 they've set up our programs for FNPs and acute care,  
3 adult gero, acute care pediatric, adult gero, I mean,  
4 it's just created its own problem in itself, but I  
5 think that's why this is so specific to acute care  
6 and FNP and it doesn't include midwives and CNSs and  
7 CRNAs. Just my observation.

8 CHAIRWOMAN KEELS: Lisa, then Jesse.

9 MS. EMRICH: Just for clarification  
10 purposes, the IG is specific to CNPs. First and  
11 foremost and not applicable to other types of APRNs  
12 because each of the four have a very separate in  
13 statute scope of practice, so whereas the current  
14 draft IG that's in front of you quotes the statute  
15 specific to the CNP scope of practice as it is  
16 defined in .43 of the Nurse Practice Act. If we were  
17 doing one about CNSs, that would be specific to the  
18 CNS's scope of practice as it is defined in .43,  
19 similar to the nurse midwife and CRNAs.

20 MR. MCCLAIN: This graph, though, creates  
21 a question for your hospitalist NPs. You know, a  
22 hospital that has a psych floor that has an  
23 obstetrics floor that has an acute care floor or  
24 critical care floor, you know, you read this and it's  
25 like, oh, my gosh, if I want to work as a

1 hospitalist, I better have my acute care  
2 certification, my psychiatry psych NP certification,  
3 my women's health certification.

4           And you're like even though as the  
5 hospitalist you're not going into that ICU to manage  
6 their critical care problem, the hospitalist isn't  
7 going in -- I mean, for the most part, you know, so,  
8 I mean, they're not going into the OB/GYN floor  
9 delivering babies. They're not going into the psych  
10 mental health floor changing their psych. They're  
11 there to handle their chronic medical condition.

12           So I just feel to have all these post  
13 grad certificates would be bizarre when you have  
14 family practice physicians that are floating freely  
15 through there. I'm not sure where the line gets  
16 drawn.

17           CHAIRWOMAN KEELS: I'm curious about that  
18 statement because we had a written comment about it  
19 as well. So as an FNP or any APRN, you have a scope  
20 of practice that your certifying body has listed for  
21 you, right. Your education program and your  
22 certifying body have outlined your scope of practice,  
23 right.

24           So to me, I thought the graphs were  
25 trying to -- to me, they do -- that if you're a

1 primary care certified NP, you have the scope of  
2 practice that you are certified in and educated in  
3 and then you continue to learn in -- through clinical  
4 experience and education within your scope within  
5 your population.

6 And in the hospitalist example, to me  
7 that means you can manage all of those because within  
8 your scope -- I mean, it's within your scope, regular  
9 routine, you know, maternity or women's health and  
10 even ED urgent care up to a certain point to which  
11 that acute condition then becomes a critical, life  
12 threatening death and destruction condition which is  
13 one you have to hand off, right, or you call for  
14 backup and reinforcement. So I guess I'm confused  
15 why people would think that you couldn't do that.

16 MR. MCCLAIN: I think -- and I don't want  
17 to speak for them -- because this discussion has  
18 gotten so confusing over three years, it does create,  
19 like, hospitalist programs are making their FNP's or  
20 adult NPs go back to school to get their acute care.

21 Then the next question is, well, I have  
22 to get my acute care to go to the ICU even though  
23 it's not setting specific. You know, I have to go in  
24 there to hand off -- go to the ICU even though I'm  
25 not handling their acute care condition.

1           Should I be going to the women's health  
2 floor? Should I be going to the psych mental health  
3 floor? This discussion has created more questions  
4 than has helped the situation.

5           MEMBER DIPIAZZA: So I can tell you  
6 working with hospitalists for most of my career as an  
7 NP, that, Jesse, has all come down from just poorly  
8 maybe educated or unaware administrative staff --

9           MR. MCCLAIN: Agree.

10          MEMBER DIPIAZZA: -- who have made those  
11 decisions.

12          And when you think about how hospital  
13 medicine is today, much of it is a consultative  
14 service. You come in for a cardiac issue, I consult  
15 cardiology. You come in for --

16          MR. MCCLAIN: Triage.

17          MEMBER DIPIAZZA: -- acute abdomen, I'm  
18 consulting general surgery. So, I mean, in the  
19 practice of hospital medicine, that's where I feel  
20 like the Interpretive Guideline would really benefit  
21 the Advanced Practice Nurse working in the hospital  
22 setting because it could help with further direction  
23 for the administrators that are making the decisions  
24 that aren't accurate, nor reflect what we should be  
25 doing.

1 CHAIRWOMAN KEELS: Any further comments,  
2 Jesse?

3 MR. MCCLAIN: I don't think so unless  
4 people have stuff for me.

5 CHAIRWOMAN KEELS: Your 20 minutes turned  
6 into an hour, so thank you for sharing.

7 MR. MCCLAIN: Sorry. Happy to answer  
8 anything.

9 (Multiple people talking at once.)

10 MEMBER BOLTON: Thank you, Jesse.

11 CHAIRWOMAN KEELS: Thank you very much.  
12 Right, go get a drink of water.

13 Do we have any other folks who wish to  
14 address the Committee? No? Okay. Just wanted to  
15 make sure we didn't skip over anybody.

16 Do we want to do -- I see Tom is here.  
17 Do you want to do legislative reports and then we'll  
18 break for lunch?

19 MR. DILLING: Sure. It will be quick.

20 CHAIRWOMAN KEELS: Does that sound okay?  
21 Stay on time.

22 MR. DILLING: Yeah, I think Jesse has  
23 already given a legislative report. I did get to  
24 meet with the OAAPN earlier this week, and they came  
25 in and explained similar to what Jesse explained as

1 to what they were doing with the bill and how they  
2 were adjusting the original legislation based upon  
3 interested party comments and on proponent/opponent  
4 positions. So we'll see what happens at the end of  
5 the year with that bill.

6 There's also a CRNA bill that is active  
7 and we've discussed previously. And all that at one  
8 point appeared to be close to a resolution. It  
9 hasn't been resolved. So parties continue to discuss  
10 on that, and we'll see what happens here at the end  
11 of the session as well.

12 I think that clinical support functions  
13 meet the topic of discussion and what those entail.  
14 I keep taking or expressing the position I think of  
15 the Board which is similar to here, we want everybody  
16 to be on the same page. What legislature decides is  
17 what the legislature decides, but we want it to be  
18 articulated in a way which we don't have to come back  
19 here and have three years of discussion either.  
20 Perhaps some of these issues are best solved with a  
21 tweak to legislation and clarification there as well.

22 There is a Committee -- there's a couple  
23 Committees, it's confusing, as to whether or not you  
24 should continue on as the Nursing Board or any type  
25 of professional Board, and that's like a bigger type

1 of issue, and we're not going to be called in front  
2 of that Committee for a year or two, I guess.

3 Then there's another Committee that's  
4 looking to subset smaller boards and commissions  
5 within Board structures. One of those is the CPG.  
6 We've been informed that they would like us to come  
7 forward and give testimony there. So that may be  
8 coming up in the coming weeks.

9 I don't think that that's too  
10 controversial really because the CPG has progressed  
11 to a point where it's an exclusionary formulary  
12 consisting of three or four sentences, and quite  
13 frankly, the PAs have already essentially eliminated  
14 their need for the Committee and so forth.

15 And I think it's just a change of course  
16 here or evolution of the CPG to kind of go away at  
17 some point in time. I think our answers to their  
18 questions will lead toward that direction and we'll  
19 see what -- if the Committee agrees to that.

20 That's something that, too, could  
21 potentially be solved in House Bill 177, but I think  
22 really the fact that it's there today is a -- more of  
23 a political thing than actual functional thing. So  
24 maybe this helps the politics if there's a Committee  
25 that, you know, is informed that not much is

1 happening in those Committee meetings. The need is  
2 there in the same way.

3 With that, I think that they will also be  
4 looking at the APRN Advisory Committee too, like a  
5 statutory -- I don't have a clear answer for you  
6 today, but it seems like they want to review  
7 statutorily based committees, so not one that the  
8 Board would just say, hey, we're going to have a  
9 Committee today on ad hoc to this or that issue but  
10 one that actually appears in the statute still.

11 We might get the Dialysis Committee which  
12 I believe is in statute as well. Gosh, I think  
13 they're still searching themselves to figure out how  
14 many of these different committees are there too, so  
15 we'll let you know. If that comes up in between  
16 meetings and so forth, we'll send something out to  
17 alert you to all of that, but I don't see that as too  
18 big an issue because it seems to be a very functional  
19 Committee.

20 You actually are doing things here. And  
21 quite frankly, I'll add in my own opinion, this was  
22 some of the best dialogue that I've ever seen at any  
23 Committee that I've been involved in, both at the  
24 Medical Board and the Nursing Board. Is that part  
25 and parcel of having taken three years to get to this

1 point? Changing in different people and so forth?

2 I'm sure there's a little bit of truth in  
3 everything, but it does go to show that when you work  
4 in a collaborative way, you bring things out in a  
5 transparent manner that often leads to the best  
6 decision-making at least, again, in my opinion.  
7 That's about it for legislative report right now.

8 CHAIRWOMAN KEELS: Any questions for Tom?

9 MEMBER BOLTON: Thanks, Tom.

10 MR. DILLING: Yeah, if you're ever  
11 interested in looking further at my reports to the  
12 Board itself, so whenever we have a Board meeting, a  
13 week before, they put materials online, the Board  
14 agenda. So you can get a copy of that easily. And  
15 oftentimes I think Chantelle and Lisa duplicate that.  
16 It just comes in at a later point in time for you,  
17 but you can keep up to date that way as well. Thank  
18 you very much.

19 CHAIRWOMAN KEELS: Thank you.

20 Okay, so we're going to stay on time and  
21 we're going to go ahead and break for lunch from  
22 11:30 to 12:30, and we'll meet back here. Thanks,  
23 guys.

24 (At 11:30 a lunch recess was taken until  
25 12:30.)

1 CHAIRWOMAN KEELS: We're back. Thank  
2 you, guys. Thank you for coming back, everyone.  
3 Next on our agenda are the general information and  
4 updates, so next up is renewal. Lisa.

5 MS. EMRICH: Thursday midnight, that's  
6 the end of renewal for RNs and APRNs. Here's just  
7 some very -- the numbers first and then some  
8 information. First of all, as of early this morning,  
9 a total of 218,554 licenses had been successfully  
10 renewed online. So the process is working. I cannot  
11 imagine paper applications for each one of those  
12 individuals.

13 For APRNs, as of this morning, 18,658  
14 APRNs have successfully renewed. So there are  
15 currently -- as of this morning, there is 751 APRNs  
16 who had renewed their RN license, meaning that  
17 they're able to renew their APRN but they have not  
18 yet done so.

19 MEMBER BOLTON: I had one of those.

20 CHAIRWOMAN KEELS: I just found one of  
21 those in my staff. They don't remember they're two  
22 separate licenses.

23 MEMBER MINIARD: That's why I did it.

24 MEMBER SIEVERS: So you're sending  
25 specifically to these folks?

1 MS. EMRICH: Yes, we have been sending  
2 e-mails to APRNs that have not renewed. Now here's  
3 another one, 1,191 are the number of current APRNs  
4 who have neither renewed their RN and then,  
5 therefore, have not obviously renewed their APRN. So  
6 that's about 1,800 total APRNs who have not yet  
7 renewed.

8 CHAIRWOMAN KEELS: So tell your friends.

9 MS. EMRICH: There's always a number who  
10 choose not to renew for whatever reason. That's  
11 where we are here now. Yes, APRNs have to renew  
12 separate of their RN license. If you have to renew  
13 your RN, before the system will make you eligible to  
14 make your APRN. So if you try to renew your APRN  
15 before you renew your RN, it won't let you do that.  
16 We put that information out in our newsletters and  
17 e-mails as well.

18 Your national certification is not the  
19 license. We have gotten those questions in the past,  
20 too. You have to maintain your national  
21 certification, but you have to renew your APRN  
22 license. They are not one and the same, so make sure  
23 of that.

24 If the renewal application is not  
25 complete as of midnight, October the 31st, the

1 license will lapse and you will not be authorized to  
2 practice unless you reinstate the license. So  
3 just... I cannot emphasize -- October 31st is a  
4 Thursday, coming up.

5 CHAIRWOMAN KEELS: Right upon us. I  
6 thought the system was pretty easy except to remember  
7 that you had to get out and get back in. That's the  
8 zinger there.

9 MEMBER MINIARD: I wish there was a  
10 statement on there that said if you're renewing an  
11 APRN license, it will not show up until after you  
12 exit and come back in.

13 CHAIRWOMAN KEELS: The program actually  
14 shut it off.

15 MEMBER MINIARD: I mean, it would be nice  
16 if there was like -- cause I just was like, oh, well,  
17 maybe I don't have to renew this year. And I'm like,  
18 yeah, I do. I'm good to go.

19 MR. DILLING: Just along those lines, not  
20 to put us on the spot, I apologize to Lisa, because  
21 when I was at the ONA Leadership Summit, something  
22 came up, an APRN afterwards made the similar comment.  
23 She was more specific to could there be a button that  
24 pops up at the end that says Press Here To Take You  
25 Back To This Page. And if that was there, she felt

1 like that would make it so much easier so just in  
2 addition to the theme there on that.

3 And also, I'm not sure I heard this from  
4 you, that we are sending out specific e-mails to the  
5 people that haven't renewed yet, so we're making an  
6 extra effort to try to pick up any stragglers and not  
7 to justify the system, but it is to justify the  
8 system, on the first initial deadline was  
9 September 15th, and after that, you pay a late fee.

10 Some people are wanting to complain that  
11 say, well, why is the late fee not attached to the  
12 October 31st? Why are there these two deadlines.  
13 And it is because if you miss the September 15th  
14 deadline, it's going to cost you a couple dollars.  
15 If you miss that October 31st, you're going to have  
16 to go through -- back through the system, reinstate  
17 and then you can't practice legally without that  
18 license. So that was born from this desire to try to  
19 be softer actually on people who miss that initial  
20 deadline. Thank you.

21 CHAIRWOMAN KEELS: Thank you.

22 MS. EMRICH: I have over the past few  
23 months, we've been working with the Department of  
24 Administrative Services and all to look at  
25 enhancements as we call it to the E-license system.

1 I think the button back to the CRNA would be a good  
2 enhancement.

3 MEMBER MINIARD: To remind you.

4 MS. EMRICH: They've been very good. We  
5 have implemented -- they have implemented a number of  
6 changes for us that we pay for, but it's been very --  
7 most of these have been more on the staff processing  
8 efficiency to help us do our work faster, but that is  
9 good.

10 Along those lines, also, I do want to --  
11 he may have already left -- I want to thank Jesse.  
12 Back on July 3rd, just as renewal began, there was,  
13 for lack of a better word, something happened with  
14 the State of Ohio E-License system and it had  
15 converted mostly CNS licenses which were about a  
16 thousand'ish. It involves two CNP licenses. I know,  
17 I counted them all, for -- that made them lapse even  
18 though it gave the current expiration date.

19 And so Jesse was very good to right away  
20 contact me and let me know so that the Board -- that  
21 prompted us to start taking action and to contact DAS  
22 and persons who could fix it. So actually, it was  
23 all resolved within the same day. We were able to  
24 notify all affected CNSs and the two CNPs and let  
25 them know what happened and that it was being

1 resolved.

2           And for those very few individuals who  
3 were obviously trying to be proactive and had already  
4 submitted a reinstatement believing that, we  
5 contacted those individuals directly, closed the  
6 applications and refunded that fee to them because it  
7 was all made in obvious error in response to whatever  
8 happened on July 3rd.

9           So, again, we appreciate -- I appreciate  
10 Jesse's reach out to me when he said he saw that on  
11 his, because he is a CNS, was affected, and he said  
12 he started to think about it and knew that it just  
13 wasn't logical, so something must have happened, and  
14 it did. So we appreciate that, so we fixed it.

15           CHAIRWOMAN KEELS: He gets the good catch  
16 award.

17           Next on the agenda, a sample of the APRN  
18 practice questions is in your folder. We sort of  
19 discussed about this previously. There was a  
20 question about how recent the questions were, and  
21 they are very recent, just in the past month or two.  
22 So whenever we get these samples, they are recent,  
23 you know, since the last meeting.

24           Anita, she printed off what the actual  
25 response was, if people want to see this. I

1 scratched out the person's name, but I can pass this  
2 around if you guys want to take a look.

3 But the Board is pretty consistent in  
4 sending an e-mail back to the person and reflecting  
5 back to your scope of practice defined by your  
6 education and your certification and then asking, you  
7 know, what are you actually asking? Are you doing a  
8 task or a procedure or are you consulting or are you  
9 managing the care? Because that's what the term is.  
10 I mean, that's important to know, so....

11 MEMBER GARRETT: So this is the response  
12 back to them?

13 CHAIRWOMAN KEELS: Yes, it's nice and  
14 long.

15 MEMBER GARRETT: No, the first sentence,  
16 I'm just curious....

17 MEMBER MINIARD: This is to No. 6, the  
18 one about that --

19 CHAIRWOMAN KEELS: I believe so.

20 MEMBER MINIARD: -- the FNP who wanted to  
21 work in the trauma ICU?

22 CHAIRWOMAN KEELS: Sure. It makes sense.  
23 Do you want to read it?

24 MEMBER GARRETT: Sure. It says regarding  
25 the appearance of generally APRN's scope of practice

1 is not determined by the setting in which the APRN  
2 practices.

3 CHAIRWOMAN KEELS: Yes.

4 MEMBER GARRETT: What about CRNA?

5 CHAIRWOMAN KEELS: Which is who we're  
6 doing, CRNA, it's been anesthesia care and the  
7 clinical support.

8 MEMBER GARRETT: I'm just -- CRNA has  
9 been asked to delineate the study by which the lack  
10 of... that's why I was asking about that response, so  
11 that's all. Just a comment.

12 MEMBER MINIARD: I can finish reading.  
13 It says, APRN's scope -- generally, APRN's scope is  
14 not determined by the setting in which the APRN  
15 practices. The focus is on what it is the APRN is  
16 doing, what care are they providing and what care are  
17 they managing and for what population.

18 APRN licensure issued by the Board is  
19 based on an applicant having current, valid RN  
20 licensure and proof of having passed a national  
21 certification examination as an APRN in a particular  
22 role, CNP, CNM, CRNA. And in one of several  
23 different population foci, family, adult, blah, blah,  
24 blah, blah.

25 Similarly, APRN licensure renewal is

1 based on current valid RN licensure and proof of  
2 having maintained one's national certification. This  
3 necessarily includes meeting all CE and any other  
4 requirements necessary to maintain that particular  
5 national certification.

6 When considering an APRN's scope of  
7 practice, it can be helpful to look at the test plan  
8 for the APRN's national certification because the  
9 APRN's practice should be aligned with the  
10 competencies validated by the national certification  
11 they obtained and maintain.

12 Test plans for most certifications are  
13 available online. Attached is an excerpt from the  
14 NCSBN Consensus Model for APRN regulation. It is  
15 consistent with the Board's approach to the APRN role  
16 and population focus. The entire document is  
17 available on both the Board and NCSBN websites. See  
18 expert from ORC section 4723.43 pasted below is the  
19 signature block and it goes on.

20 4723.804 OAC and APRN CSA would  
21 necessarily include a statement of services to be  
22 provided by the APRN. Regarding specific procedures,  
23 treatments, et cetera, have you had a chance to  
24 review the attached APRN Decision Model that assists  
25 APRNs? It assists APRNs in determining if a

1 particular procedure is within their scope and may be  
2 performed consistent with standards. It is attached  
3 for convenience -- it says that twice. It is  
4 attached for your convenience and it is attached for  
5 your convenience.

6 Then she explains -- that's okay -- the  
7 Nurse Practice Act and administrative roles adopted  
8 thereunder are available for your review at the  
9 website. Also attached for general reference are a  
10 few of the practice resources available on the Board  
11 website.

12 CHAIRWOMAN KEELS: So that's an example  
13 of a question with the feedback you provide to those  
14 who ask the questions which is consistent with what  
15 we've been talking about in this spot.

16 MEMBER GARRETT: Can we get not that  
17 e-mail but that response sent to us as an example?

18 MS. DIPASQUALE: Sure. I can actually  
19 print them now or....

20 MEMBER GARRETT: Or just e-mail to have  
21 it on file, and I don't want that -- just that  
22 response. That would help with our file.

23 CHAIRWOMAN KEELS: Any other comments  
24 about the questions that -- the sample of questions  
25 because the Board gets more than just that in front

1 of you, but it was sort of a representative sample.

2 MEMBER ZAMUDIO: Uninformed question,  
3 then a comment. The uninformed question, do we see  
4 those on the website? I don't know. Sorry.

5 MS. EMRICH: The responses, no.

6 MEMBER ZAMUDIO: Oh, but the questions?

7 MS. EMRICH: No.

8 MEMBER ZAMUDIO: So the other question I  
9 had was about the response to the EPT, the Expedited  
10 Partner Therapy, to reaffirm that person was told  
11 they could give the partner a prescription for  
12 prophylaxis regarding Chlamydia trachomatis, that was  
13 one of the questions on there?

14 CHAIRWOMAN KEELS: Yes. Only up to a  
15 certain number of partners.

16 MEMBER ZAMUDIO: Two partners. So only  
17 have sex with two people because that's the only  
18 number of partners that can be treated if there's an  
19 STD but that's statute.

20 MS. EMRICH: Right. And even a nurse  
21 midwife whose statutory scope is limited to females  
22 are the except -- the expedited therapy does allow  
23 CNMs to provide that to males.

24 MEMBER ZAMUDIO: Okay, thank you.

25 MEMBER GARRETT: Just to clarify, just

1 take a task of intubation, obviously because it's  
2 common to all of us, doesn't matter where it's at as  
3 long as it's for that patient population that you're  
4 managing, right? It doesn't matter where it's at in  
5 the hospital; is that what that's saying? I'm trying  
6 to understand your role, so....

7 CHAIRWOMAN KEELS: Well, first, it's is  
8 it within your scope.

9 MEMBER GARRETT: Yeah, so a CRNA, an NP  
10 or somebody who has training and licensed and  
11 credentialed and all that stuff, so it doesn't matter  
12 where it's at in the hospital, it's just that if by  
13 definition --

14 CHAIRWOMAN KEELS: If a baby came into  
15 the Emergency Department and was born out in the  
16 parking lot, I would be called down there and I would  
17 resuscitate that baby and intubate.

18 MEMBER GARRETT: I'm just using  
19 intubation as a comment....

20 CHAIRWOMAN KEELS: Yeah.

21 MEMBER GARRETT: All right. So it's not  
22 the only issue if you're inside these four walls....

23 CHAIRWOMAN KEELS: I believe with NPs,  
24 correct me if I'm wrong, if they're a hospitalist,  
25 they may be trained in intubation because they would

1 be a first responder.

2 MS. EMRICH: And a Registered Nurse may  
3 potentially in an emergency --

4 CHAIRWOMAN KEELS: Like a transport team  
5 or....

6 MEMBER GARRETT: So it could be a skill,  
7 but it's not related to the four walls as delineated  
8 in a hospital location, all right.

9 MS. EMRICH: And that's not necessarily  
10 providing anesthesia care. It's a specific task.

11 CHAIRWOMAN KEELS: Lisa.

12 BOARD MEMBER KLENKE: I think that's  
13 where a lot of the confusion came from with the term  
14 acute care. I don't want to rehash the last three  
15 years --

16 MEMBER GARRETT: Oh, no, no, no, no.

17 BOARD MEMBER KLENKE: But I think a lot  
18 of it had to do with they were equating acute care  
19 and setting up care. And to your point that they  
20 even equated it to a hospital setting, in a lot of  
21 terminology, care that's provided in a hospital is  
22 acute care versus long-term care in others, so it did  
23 revolve around the concept of setting.

24 MEMBER GARRETT: Yeah, the e-mail was a  
25 general e-mail to all APRNs, and we've been asked at

1 times to put ourselves, well, if you're inside these  
2 four these walls, you can do it, but if you're in  
3 these four walls, maybe, maybe not. I'm not saying  
4 that's a pass. I'm just saying that's discussions  
5 that occurred. It didn't seemed like a general list  
6 for all APRNs where it's not limited to any  
7 geographical setting in a facility or something like  
8 that.

9 CHAIRWOMAN KEELS: Your population would  
10 be the -- preparing the anesthesia patient, right?

11 MEMBER GARRETT: What if you're asked to  
12 go intubate....

13 CHAIRWOMAN KEELS: A baby in the NICU,  
14 right.

15 MEMBER GARRETT: Right.

16 MEMBER DIPIAZZA: The airway.

17 CHAIRWOMAN KEELS: You're the most  
18 experienced in the room.

19 MR. DILLING: Yeah, I apologize, this is  
20 in your materials and I thought maybe it's a good  
21 time to remind people that in April of 2019, the  
22 Board published a Practice of Nursing and Scopes of  
23 Practice. It's a one pager, and it might add a  
24 little clarity to understanding as well on some of  
25 these questions. That's on the Board's website under

1       APRN practice.

2                   CHAIRWOMAN KEELS:  Is it in the Momentum.

3                   MR. DILLING:  Yes, it's in the Momentum,  
4       too.

5                   CHAIRWOMAN KEELS:  Okay.  So sort of  
6       along the line of Frequently Asked Questions, we have  
7       discussed the idea of an FAQ to go with the  
8       Interpretive Guideline that might even be more  
9       helpful.

10                   Lisa has been bombarded with licensure  
11       and relicensure renewals, but she took the time to  
12       write down frequently asked questions, not the  
13       answers but just the kinds of questions that come in  
14       that we may want to draft an FAQ around.

15                   And it's in no particular order and in no  
16       particular order of importance or topic, but we  
17       thought we would pass that out and we can post these  
18       with the meeting materials I suppose.  And the draft  
19       is to be highlighted.  This is hot off the press,  
20       meaning hot off of Lisa's brain power.  And I'm sure  
21       that there are a lot of other questions that come to  
22       mind that you might want to see in there.  What did I  
23       do with a copy....

24                   I'll read off of yours.  So, again, this  
25       is just a draft, and for those who don't have a copy,

1 questions include: What are Ohio's requirements for  
2 APRN licensure?

3 How will I know that the graduate program  
4 I plan to attend will lead to eligibility for my  
5 desired national certification?

6 Can I obtain my Ohio APRN license prior  
7 to obtaining national certification?

8 Which APRN license and designations  
9 authorize the licensee to prescribe?

10 How will I know that my prescribing  
11 practice is consistent with Ohio laws and rules and  
12 within the standards of practice?

13 What are the minimum requirements for a  
14 CRNA to provide anesthesia care in a hospital surgery  
15 department?

16 I am a CRNA providing care in a  
17 nonsurgical ambulatory clinic where there is not a  
18 physician on site. How will I know I am practicing  
19 consistent with Ohio laws and rules?

20 I am a CNS whose national certification  
21 is in child adolescence psych mental health. This  
22 certification examination and its resulting national  
23 certification are now retired and no longer  
24 available. Seeking the current national  
25 certification in psych mental health across the

1 lifespan is not my career plan. May I continue to  
2 practice as long as my national certification is  
3 maintained?

4 I am a CNM. My national certification  
5 addresses the performance of newborn circumcision. is  
6 this within my scope of practice in Ohio?

7 As a CNM may I provide Expedited Partner  
8 Therapy to my patients' male partners?

9 How does the APRN know whether he is or  
10 she is prepared and authorized to medically manage --

11 (Multiple people talking at once.)

12 CHAIRWOMAN KEELS: Oh, you didn't get the  
13 second page?

14 MS. EMRICH: Sorry about that. Here's  
15 the second page. Some got front and back....

16 CHAIRWOMAN KEELS: We can send it back  
17 out. How does an APRN know whether he or she is  
18 prepared and authorized to medically manage a  
19 particular patient population?

20 May a CNS or CNP who holds national  
21 certification in psych mental health across the  
22 lifespan collaborate with a pediatrician?

23 I am aware of the licensure exemption  
24 section in 4723.32, Ohio Revised Code, that is  
25 applicable to any person acting in an emergency.

1 Since I indeed hold an APRN license, how is this  
2 applicable to my APRN practice?

3 Again, these are just a sample of  
4 questions that Lisa has gotten questions about that  
5 we can formulate some answers around that could be  
6 posted and hopefully help people.

7 MS. EMRICH: These are, of course, unlike  
8 the IG, are more global and address all types of  
9 APRNs and certainly each one can be expounded upon in  
10 more detail.

11 MEMBER GARRETT: I was going to answer  
12 for one. Do you want me to read No. 8 or say that  
13 now? Part of my seniority --

14 CHAIRWOMAN KEELS: Does this pertain to  
15 this?

16 MEMBER GARRETT: Oh, I'm sorry. I was  
17 just asking, part of my No. 8 is --

18 CHAIRWOMAN KEELS: You want to take an  
19 FAQ?

20 MEMBER GARRETT: If I can take an FAQ.

21 CHAIRWOMAN KEELS: Yeah, go ahead.

22 MEMBER GARRETT: The CRNA specialty is  
23 the first specialty that is going to require you to  
24 get your doctoral degree, and 90 percent of programs  
25 are holding this over. Ohio is kind of the last

1 holdout. So the traditionally doctor-prepared nurses  
2 are then in academia or in a research setting. And  
3 now you're going to have APRN CRNAs who are not  
4 prepared going into the hospital.

5 And so I have -- there's -- I'd like to  
6 get into a discussion of that, but I think it would  
7 be an FAQ because I've had two inquiries of program  
8 directors in Ohio, and myself, I have a doctoral  
9 program that the first graduate would be seven years  
10 in the doctoral program. As many others, how that is  
11 handled?

12 I've seen several legal opinions in the  
13 FAQs. So if we get an inquiry or if we're in the  
14 middle of class teaching students and it comes up, I  
15 can say here's the Ohio Board of Nursing FAQ and  
16 everybody's clear on it. And I think if we can do  
17 that, that would be great.

18 And then as the other specialties move  
19 towards mandating it, if it ever comes, then it will  
20 already be answered for them.

21 MEMBER DIPIAZZA: This is about using the  
22 title of doctorate.

23 MEMBER MINIARD: Okay, I was like what  
24 are we talking about?

25 CHAIRWOMAN KEELS: Yeah, before APRNs

1 become doctorally prepared, how is that used in the  
2 context of the clinical side.

3 MEMBER MINIARD: It's not.

4 MEMBER GARRETT: There's a lot of  
5 unwritten rules in hospitals, some hospital subsets  
6 of it, but what is the Board and statutory  
7 requirement or are we breaking a rule.

8 Let's say somebody uses it inadvertently  
9 and somebody calls the Board of Nursing and turns  
10 them in, right, do they get in front of the Board?  
11 Is this a Board problem? Is there a penalty for --  
12 You know, I get -- My students walk up to me in the  
13 pre-op area, "Hey, Dr. Garrett..." I say, "Don't use  
14 Dr. Garrett. I don't need any more hassle than I  
15 already get. Just call me Brian."

16 But, you know, if a physician sees it or  
17 a patient sees it and they call the Board of Nursing,  
18 "He called him doctor," I mean, I just -- I want  
19 to -- I just ask to be proactive because this is  
20 going to come hard and heavy with the CRNAs and I  
21 just want to be proactive.

22 CHAIRWOMAN KEELS: Where the line is for  
23 the academic title versus misrepresenting yourself as  
24 a physician....

25 MEMBER GAGER: I think you can encompass

1 DNP's out practicing with the same question.

2 MEMBER GARRETT: There's a lot of post  
3 Master's.

4 MEMBER MINIARD: I think it should just  
5 be what you do with a --

6 MEMBER GARRETT: -- doctoral-prepared  
7 nurse.

8 MEMBER MINIARD: Right, because you see  
9 that all the pediatric programs, we're going complete  
10 DNP soon.

11 MEMBER GAGER: We're heading that way as  
12 well. We have an opt out, but the plan is to remove  
13 that at some point.

14 MEMBER GARRETT: They're being proactive  
15 and we want to have --

16 (Multiple people talking at one time.)

17 MEMBER SIEVERS: I love the idea of the  
18 FAQs. I think it would save the Board a lot of time  
19 if you have questions that keep coming up, so the  
20 idea of posting that, pre-front review, make sure  
21 there's some kind of -- and these folks could start  
22 there. If their question wasn't addressed, then if  
23 you have one where you're getting a couple of the  
24 same questions, maybe it needs to be added on there.

25 MEMBER GARRETT: In the professional

1 organizations or other... their system can guide them  
2 there.

3 MEMBER SIEVERS: And that's the answer  
4 that you read, Jody, was pretty general.

5 MEMBER MINIARD: Yeah.

6 MEMBER SIEVERS: I mean, it didn't even  
7 address the specifics of the question. It just  
8 showed them where to go. So maybe having those  
9 pieces in there of like almost a decision-making sort  
10 of thing itself.

11 MS. EMRICH: The FAQ would be probably  
12 more definitive in the response.

13 MEMBER MINIARD: Yeah.

14 MEMBER SIEVERS: More directive.

15 MEMBER MINIARD: Yeah, that would be  
16 nice.

17 CHAIRWOMAN KEELS: Probably won't capture  
18 all clinical scenarios, but if you can -- but the  
19 answer to the question we read does encompass a lot  
20 of questions that may come, like where do I start and  
21 how do I figure this out which is what we're trying  
22 to do with Interpretive Guideline but perhaps FAQs  
23 might be either more helpful or together would be  
24 really good, and we're going to get to that in a  
25 second.

1 I do want to make a quick announcement  
2 that Lisa can, the Board website is going to be  
3 updated. I don't know if you all were aware of that.  
4 So I saw a demo a little while ago and it looks  
5 really nice. It feels like it's easier to navigate.

6 MS. EMRICH: User friendly. It's  
7 supposed to be able to get you to where you want  
8 within two clicks.

9 CHAIRWOMAN KEELS: Looks like all the  
10 APRN content was still pretty much together, so that  
11 feels like in a week....

12 MS. EMRICH: Early next week.

13 CHAIRWOMAN KEELS: So be on the lookout  
14 for that. Perhaps that makes things a little bit  
15 easier as well, and then at our next meeting, we can  
16 come with feedback on the go live.

17 Do we want to dig into the Interpretive  
18 Guideline? So this document along with the IG, we've  
19 got three written comments, so thank you for them,  
20 for writing, as well as OAAPN sent comments, written  
21 comments. These are all in your folder and were in  
22 the meeting materials.

23 So I'm assuming everybody's had a chance  
24 to review. So why don't we go around the able and  
25 everybody sort of individually provide some feedback

1 for a few minutes, not too long. I might have to use  
2 the gavel if we go too long, so we can get some --  
3 see where our areas of consistency are and where our  
4 areas of diversity are. Do you want to start?

5 MEMBER GARRETT: No.

6 CHAIRWOMAN KEELS: Pete, do you want to  
7 start?

8 MEMBER DIPIAZZA: No, I didn't really  
9 have any comments. I think that we need an  
10 Interpretive Guideline. I know there's a lot of  
11 hangup around the graphs or the pictures that were  
12 provided. I like them because it's a nice visual,  
13 and I'm a visual kind of person.

14 I did read the three comments that came  
15 in to the Board, as well as the one from the OAAPN  
16 attorney. I thought they all made great arguments  
17 for why they don't feel like we need one, but I don't  
18 know if it swayed me into saying no, we really do  
19 need an Interpretive Guideline. They all had enough  
20 of differences if they even have differences, so we  
21 lacked some clarity.

22 CHAIRWOMAN KEELS: Did you have any  
23 recommendations or suggestions for revisions or  
24 tweaks?

25 MEMBER DIPIAZZA: I mean, no, I don't. I

1 thought Lisa did a great job of lowering the lines  
2 down.

3 MS. EMRICH: It was actually Chantelle.

4 MEMBER DIPIAZZA: Chantelle, you did a  
5 great job with the wavy lines.

6 MS. EMRICH: She comes up with the  
7 graphics, so....

8 MEMBER DIPIAZZA: I do think it looks  
9 better to me at least with every vision.

10 CHAIRWOMAN KEELS: Thanks.

11 Angela.

12 MEMBER GAGER: I agree, I think that we  
13 need the Interpretive Guideline over the idea of the  
14 graphs. I find the graphs confusing. I guess I  
15 can't see much of a difference with the wavy lines.  
16 I'm sorry, Pete.

17 MEMBER DIPIAZZA: No, you're fine.

18 MEMBER GAGER: I still think there's a  
19 lot of gray in here. Where does red stop and orange  
20 begin, and what defines that? And I just -- I don't  
21 know, I think it's just going to create new  
22 questions. So I like more of a decision-making tree  
23 and the FAQs versus graphs. I think it's a little  
24 more concrete rather than I feel a vague visual  
25 representation. But I do think we need something to

1 answer questions across the Board, not only for  
2 practicing APRNs but for employers, for all of us.

3 CHAIRWOMAN KEELS: Thank you.

4 Sherri.

5 MEMBER SIEVERS: I agree, we need  
6 something. I'm not sure if the graph is helpful. I  
7 have to agree with you, that the wavy lines didn't  
8 help me. I didn't really understand what the  
9 difference was because it still -- the top of where  
10 the wavy line is I think where the solid line was  
11 before, so it still is vague.

12 And the question I can already hear from  
13 my students is what is a red patient? Is this  
14 patient a red patient or is this patient a red  
15 patient? And I'm not sure why there was no wavy  
16 lines for the women's health.

17 And then I had a question about the  
18 definition. So we added, I believe -- this was all  
19 new, correct, the paragraph on the very first page?  
20 We keep saying it's not about setting, but yet the  
21 second half of this paragraph is all settings.

22 CHAIRWOMAN KEELS: Can you read that for  
23 me?

24 MEMBER SIEVERS: The paragraph says, "The  
25 term acute care encompasses a range of clinical

1 health function including emergency medicine, trauma  
2 care, pre-hospital emergency care, acute care  
3 surgery, critical care, urgent care and short-term  
4 inpatient stabilization." So those to me are all  
5 locations because the patient that might be under the  
6 umbrella of emergency medicine can be very vast.

7 So we have folks in the fast track seeing  
8 patients who are coming in with an ear infection  
9 which is a primary care function. We have folks that  
10 we already talked about today in a hospitalist  
11 setting which might be a short-term inpatient  
12 stabilization which could be totally appropriate for  
13 some of the roles that we were debating.

14 So that really is confusing I think to  
15 have those locations in there. I think taking out --  
16 if we get to where we're keeping this and any part of  
17 that, I think that would definitely need to be  
18 eliminated there.

19 MEMBER GAGER: Can I add something to  
20 your statement?

21 MEMBER SIEVERS: Yes, please.

22 MEMBER GAGER: I think that this part  
23 also, so much of this overlaps. You can have various  
24 key issues develop in a primary care setting and you  
25 are going to intervene in that as you pass that

1 patient on to the appropriate setting or the  
2 appropriate provider and that's where this gets gray.

3 MEMBER DIPIAZZA: That's what the wavy  
4 line is for.

5 MEMBER GAGER: But I don't think that  
6 that really -- so I have a patient who's having an  
7 active MI in my office, they're definitely in the  
8 red, but I help treat and stabilize that patient  
9 for -- until the appropriate people get there, but  
10 where does that say I cared for a patient in the red  
11 on this graph?

12 MEMBER SIEVERS: I think we have the  
13 example about intubation. I should have wrote it  
14 down. So is that patient -- if they're being  
15 intubated and the FNP can perform that, which I think  
16 is what you said, but is the patient red? So that's  
17 where it's like....

18 CHAIRWOMAN KEELS: So it sounds like  
19 you're looking at first responder type?

20 MEMBER SIEVERS: I forget. Do you  
21 remember the scenario that you....

22 CHAIRWOMAN KEELS: Well, if you're a  
23 hospitalist.

24 MEMBER SIEVERS: That's what it was.

25 CHAIRWOMAN KEELS: Most of the patients

1 that come through the ED have acute illnesses or  
2 conditions but not all of them are critically ill,  
3 bleeding out from a chest wound, right. So it's  
4 appropriate for that person to be there, but when the  
5 critically ill patient comes in, that hospitalist  
6 needs to respond, right, until the appropriate  
7 critical care provider gets there.

8 MEMBER SIEVERS: Right.

9 MEMBER DIPIAZZA: It's not about living  
10 in the red. It's about going into the red to  
11 stabilize until the appropriate individuals can come  
12 in.

13 MEMBER BOLTON: This happens a lot in our  
14 infusion center where we have oncologic patients that  
15 come in and they are septic and they don't know that  
16 they're septic until they get there and the NP goes,  
17 "Oh, my gosh, you're septic, you need to be admitted  
18 to the hospital." We have adult NPs who are in there  
19 taking care of that patient to stabilize them to  
20 transfer them to the hospital.

21 MEMBER SIEVERS: Right. I guess I'm just  
22 raising that question is that clear from this --

23 CHAIRWOMAN KEELS: Probably not.

24 MEMBER SIEVERS: -- and answers students'  
25 questions or does it make it more confusing. And

1 worse, is it going to be used against someone with  
2 good intentions who was trying to do the right thing  
3 but because it's gray it can always be gray to a  
4 negative and not always gray to support us in what  
5 we're trying to help people do the right thing.

6 So just raising the question if we had  
7 strong FAQs, which I love that idea, we do that a lot  
8 for issues that are not clear for folks because it  
9 gives them real life scenarios. It's actually what  
10 the PNCD guidelines of is it the right setting. We  
11 kind of did a similar thing. They gave little  
12 scenarios, is this an appropriate role.

13 So it's very similar to what they did for  
14 the pediatric folks, that with some sort of decision  
15 tree, would that meet our needs without being --  
16 opening up like a whole new set of questions.

17 MEMBER GAGER: And, you know, I  
18 understand my scope in that area, but are people  
19 going to interpret it that way based on a drawing is  
20 my concern.

21 CHAIRWOMAN KEELS: Okay, great, thanks.  
22 Michelle.

23 MEMBER ZAMUDIO: So I did a lot of  
24 preparation for this part. I want to start with  
25 saying I agree with what's been said so far, that we

1 do need something. I do think we need a  
2 Decision-Making Model, and I use those words from the  
3 Consensus Model from all of the research articles.  
4 They all recommended DMM, one set a DMT,  
5 decision-making tool, so we do need something to  
6 clarify it.

7 And I'm not saying that there's been  
8 evidence that Ohio citizens have been harmed. That's  
9 not the criteria. But the criteria would be the  
10 volume of questions, right, that obviously we need  
11 clarification. So I like the idea of a  
12 Decision-Making Model. Now, we have our DMM, and  
13 like I said, it was updated in 2017, but it doesn't  
14 cover everything. So I do think that needs to be  
15 shored up or changed, but we need a DMM.

16 I don't believe we need this Interpretive  
17 Guideline specific to only one of the four roles.  
18 All of us can have just as many queries and  
19 uncertainties as FNP and acute care. It's just the  
20 one we've been talking about because it was brought  
21 to the forefront. As I pointed out earlier, between  
22 women's health and nurse midwives, we all have these  
23 kind of issues. So I think making something more  
24 encompassing like a DMM would be helpful to us.

25 I do agree with Sherri, the graphs are

1 only fodder for the attorneys. That is going to be  
2 presented in a court, it's going to be blown up on a  
3 screen and to be honest with you, not everybody  
4 prints in color, okay. So this is going to be black  
5 and white when it's printed off, right.

6 So even the person who's just trying to  
7 get guidelines, I think that's not a good idea to use  
8 the graphs, to use the red. It looks like an  
9 incredible amount of work went into that, and I  
10 appreciate that. I just don't think it's going to be  
11 helpful for just that specific population.

12 The other thing that I noticed was that  
13 it's specific to those eight different roles,  
14 specialties, what term we want to use, but I also  
15 found five that have come and gone. So we're saying  
16 these are the eight that exist right now, but there's  
17 been several roles that have come up, people have  
18 been certified, that went away.

19 So I think this could quickly become  
20 obsolete if we use those eight models -- or I mean  
21 eight graphs there. So I don't think the graphs are  
22 helpful. I do think we need a Decision-Making Model.  
23 I do think ours needs to be changed and updated. I  
24 think we should avoid pigeonholes again for the  
25 attorneys.

1           We do have a lot of layers of checks and  
2 balances, but I like Erin's idea that this isn't  
3 about checks and balances, this is about helping us  
4 too as NPs. Like, this is to help us. That's what  
5 we are trying to do, our charge on this Committee, is  
6 to help other NPs look at that website. So I think  
7 we should do something to help provide clarification.

8           Let's see... Yeah, the women's  
9 health/gender, that's going to get tricky, right.  
10 That's a very fluid term. So, again, I would avoid  
11 putting that in a graph. I would avoid putting that  
12 into any kind of pigeonhole legislation if you're  
13 going to write women's health/gender.

14           And then to recognize CME training, so I  
15 took the ones we had before, our proposed  
16 Interpretive Guideline, I compared it with the  
17 current. I loved Erin's summary for us at the  
18 beginning so we could see it. I don't think we need  
19 that definition that's in there.

20           The World Health definition that's  
21 listed, it could describe somebody in labor on some  
22 of those. I don't think that that should be in  
23 anything that we do. I think it should stay more  
24 focused on the legislation and the rules and laws  
25 than necessarily providing a definition that you guys

1 might get in school or something, but I don't think  
2 that's appropriate to put in this guideline.

3           So I don't think if anybody's brought up  
4 the responses yet, but the OAAPN did have a response  
5 with a suggested decision-making tool. So what I did  
6 was take their tool, I looked at Texas, Oregon,  
7 Kentucky and Ohio's and just to get an idea of what  
8 everyone else has, and some of those really were  
9 miserable, by the way. Ours was much better than  
10 some of the ones I looked at.

11           But I think the way they have it set up  
12 as a yes/no, like a hard stop or continue, that's  
13 what a lot of the states have. So aside from the  
14 graphs, I think it's good that we do a  
15 Decision-Making Model. My suggestion is just to  
16 shore up the one we have. I like the yes/no format  
17 or the one that we have and kind of be filled up a  
18 little bit. Obviously we need to do that every  
19 couple of years anyway, medicine changes quickly, and  
20 then the FAQs to go along with that. Loved Brian's  
21 suggestion about the continuing education. That's  
22 all I've got.

23           CHAIRWOMAN KEELS: Thank, Michelle. I  
24 have a question. So to be clear, we're not talking  
25 about new legislation. I heard you say legislation.

1 This is not legislation.

2 MEMBER ZAMUDIO: No, I'm saying it  
3 should -- but this could just reference the  
4 legislation. Like the answers, I love that, that  
5 gives them hard facts, here's what we think, not  
6 necessarily a definition that we all randomly chose  
7 for their practice. That's not appropriate. That  
8 should be done through the national certifying  
9 bodies.

10 CHAIRWOMAN KEELS: Do you feel, because  
11 we have talked about that here, that we were  
12 concentrating on CNPs because that's where the bulk  
13 of the questions were coming in from? But we do have  
14 questions from the other three roles that we could  
15 potentially -- and I don't know if you would still  
16 call it Interpretive Guideline -- but to me it feels  
17 helpful to have the other information in front of me  
18 with what I need to know to practice in Ohio, here's  
19 where my statute and rules are, here's references to  
20 go back to your professional organization or the rest  
21 of this IG. I'm wondering if you thought that would  
22 be helpful.

23 MEMBER ZAMUDIO: Absolutely. I love  
24 that. I like the idea that they can click on their  
25 link, right, so they're not printing off the IGs,

1 they're not thinking about where the -- the lines  
2 are, but they can actually look in the rules. I  
3 think that's very helpful to them. Whether you're an  
4 experienced provider or a new graduate, I think that  
5 would be helpful. The OAAPN version that they put  
6 forth, it was kind of a yes/no....

7 CHAIRWOMAN KEELS: I don't have it in  
8 front of me. I thought that was a general  
9 nursing....

10 MEMBER ZAMUDIO: It was. That's what I  
11 was going to say. Most of those apply to general  
12 nursing, but if we could do something in that format  
13 that says some of the states link that code number  
14 right with it, here's a DMM, here's your FAQs, we're  
15 done.

16 CHAIRWOMAN KEELS: Okay. Thanks for your  
17 comments. Appreciate that.

18 Lisa.

19 BOARD MEMBER KLENKE: I think that both  
20 the decision-making model and the Interpretive  
21 Guideline are intended to assist our APRNs or RNs or  
22 whoever our intended audience is with understanding  
23 what it is they're held accountable for.

24 And I like Pam's comment earlier, the  
25 current Decision-Making Model, which might be the gap

1 that we talked about, the very first question is, is  
2 it within your scope of certification. Well, if they  
3 can't make that decision, then they can't follow the  
4 Decision-Making Model. And so I wonder if the  
5 Interpretive Guideline provides the context to  
6 support the Decision-Making Model if we don't expand  
7 the Decision-Making Model.

8 I agree with I think it was Sherri's  
9 comment about the -- it was in the paragraph that  
10 talked about range of clinical functions, but then it  
11 goes on to describe, again, clinical settings. So I  
12 think that there's complexity within all of those  
13 settings and there's less acute, if you will, reasons  
14 why somebody that's not in acute care, a nurse  
15 practitioner may be working in those settings but not  
16 necessarily performing all of the functions that  
17 would be required to fully manage a patient in those  
18 settings. So I think that that may create a little  
19 bit more confusion in terms of where we've already  
20 been.

21 Then the only other thing, in terms of  
22 the attachment, I know that the attachment is  
23 intended to identify those gray zones, and if  
24 anything, I think we should recognize that it's not  
25 an easy decision and allow nurses to know this is

1 intended to help guide, but it's -- a patient  
2 situation is so fluid and changes so easily, that  
3 there may be times when while you're waiting for  
4 handoff to somebody who has more expertise to manage  
5 that patient, you'll find yourselves in a situation  
6 with trying to manage the situation as opposed to the  
7 whole patient.

8           So I don't know if almost recognizing  
9 that or in the guideline acknowledging the fact that  
10 this is not an easy -- the scopes have overlap and  
11 it's not easy always to identify specifically. And  
12 they all -- I mean, I think everybody does try to act  
13 on the best interests of the patient when they're in  
14 these situations but it's very difficult to define  
15 it.

16           CHAIRWOMAN KEELS: Yeah. Thank you.

17           Pam.

18           MEMBER BOLTON: I agree with a lot of the  
19 comments and I appreciate the comments. I believe  
20 that we do need an Interpretive Guideline. I think a  
21 model would be nice to be able to make it as simple  
22 as possible.

23           I also think that a graph would be  
24 helpful, but I think a couple things. When I look at  
25 some of the individual comments, one talked

1 specifically about chronic conditions. I almost  
2 think that we need a graph that looks at acute,  
3 chronic, stability, instability.

4 And the reason I say that is because in  
5 the primary care setting, you have acute conditions.  
6 In the hospital or the more intensive environment,  
7 you have acute conditions, but those acute conditions  
8 are very different.

9 And I don't think this does a -- I don't  
10 think it's very clear in how those two are  
11 differentiated, and I think that's something that we  
12 might need. Maybe it's not the individual roles.  
13 Maybe it's one continuum that identifies those  
14 various spots and then you have the roles and where  
15 they overlap. That would truly give us an indication  
16 of where the roles overlap and where they end. So  
17 that's just one thought.

18 Erin, I liked your comment about the four  
19 roles. I do think that we have many CNSs who are  
20 functioning very much like a CNP, so I don't think  
21 that we should exclude them. I have four of six that  
22 are functioning in that role, and I think we also  
23 need to give some direction to them as well. And  
24 that's it. I'll turn it over to my friend Jody.

25 CHAIRWOMAN KEELS: Thanks so much.

1 Jody.

2 MEMBER MINIARD: I go back and forth. So  
3 I like the idea for those people who are real  
4 visual --

5 CHAIRWOMAN KEELS: You go back and forth  
6 on the graph?

7 MEMBER MINIARD: Yes. I like them for  
8 people like Pete who like them, but for people like  
9 me, I don't like them. I agree with everyone on that  
10 side of the table and maybe Pam too, but I feel like  
11 it -- to me it brings more questions to me who I feel  
12 I have a good understanding of scope of practice and  
13 the different -- I'm going to stick with NPs because  
14 that's what this is specific to -- or CNPs, but it  
15 confuses me. It grays the lines for even in my own  
16 mind for that scope of practice. So I have to kind  
17 of not look at it for me.

18 I like the idea of a decision-making tool  
19 or model. Maybe if you revise that, work off the  
20 current one, put current links to these comments  
21 about -- from NONPF about an acute nurse practitioner  
22 can take care of a chronic -- it says chronic --  
23 chronic, complex or deteriorating patients and then  
24 what the statement is for NONPF about FNPs, you know,  
25 stable, primary care, you know.

1           And maybe you would just have links to  
2 those statements and you just click on that. Is this  
3 within your scope of practice; if you're an FNP,  
4 click here. And then they can -- that to me makes  
5 more sense than graphs and language in the front  
6 because I would agree with the comment that Sherri  
7 made I think about it's very setting specific in that  
8 language that's on that first page, and I think  
9 that's going to create a lot of issues.

10           Maybe not for those folks in acute care  
11 or maybe taking care of chronic complex conditions.  
12 They're not taking care of patients who are acutely  
13 declining in that moment and need to be lined and  
14 resuscitated because that's not what acute care NPs  
15 do all the time. And I think this does blur lines  
16 for FNPs like Angela -- sorry, Angela. I was going  
17 to call you Angie....

18           But that red zone, I don't know, that's  
19 just my -- I think if we had like the facts and the  
20 decision-making where there were links to specific  
21 definitions and then they could follow that down the  
22 tree, you're really giving them the information  
23 without presenting something that could be held  
24 against them later. That's just my opinion.

25           CHAIRWOMAN KEELS: Thank you.

1           MEMBER DIPIAZZA: I know we're going  
2 around, but can I just point something out to  
3 everyone really clearly. When you're looking at that  
4 paragraph and you're saying that it's setting  
5 specific, I wouldn't agree with that, but if you read  
6 the sentences before, it says a proposed definition  
7 of acute care includes... and it goes on to say, but  
8 then it says used to treat sudden, often unexpected,  
9 urgent or emergent episodes of injury and illness  
10 that can lead to death or disability without rapid  
11 intervention. That's the definition they're giving.

12           It's almost the same definition from  
13 World Health Organization, CNS's definition, but I  
14 just want to point that out because when I look at  
15 this, I don't think emergency medicine setting or  
16 trauma care. None of that to me is setting. It's  
17 just talking about where this could function in the  
18 world of medicine today. That's where they see this  
19 acute care. Does that make sense?

20           MEMBER SIEVERS: But emergency  
21 medicine --

22           MEMBER MINIARD: It does go on to list  
23 sites.

24           MEMBER DIPIAZZA: It doesn't say  
25 settings. It says encompasses a range of clinical

1 health care functions including... It doesn't say  
2 settings.

3 MEMBER SIEVERS: But to my point,  
4 emergency medicine -- functions of emergency medicine  
5 are very wide, and it could be, to Jody's point, I  
6 agree, misinterpreted that all emergency -- somebody  
7 will take this and say all emergency medicine people  
8 have to be acute care, all short-term inpatient are  
9 acute care.

10 MEMBER DIPIAZZA: I just wanted to remind  
11 people of the other sentences before that, though,  
12 because they're just as important as that focus.

13 MEMBER SIEVERS: Right, but to Jody's  
14 point --

15 MEMBER MINIARD: I think it's going to be  
16 misinterpreted.

17 MEMBER SIEVERS: -- I think it's having  
18 people that aren't always -- they might be acute care  
19 certified, but they're not always in a life and death  
20 situation. They are down here which this is just as  
21 vague for your folks on the opposite end that are in  
22 some specialty clinics. Somebody could say, well,  
23 that patient's green because they're in an outpatient  
24 clinic and they're all good and your people shouldn't  
25 be in there.

1 CHAIRWOMAN KEELS: So if we remember why  
2 we were looking for that definition, we were trying  
3 to articulate where a primary care certified person's  
4 care management of that patient probably ends and is  
5 handed off, and it's when that could lead to death or  
6 disability without intervention.

7 What we were trying to get at, in my  
8 mind, we could even potentially put it in an FAQ and  
9 drop that last sentence so it's not setting specific,  
10 but we were trying to figure out where if I'm the  
11 primary care person and I'm in the urgent care, where  
12 do I need to call for help, where do I need to get  
13 the acute care person in, whether it's an APRN or  
14 whomever. That's really what --

15 MEMBER DIPIAZZA: That's how I read that  
16 paragraph.

17 MEMBER MINIARD: That's how I read, but I  
18 should have said that. I understand what it says,  
19 but when you first read it, it does -- someone -- I  
20 agree with Sherri, someone is going to misinterpret  
21 that and say that if you're going to work in an  
22 urgent care, you have to be ACSE or AG CSE certified.

23 CHAIRWOMAN KEELS: So we've become  
24 hypersensitive to anything that might reflect back on  
25 settings.

1                   MEMBER MINIARD: I like the beginning of  
2 it too.

3                   MEMBER SIEVERS: I agree with you.

4                   MEMBER DIPIAZZA: I did not -- reading  
5 this as an FNP and having worked in hospital  
6 medicine, I would not have taken it as it's these  
7 settings. I would have taken it as, okay, when I  
8 reach the point of end organ failure and death, I  
9 need to pass this patient on because now it's outside  
10 of my scope.

11                   CHAIRWOMAN KEELS: Good points, guys.  
12 Brian.

13                   MEMBER GARRETT: Something I said, why do  
14 we have call it an Interpretive Guideline. Why can't  
15 we call it practice consideration. Technically, this  
16 could be an FAQ with about two sentences. You could  
17 put a question right before this paragraph here for  
18 the purpose of, you know, what is the level of care,  
19 blah, blah, blah, and that's a question and then  
20 here's your answer.

21                   And you could put on the next page what  
22 is the responsibility of the APRN-CNP related to the  
23 role as far as accountability and responsibility as  
24 an FAQ. I just -- when I hear people talk, the word  
25 interpretive, it gets everybody anxious. And it's a

1 guideline that isn't quite as -- are we really  
2 interpreting anything or are we just guiding them to  
3 the current information.

4           So to soften the message and say practice  
5 considerations or have the same thing in here and  
6 call it an FAQ, it can be turned into an FAQ in about  
7 two sentences and still gives you the same  
8 information and it softens the word interpretation.

9           I would just say for the locations piece,  
10 I did think location but obviously I go on to  
11 surgery/critical care, but I'd maybe put the word --  
12 term acute care may encompass, may or may not  
13 encompass, right? And so that it just gives more  
14 flexibility and keeps...

15           Then the graphs from an adult learning  
16 standpoint, I have the word inclusionary versus  
17 exclusionary. If you take these eight things -- for  
18 example, if I gave somebody eight drugs and they had  
19 80 percent of, say, things in common for all eight  
20 drugs, I wouldn't tell the adult learner to memorize  
21 the stuff that's the same for each of them. I would  
22 have them memorize the things that are exclusionary  
23 or different about the drugs.

24           I see there's a lot of similarities, so  
25 maybe redo the graphs where it's here's what excluded

1 instead of included because I see a lot of color and  
2 very little white. And if you flip it around and  
3 delineated to that, that's just teaching adults and  
4 teaching exclusionary stuff. Well, we have the  
5 exclusionary and inclusionary, well, there you go.  
6 Everybody is all happy. So it's just something....

7 CHAIRWOMAN KEELS: Good point.

8 MEMBER SIEVERS: Could you do that in a  
9 question, then, if it's very little to answer --

10 MEMBER GARRETT: Yeah, that's what I  
11 mean, it could be what is --

12 MEMBER SIEVERS: Right, I think if you  
13 could get it as a question without -- because I just  
14 think of our students, they're going to say what does  
15 this mean.

16 MEMBER GARRETT: So you're going to say  
17 what are the populations excluded for this major and  
18 specialty and, bam, just put that in there instead of  
19 what's included, what's excluded....

20 MEMBER SIEVERS: But I think we're still  
21 trying to put everybody in a box and there's a lot of  
22 different scenarios. So I like Jody's idea to have  
23 kind of the question and then the link which allows  
24 them -- they have to work through a set of questions  
25 to say was I trained in this? Do I have education?

1 Was this part of my certification? Was this in the  
2 content outline for my test? And if they get any  
3 no's....

4 MEMBER MINIARD: Because I kind of think  
5 any other way you do it, it's going to be really  
6 difficult to give people the answers that they're  
7 seeking because as we all know, there's a gap,  
8 there's a gray area, and that's where the questions  
9 are.

10 And you can't take something this gray  
11 and try to make it concrete. I mean, I think there  
12 has to be some responsibility on that NP or CNP to be  
13 able to work their way through a tool to decide  
14 whether or not they can do it. And when you start  
15 making the gray -- trying to line up the gray or  
16 however, I don't know what the best way to say it is,  
17 I think you do start to put people in a box and I  
18 think that it becomes -- I just think it's going to  
19 create more issues than it's going to help.

20 And I think if we stick with what we  
21 already know what the competencies are and we just  
22 direct those people to them, then the responsibility  
23 of whether or not they should be doing what they're  
24 doing is going to be on them, okay.

25 And then there is some -- and then

1 whoever's employing them, if they were credentialed  
2 to do that, I mean, I think you're still going to get  
3 questions, but I don't know that making a graph is  
4 probably the best way to let the gray.... You're  
5 just filling up the stuff that people already know  
6 they can do and help making the gray wider, I think.

7 CHAIRWOMAN KEELS: Well, I personally --  
8 I agree with everything you guys have said about the  
9 graph. I think it causes more questions than it  
10 actually may answer, so apologies to those who worked  
11 on that. I know, I'm sorry. I think -- and I'm not  
12 sure, and I appreciate visual learners, but I think  
13 we could probably do without Attachment A is my  
14 recommendation.

15 I feel like whether we call it an  
16 Interpretive Guideline or not, I like the idea that  
17 for each role there is a section that I could go  
18 under and see where all of my statutes and rules are,  
19 and if that's an Interpretive Guideline or not,  
20 however we want to manage that.

21 I like having this all in front of me.  
22 I like the definition of acute care for the purposes  
23 of the acute care certified practitioner to help  
24 provide that sort of guidepost there. I like that  
25 there's accountability and responsibility for the

1 individual sort of pulled out.

2 I also like the idea of a  
3 Decision-Making Model but not the general RN. I feel  
4 that the first question has to be do you know what  
5 your scope is, are you clear about what your scope is  
6 within your population focus. And if we can  
7 accomplish that through links back to competencies or  
8 tests or professional organization statements, that  
9 would be really helpful, I think.

10 So it sounds like we have a lot more  
11 yeses together on similar situations. I think one  
12 decision we have to make is do we retain the graphs  
13 or no, and I make a recommendation that we do not  
14 move forward with the graphs. All in favor of not --  
15 Can we make a recommendation in the negative?

16 MS. EMRICH: You're the Chair.

17 CHAIRWOMAN KEELS: I make a  
18 recommendation that we do not move forward with the  
19 graphs.

20 MEMBER BOLTON: Second.

21 CHAIRWOMAN KEELS: It's been seconded.

22 All those in favor....

23 (All respond aye.)

24 CHAIRWOMAN KEELS: Okay, so thank you for  
25 trying to do that. I really do appreciate that.

1           Question 2, I think everybody is on Board  
2 with FAQs, so I think -- I know Lisa and her staff  
3 wants to get through renewal time and we'll be able  
4 to work more on that and perhaps have a draft for our  
5 next meeting. So I like the FAQs, and I think that  
6 will be very helpful.

7           So the next thing is do we move forward  
8 with an Interpretive Guideline with the graphs  
9 removed and some of the suggestions people have made.

10           MEMBER MINIARD: Can I make a motion?

11           CHAIRWOMAN KEELS: Yes, make a motion.

12           MEMBER MINIARD: I make a motion that we  
13 do move forward with the suggestions with maybe  
14 removing that part about the setting, yes.

15           CHAIRWOMAN KEELS: Is there a second?

16           MEMBER BOLTON: Second.

17           CHAIRWOMAN KEELS: All in favor? One,  
18 two, three, four, five, okay, motion passes. So we  
19 will continue to work on that.

20           MEMBER SIEVERS: I have a question.

21           MS. EMRICH: So just to clarify, on the  
22 draft IG in front of you, we are going to remove from  
23 that first indented paragraph, which is actually the  
24 third paragraph, we're going to remove the last  
25 sentence which is cited from Hershon Brisco, correct?

1           MEMBER MINIARD: Right, starting with the  
2 term acute care encompasses.

3           MS. EMRICH: Okay. We'll remove that  
4 sentence.

5           CHAIRWOMAN KEELS: We would also remove  
6 the sentence ahead of it, for the purposes of this  
7 Interpretative Guideline, the higher red level of  
8 care required by the patient condition in Attachment  
9 A, we'll remove that, and I think it should read  
10 something to the effect of for the purposes of this  
11 Interpretative Guideline....

12           MEMBER MINIARD: The term acute care  
13 explained by....

14           CHAIRWOMAN KEELS: What we were hoping  
15 was to tie it back to acute care certified, not acute  
16 care because everybody provides acute care, but where  
17 does the primary care scope sort of end for  
18 management.

19           MEMBER ZAMUDIO: Instead of looking for  
20 different definitions, does acute care certification  
21 have its own definition?

22           MEMBER MINIARD: Yes.

23           MEMBER ZAMUDIO: Well, why don't we use  
24 that one?

25           MEMBER MINIARD: It's in the National

1 Organization Nurse Practitioner Faculty white paper  
2 further notes that primary care is not limited to  
3 preventive maintenance for the well person. On the  
4 other hand, the acute care NP provides care for  
5 patients with unstable, chronic, complex, acute and  
6 critical conditions.

7 MEMBER GAGER: I think unstable is one of  
8 the key words.

9 MEMBER ZAMUDIO: Yeah. The certification  
10 program --

11 (Multiple people talking at once.)

12 CHAIRWOMAN KEELS: We can't use it  
13 because it's from a national body. Do you have a  
14 point to make?

15 MEMBER DIPIAZZA: No, go on.

16 CHAIRWOMAN KEELS: I'm fine with that,  
17 too, if you think that's clear enough because that's  
18 what we were really struggling with, at what point do  
19 our primary care colleagues sort of understand where  
20 that ends and the acute care provider --

21 MEMBER MINIARD: I mean, I think the key  
22 is, you know, that you're kind of encompassing all of  
23 the gray, right, so the unstable patient, that they  
24 can care for chronic, complex, acute. I think most  
25 NPs at this level are going to know what complex,

1 acute patient is.

2 MEMBER DIPIAZZA: I don't know about  
3 that.

4 MEMBER MINIARD: Well, I mean, we can  
5 just give definitions that....

6 MEMBER DIPIAZZA: I take care of some  
7 very complex patients, but they've been stabilized at  
8 some point. Some internal medicine docs would  
9 probably run away from them. I mean, I'd like -- I  
10 mean, I'm fine with using the NONPF definition, but I  
11 still do think we need something in there that  
12 stresses the whole what is an acute person really  
13 look like.

14 MEMBER MINIARD: Unstable.

15 MEMBER DIPIAZZA: But what's unstable?  
16 And I think that this does an okay job of saying  
17 unexpected, urgent, emergent episodes, injury,  
18 illness that can lead to death or disability without  
19 rapid intervention. I mean, to me, that's pretty  
20 clear because I have some, like I said, some really  
21 complex patients.

22 MEMBER GARRETT: A transplant patient is  
23 a complex patient but they're stable.

24 MEMBER DIPIAZZA: Right. And so I think  
25 really just going one step further and making it very

1 clear what we're saying here is acute is they're  
2 going to die if you do nothing with them.

3 MEMBER BOLTON: Well, but I think I  
4 struggle with that, without rapid intervention,  
5 because you have acute care certified practitioners  
6 in a cardiology setting that are seeing stable  
7 cardiac patients, they don't have any immediate  
8 intervention.

9 What I think -- Where I think the overlap  
10 is, is that FNPs and primary care take care of acute,  
11 acute care certified take care of acute. There's a  
12 different version of acute. The same goes for  
13 complex. You know, the complexity of the illness can  
14 get them in an acute situation with their chronic  
15 condition.

16 The same holds true for when you're  
17 taking care of very complex, chronic patients that's  
18 stable. So I think that those are the overlaps. I  
19 think with this, what I struggle with is without  
20 rapid intervention, we're not constantly  
21 resuscitating someone or putting them on a vent or  
22 getting them on CRT. You know, we are -- we are also  
23 managing those chronic acute conditions.

24 MEMBER DIPIAZZA: I'm looking at it just  
25 from the FNP side. This is what defines where my

1 role ends in the care of this individual.

2 MEMBER MINIARD: Well, maybe you should  
3 define that rather than defining acute.

4 MEMBER BOLTON: You know....

5 MEMBER MINIARD: Maybe you need to define  
6 where the line ends for primary care rather than  
7 where it begins for acute.

8 MEMBER DIPIAZZA: I would say and organ  
9 failure and death, immediate death. That's literally  
10 how I've defined it in the past.

11 MEMBER MINIARD: Right. I'm not trying  
12 to throw a wrench in it. I'm just....

13 MEMBER ZAMUDIO: It's a good point.

14 MEMBER DIPIAZZA: There's a lot of  
15 overlap. That's where we have to get used to living  
16 in the gray.

17 MEMBER GAGER: And maybe -- I don't know  
18 that you can define it because it's situation based.

19 MEMBER MINIARD: Maybe we just need to  
20 say that acute care doesn't mean hospital care.

21 (Multiple people talking at once.)

22 CHAIRWOMAN KEELS: Oh, yeah. I would  
23 actually like to see it's not something specific and  
24 there's a difference between performing procedures,  
25 performing consultations, first response and then

1 management.

2 MEMBER MINIARD: Maybe you should refer  
3 them back to what NONPF says is their competencies,  
4 and then, you know, it says unstable, chronic,  
5 complex conditions. And it doesn't -- you can take  
6 care of acute things, but you just got to refer them  
7 back to what's already there. I don't know that you  
8 can -- when you start trying to put specific  
9 definitions on stuff....

10 MEMBER DIPIAZZA: I think you're going to  
11 get questions about, well, what's unstable then?  
12 That's what you're going to get, is what's unstable.

13 MEMBER ZAMUDIO: What's chronic? How  
14 long?

15 MEMBER DIPIAZZA: I think you need to  
16 go -- I think you just need to go one step further  
17 and define what's unstable.

18 CHAIRWOMAN KEELS: Would you propose that  
19 sentence to define?

20 MEMBER MINIARD: You can define what  
21 unstable is, but I don't think you should define what  
22 acute is.

23 MEMBER BOLTON: I wonder if we should  
24 take a back door to this. Maybe we should try to  
25 create that Decision-Making Model and then let the

1 Decision-Making Model decide what needs to be defined  
2 and what doesn't.

3 MEMBER MINIARD: That's a good idea.

4 CHAIRWOMAN KEELS: I've never made a  
5 Decision-Making Model before, so I'm looking at Lisa.

6 MS. EMRICH: Well, we have the current  
7 late term Decision-Making Model which uses --  
8 references the particular and applicable statutes for  
9 your national certification, your scope of practice  
10 and so forth. I'm envisioning it. We could  
11 potentially break down the acute versus primary and  
12 make a Decision-Making Model.

13 MEMBER ZAMUDIO: Can you do that without  
14 definitions, without this Committee coming up with  
15 its own definition but just link it back to their  
16 national -- their competency --

17 MEMBER BOLTON: I think we all know. I  
18 think all of us sitting around this table know this.  
19 And I wonder if it's more about just asking that  
20 specific question -- I'm sorry, Sherri.

21 MEMBER SIEVERS: Just when you're done.  
22 Just don't want to be forgotten.

23 MEMBER BOLTON: That would drive them  
24 there. That would drive them to their competencies,  
25 drive them to their test exam. I mean, when I was

1 trying to determine what scope was for my  
2 institution, that's where I went, you know. And I  
3 did seek the Board's assistance because....

4 MS. EMRICH: And remember, what started  
5 all of this were questions we were receiving  
6 frequently that really gave us a lot of concern that  
7 primary care were providing truly, truly acute care  
8 services or practicing -- than their practice. It  
9 wasn't about even -- it was about their practice,  
10 what could be acute care, thus the 2016 article which  
11 now here we are. So, just remember, there was a  
12 beginning to all of this, so....

13 CHAIRWOMAN KEELS: And maybe there will  
14 be an end perhaps. Yes, Sherri.

15 MEMBER SIEVERS: I just want to back up.  
16 When we went around, I heard those using  
17 Decision-Making Model and Interpretative Guidelines  
18 kind of interchangeably, so I'm questioning if  
19 folks -- what is everyone's understanding of the  
20 difference between the two and would we really have  
21 both and why would we call it Interpretive Guideline  
22 versus Decision-Making and have FAQs?

23 Is there something we're gaining  
24 specifically by the Interpretive Guideline? Maybe  
25 this is more explanation before we have a vote. And

1 then I saw somewhere in the voting we have a period  
2 of discussion too; isn't that right?

3 So just backing up, is there something --  
4 I think the folks who just voted yes, though, was  
5 there something you were looking for specifically in  
6 an Interpretive Guideline that we couldn't accomplish  
7 with a Decision-Making Model and FAQs? Because it  
8 sounds like it's a more involved process. It has to  
9 go to the Attorney General, right. It's a little bit  
10 more I don't want to say restrictive or enforceable.

11 MEMBER GARRETT: That's why I didn't vote  
12 for the motion.

13 MEMBER BOLTON: Last time you talked  
14 about the Board's description of an Interpretive  
15 Guideline, could you repeat that? I think that would  
16 be helpful.

17 MS. EMRICH: Statutes and rules are  
18 enforceable. The Board is obligated to administer  
19 and enforce them. An Interpretive Guideline itself  
20 is not enforceable. It is a guideline. Whether I've  
21 got an Interpretive Guideline by the Board, takes  
22 specific statute and rules and applies it to certain  
23 circumstances, okay.

24 In the past, these IGs have really been  
25 prepared for RN and LPN kind of practice because they

1 needed some more information about how to apply laws  
2 and rules to very specific practices. This is the  
3 first one we've had as far as APRNs, that it seems to  
4 be requested and appropriate. So it's about taking  
5 existing law and rules and applying it to the CNP  
6 scope of practice and how did the laws and rules  
7 about national certification population folks, all of  
8 that is applied from the laws and rules down.

9 It is not intended necessarily -- the  
10 usual application of an Interpretive Guideline is to  
11 get from the very broadly -- usually more broadly  
12 written law and rules to get down to facility policy,  
13 for example. And it should all be congruent, and  
14 then facility policy credentialing or practice  
15 policies and then individuals' standard of care  
16 arrangement, for example. That should all fill in  
17 the rest. It should all be congruent.

18 It just helps to get from point A to  
19 point B and fill in the gaps of information, of more  
20 detailed information, but it is not enforceable.  
21 Now, an IG, though, is a more -- in essence, it is a  
22 more formal process than just an FAQ, not only  
23 because the Board itself has to review and adopt it  
24 or approve it for publication, and then whatever is  
25 approved or published, our IGs have always had the

1 okay and review of our Attorney General -- Assistant  
2 Attorney General.

3 MEMBER SIEVERS: So contrast for me,  
4 please, an FAQ and a Decision-Making Model. Would it  
5 not be reviewed by the Board and the questions vetted  
6 through the attorney?

7 CHAIRWOMAN KEELS: Do you want Lisa to  
8 address that?

9 MS. EMRICH: Sure.

10 CHAIRWOMAN KEELS: Lisa, do you want to  
11 try to address --

12 BOARD MEMBER KLENKE: No, I don't want to  
13 address her. I have another....

14 MS. EMRICH: So an FAQ, an FAQ is staff  
15 usually prepares FAQs. We have FAQs on the Board's  
16 website for various things, practice and so forth.  
17 They're reviewed internally. The Board may -- The  
18 Board is generally informed about the FAQs and all,  
19 but I don't remember the Board needing to approve  
20 them individually because they're more taking -- an  
21 FAQ should not be inconsistent with how we're  
22 responding to practice questions as they come in, and  
23 we do that on a day-to-day basis.

24 MEMBER SIEVERS: What about a  
25 Decision-Making Model?

1 MS. EMRICH: The Decision-Making Model,  
2 the Board has reviewed and approved those.

3 CHAIRWOMAN KEELS: Lisa.

4 BOARD MEMBER KLENKE: I was addressing  
5 the issue but not from a legal perspective, more from  
6 a practical perspective. Most often what I've seen  
7 is that people try to use the Decision-Making Model,  
8 and I'm going to refer to the RN versus the APRN.

9 So they've gone through that process and  
10 they still don't know if a nurse can pass --  
11 administer a drug that's got a black box warning that  
12 can only be administered by a physician or somebody  
13 licensed in the practice of anesthesia during an  
14 emergent intubation.

15 So the Board would get a lot of questions  
16 about that from, say, an ER where there's one  
17 physician and then the nursing staff, and if this  
18 physician wasn't intubating, the physician might be  
19 giving the drug, but, you know, they both need to be  
20 done in tandem.

21 So what was happening -- and the reason  
22 the Interpretive Guideline started was they gave more  
23 clarity to following that model for a specific  
24 situation. So it doesn't -- they both work, but if  
25 you can't get your questions answered from using the

1 Decision-Making Model, then you go to the  
2 Interpretive Guideline.

3 The FAQs are really prepared by the Board  
4 Staff based on their in and out as their law and rule  
5 on an everyday basis. When the Interpretive  
6 Guidelines are created, it involves the stakeholders  
7 just like this group has.

8 So you have the discussions with the  
9 people who are impacted by the Interpretive Guideline  
10 to make sure that the Board is really understanding,  
11 oh, the issues that are out there, and then you try  
12 to draft the guidelines to support -- it has to be in  
13 sync with the law and rule, but it also supports  
14 maybe the issues that have been raised by the  
15 stakeholders.

16 CHAIRWOMAN KEELS: Everybody wants to  
17 talk. Let's go to Pam, Angela and then Michelle.

18 MEMBER BOLTON: Thank you, Lisa, for  
19 saying that because that's exactly what I was  
20 thinking. I think when I said kind of back end this,  
21 the best way to do that would be to create that  
22 Decision-Making Model around the APRN and then what  
23 is not clear in that model or cannot be answered  
24 could be, therefore, clarified in the Interpretive  
25 Guideline. So I think both would be a nice

1 synergistic document.

2 CHAIRWOMAN KEELS: Thank you.

3 Michelle.

4 MEMBER ZAMUDIO: Just for clarification,  
5 when you said the Interpretive Guidelines were not  
6 enforceable, what does that mean?

7 MS. EMRICH: It means that the Board  
8 cannot say you, Michelle, CNM, are not complying with  
9 the Interpretative Guidelines, therefore, we are  
10 going to issue you a citation or a notice.

11 MEMBER ZAMUDIO: So they're not  
12 enforceable by the Board --

13 MS. EMRICH: No.

14 MEMBER ZAMUDIO: -- for the --

15 MS. EMRICH: No, it's the actual law and  
16 rules....

17 MEMBER ZAMUDIO: But those are public.  
18 My concern would be obviously not the Board but the  
19 JDs and everybody else putting it up on a really big  
20 screen in a courtroom.

21 MS. EMRICH: It's -- it is the statute  
22 and law that is enforceable. So, for example, if our  
23 law says X,Y, Z and that is referenced in the IG, it  
24 would be what the law is....

25 CHAIRWOMAN KEELS: The wording IG

1 contains -- is nothing new. It's already out there.  
2 It's just pulled into one document.

3 MEMBER GARRETT: So why can't you say at  
4 the beginning of the IG this is not an enforceable  
5 thing right off the bat....

6 MS. EMRICH: We have an overarching  
7 document called Utilizing Interpretive Guideline that  
8 discusses that. And also I believe that's the back  
9 end of this also.

10 MEMBER BOLTON: Yeah, it references.

11 CHAIRWOMAN KEELS: Angela, did you have a  
12 comment?

13 MEMBER GAGER: Yes. I just think when  
14 we're talking about this too we need to be careful  
15 not to make this too restrictive because scope of  
16 practice expands with clinical experience, and I  
17 think we need to make sure that we're addressing  
18 that.

19 CHAIRWOMAN KEELS: Thank you for bringing  
20 that up because what I really liked in the OAAPN  
21 document was the paragraph about ongoing clinical  
22 experience and knowledge gained from formal and  
23 informal education within -- but it has to be within  
24 your population focus.

25 MEMBER GAGER: Correct, because the scope

1 of practice of a brand new NP versus someone who's  
2 been practicing for 15 years is very different.  
3 They're still practicing within their scope, but they  
4 have a different range within that scope of practice.  
5 I'm afraid the way a lot of things are worded in this  
6 is going to restrict practice for NPs who gain  
7 additional experience, gain additional training.  
8 Yeah, I think they need to be very careful with that.

9 CHAIRWOMAN KEELS: I was thinking -- I  
10 was thinking the process would be parsed out in an  
11 FAQ because we can't put anything that's not already  
12 in statute or rule in the IG, but I really liked the  
13 summary of how you continue to gain expertise within  
14 your practice.

15 MEMBER BOLTON: Angela, can you expound  
16 on that a little bit? Can you give an example of  
17 that?

18 MEMBER GAGER: Sure. Let me think for a  
19 minute.

20 MEMBER BOLTON: Okay, that's fine. Go  
21 ahead.

22 MEMBER GAGER: Well, birth control  
23 options. FNPs, I work with several FNPs who do IUDs.  
24 I don't do an IUD. I don't have supporting  
25 physicians that work with me. I don't have the

1 training. At one point, I was being trained to do  
2 colposcopies, but that requires the training, the  
3 continuing with that certification, so there's an  
4 additional skills and certifications you can get  
5 within your scope.

6 MEMBER BOLTON: Perfect. Those are great  
7 examples --

8 (Multiple people talking at once.)

9 MEMBER GAGER: Right, and NPs practicing  
10 for six months would not have --

11 MEMBER BOLTON: That's excellent. I love  
12 that example.

13 MEMBER GAGER: -- the skill to put in an  
14 IUD.

15 MEMBER BOLTON: Yeah, I know. Thank you.

16 CHAIRWOMAN KEELS: Good point.

17 MEMBER SIEVERS: You just sparked a  
18 question for me. So if it's not enforceable, could  
19 the group live with the content and not calling it an  
20 Interpretive Guideline? What would be the negative  
21 for us, for our practice, for the people that we  
22 manage, our students, the APRNs in Ohio for not  
23 calling it an Interpretive Guideline but  
24 accomplishing the same end goal which is to provide  
25 clarity?

1 MEMBER BOLTON: Can I ask a question?

2 MEMBER SIEVERS: Yes.

3 MEMBER BOLTON: What's adverse to  
4 Interpretive Guideline?

5 MEMBER SIEVERS: What -- what Michelle  
6 alluded to as being -- how it is impacting folks  
7 negatively. While the Board cannot enforce it, I  
8 think because of what it is, and correct me if I'm  
9 wrong if there's legal folks that can weigh in, that  
10 it carries a different weight.

11 MEMBER MINIARD: But isn't that just a --

12 MEMBER GARRETT: It doesn't matter how  
13 people are perceiving it. It's like we said last  
14 time when we asked for the Interpretive Guidelines,  
15 what was the Interpretive Guideline last time?

16 CHAIRWOMAN KEELS: Pete.

17 MEMBER DIPIAZZA: You know, I wanted to  
18 say so that's why we need the Interpretive Guideline,  
19 though, because all of these health systems have  
20 interpreted it -- they've hyper-reacted to the  
21 Momentum article, and that's why having Interpretive  
22 Guideline would be really helpful because now it's  
23 more, for lack of a better word, official from the  
24 Ohio Board of Nursing that the Ohio Board of Nursing  
25 has come out with these Interpretive Guidelines that

1 allow us to practice more freely or in a way we  
2 should be practicing.

3 CHAIRWOMAN KEELS: It still has rules and  
4 statutes, and that's what it's all around, so it's  
5 nothing new. It's all pulled together in one place.

6 Jody.

7 MEMBER MINIARD: I mean, I think a lot of  
8 the fear comes from just not knowing what the word  
9 Interpretive Guideline means, but I mean, as long as  
10 people can educate themselves on what that means,  
11 then there's nothing to be afraid of of the term  
12 other than it's more official.

13 I don't see a downfall to it. And I  
14 think the more official it is, the better it will  
15 serve the people that we are serving, APRNs and the  
16 public and the hospital systems that are hiring the  
17 APRNs, because nobody wants -- in those situations  
18 nobody wants "well maybe," they want, "Oh, well, the  
19 Ohio Board of Nursing says that this is the way this  
20 should be interpreted." I think it gives a more  
21 official backbone to it. I personally like it. At  
22 first it's kind of scary because I didn't know what  
23 the term meant until Lisa explained it to me, but....

24 MEMBER GARRETT: All I'm asking from last  
25 time, if we keep the word Interpretive Guideline, I

1 don't have a problem, but it just needs to be what  
2 you just said in bold letters right underneath it:  
3 Interpretive Guideline is... not blah, blah, blah  
4 because they're not going to go to the other part of  
5 that. We all know how we are, we're not going to go  
6 to the other part of the website, we're not going to  
7 go look it up, we're going to go right here and then  
8 we're good.

9 But if we don't put that up there, then  
10 I -- we have to soften the message which is what  
11 Jesse was saying, the word interpretive gives  
12 everybody anxiety. So if you put it right here,  
13 "Interpretative Guideline is...", what you just said  
14 in bold letters right here, everybody knows it's  
15 clear as mud for everybody.

16 CHAIRWOMAN KEELS: Thank you,  
17 Mr. Process.

18 MEMBER DIPIAZZA: We've had a lot of  
19 knee-jerk responses from folks just based off of that  
20 article. And whether we think it's appropriate or  
21 inappropriate, I think the only way to really fix  
22 this now is for something to come from the Committee  
23 and the Board of Nursing.

24 MEMBER SIEVERS: Is there anything else  
25 we could call it?

1 CHAIRWOMAN KEELS: No, not if we do it in  
2 this form, but Lisa has a handout and we sure can  
3 address that.

4 BOARD MEMBER KLENKE: Well, I would just  
5 read from the -- there is a Board document that talks  
6 about how you use Interpretive Guideline, and they've  
7 got a brief statement in here that says, "An  
8 Interpretive Guideline is not a regulation of the  
9 Board and does not carry the force and effect of law.  
10 An Interpretive Guideline is adopted by the Board as  
11 a guideline to licensees who seek to engage in safe  
12 nursing practice."

13 CHAIRWOMAN KEELS: There it is.

14 MEMBER MINIARD: Period. Bolded at the  
15 top.

16 CHAIRWOMAN KEELS: Perfect. So I don't  
17 know that the Board issues any other document types,  
18 so I think if we want to do that, I agree, I think  
19 that a Decision-Making Model and IG can be commensal  
20 and support each other. And then we may still need  
21 FAQs too for certain situations and scenarios that  
22 sort of continue to sort of crop up, like does the  
23 Board -- does my national certification satisfy as my  
24 license, things like that.

25 Michelle.

1           MEMBER ZAMUDIO: So to avoid another  
2 three years of coming up with that, could we involve  
3 all the stakeholders? And we can get this done if we  
4 just have a work group sit and do the document.  
5 Instead of us continually just responding to what the  
6 Board gives us, why not come up with the document,  
7 include the stakeholders and get the IG done?  
8 Because there's going to be less back and forth and  
9 we're only meeting every couple of months.

10           CHAIRWOMAN KEELS: Now, I think you are  
11 representing the stakeholders. You are. We've got  
12 education here, we have --

13           MEMBER ZAMUDIO: We do, but I think the  
14 OAAPN has been clear about their willingness to help  
15 and they represent thousands -- many thousands.

16           CHAIRWOMAN KEELS: And they have provided  
17 a lot of input that we will incorporate.

18           MEMBER DIPIAZZA: They don't represent  
19 all of the stakeholders.

20           MEMBER ZAMUDIO: No, no, definitely. I'm  
21 not saying that. I'm certainly not -- I had some  
22 significant problems with the one they put forth too.  
23 What I'm saying, to avoid what's been going on, if  
24 you look at our process so far, it's not very  
25 effective and that is that it keeps coming back to

1 us. We're responding. A month later, it goes back.  
2 A month later, it comes back. Either meet more  
3 frequently or let's just get this done.

4 CHAIRWOMAN KEELS: Brian.

5 MEMBER GARRETT: Can you amend your  
6 motion to just put what she just said about  
7 underneath it?

8 CHAIRWOMAN KEELS: Do we have to make  
9 another motion?

10 MEMBER MINIARD: I was just going to say,  
11 do I need to make another motion to improve the  
12 Interpretive Guideline?

13 MEMBER GARRETT: Now I'll vote for your  
14 motion.

15 CHAIRWOMAN KEELS: Oh, well, thanks.

16 MEMBER MINIARD: I mean, we've really  
17 just had the discussion how accurately --

18 CHAIRWOMAN KEELS: Sorry about that.

19 MEMBER MINIARD: That's why I said should  
20 we do it again?

21 CHAIRWOMAN KEELS: Lisa said we don't  
22 have to.

23 MS. EMRICH: Well, we can preface this  
24 with either the companion documents or we can even  
25 insert it in here.

1 CHAIRWOMAN KEELS: The motion was that we  
2 move forward with an IG with suggestions that have  
3 been made to help.

4 MEMBER BOLTON: And, Michelle, I  
5 totally -- I understand where you're coming from and  
6 I agree there probably are some ways to make this a  
7 little faster, but I also appreciate the expertise of  
8 the Board and knowing the statutes and the rules and  
9 the other accompanying documents.

10 So maybe if that -- and I don't know what  
11 your timeline is, but maybe that could be drafted and  
12 then sent out via e-mail and we can get some input  
13 that way so that when we come to the table we're  
14 addressing the issues of our guests that are coming  
15 in and then any other specifics with which we would  
16 need to vote.

17 CHAIRWOMAN KEELS: Jody?

18 MEMBER MINIARD: Last comment, promise.  
19 I would say I've been here for a year, and when I  
20 came, none of this existed. It was still sitting at  
21 this table talking about this. So I think it has  
22 taken a while, but if you think about how far -- and  
23 you were here before I was.

24 MEMBER ZAMUDIO: I've come and gone.

25 MEMBER MINIARD: How far they have come

1 in the last year to even have anything remotely like  
2 this....

3 MEMBER ZAMUDIO: Again, I'm not saying it  
4 wasn't a lot of effort, but I'm saying we could be  
5 more expeditious in our charge. And that is if we're  
6 going to suggest changes to this like taking out that  
7 paragraph, et cetera, let's do it and maybe, like you  
8 said, e-mail that out. I just don't want us to keep  
9 being responsive to things that we could have just  
10 said out loud and get it finished, you know.

11 CHAIRWOMAN KEELS: Well, I think two  
12 things. I think the things that we said at the last  
13 meeting were incorporated. And the other thing is  
14 life happens and people have workloads, and I think  
15 Lisa and her staff are doing a great job in getting  
16 it down and getting it back to us.

17 MEMBER SIEVERS: One more question, if  
18 Tom could resay what he said is already out there,  
19 and so that's something that's posted out there about  
20 scope of practice, would that not be an option to  
21 have that document include this information?

22 MEMBER DIPIAZZA: It's on the site.

23 MS. EMRICH: Yeah, it's a statement about  
24 the Board -- a statement about APRNs working to the  
25 full extent of their licensed authority.

1           MEMBER SIEVERS: Right. Could that not  
2 be what we're talking about and it's something this  
3 Board publishes and has their name on?

4           MEMBER DIPIAZZA: It's on there already.

5           MEMBER MINIARD: I think that's what  
6 she's saying.

7           MEMBER SIEVERS: Right. I'm saying could  
8 this not be -- could that not be beefed up to  
9 incorporate this information and it's something that  
10 the Board -- and could it not serve the same purpose?

11           MEMBER MINIARD: That's why I asked if we  
12 should revote.

13           MEMBER SIEVERS: I just think that the IG  
14 with the process it goes, if we want to make changes  
15 later, it's a much more complex process.

16           MS. EMRICH: No, not really. The Board  
17 has about six existing IGs, and we have a process  
18 whereby we review each one every two years to make  
19 sure it's current, consistent. We ask for outside  
20 stakeholder input before the Board considers each  
21 one. It's not a complicated -- it's not a process.

22           MEMBER MINIARD: It's not like changing a  
23 rule or statute?

24           MS. EMRICH: Right, exactly.

25           MEMBER DIPIAZZA: What she's referring to

1 is the Practice of Nursing Scopes of Practice  
2 document that you guys have published already.

3 CHAIRWOMAN KEELS: We can reference it in  
4 the Decision-Making Model or in the Interpretive  
5 Guidelines somewhere.

6 MEMBER BOLTON: This is inclusive of all,  
7 right, APRNs and --

8 CHAIRWOMAN KEELS: Yeah, it was for all  
9 RNs including APRNs and that came about because --

10 MEMBER BOLTON: I don't want there to be  
11 confusion. I think that right now the  
12 Decision-Making Model, even though it is APRN, I  
13 think it very much drives -- it doesn't drive it in  
14 the way that we want it to. It's for clarity. And  
15 so I would hesitate combining it with something  
16 that's RN. I would really separate that out.

17 CHAIRWOMAN KEELS: For a Decision-Making  
18 Model.

19 MEMBER SIEVERS: I agree with your  
20 previous statement that it needs to be redone. I  
21 think it needs clarity. I'm just hung up on the IG  
22 piece. I think going in a direction -- you know,  
23 Lisa said this is something we've not had in the  
24 past, it's not something that is universal and across  
25 all states, and I think it just, again, is us going

1 in a too conservative approach, and I think it's  
2 going to limit practice.

3 MEMBER BOLTON: With that, should we vote  
4 on that?

5 CHAIRWOMAN KEELS: It does not have to be  
6 unanimous unless enough people are concerned about  
7 that. I don't -- I just don't see how it further  
8 restricts. It is referring back to current statute  
9 or rule in one place for somebody instead of trying  
10 to go find it and then go find another thing. We'll  
11 define what Interpretive Guideline means so that  
12 people understand this is not anything new, it's just  
13 pulling everything together, Jody.

14 MEMBER MINIARD: I agree. I mean, I  
15 think I feel like it's been sort of a consensus and a  
16 lot of misunderstanding after the meeting, like I  
17 mentioned to Jesse earlier at OAAPN. At that summary  
18 there was this whole thing about how it's going to  
19 restrict practice and there's more rules.

20 And no one here is setting rules or  
21 legislation. We're simply giving guidance. If  
22 someone chooses to misinterpret that and use it to  
23 regulate NP practice, that's on the employer. It's  
24 not going to come from the State or the Board of  
25 Nursing.

1 I think we have to erase that idea that  
2 what we're doing here with IGs and scope of practice  
3 is trying to limit practice. We're trying to make  
4 practice better. We're all fighting to get  
5 independent practice. We're not fighting to regulate  
6 your practice. We're fighting to give you guidance  
7 in your practice so it makes it better for all of us.

8 Because the more that we understand, we  
9 all as a community, as a society, understand what  
10 APRNs are, what they do and what their roles are, the  
11 better we will all be, but just -- I just -- I don't  
12 want people to think that -- That word regulation  
13 keeps getting thrown around at the table by lots of  
14 different people. And I think it's -- that's not at  
15 all I think what's happening here.

16 MEMBER ZAMUDIO: So for clarification, I  
17 think that personally the part that I was most  
18 concerned with is the definition because that is new  
19 and that is not in the statute, that's not in the  
20 rules, so we are drafting new things there.

21 MEMBER MINIARD: Yes.

22 MEMBER ZAMUDIO: So removing our own  
23 definitions that we've come up with would make it  
24 more palatable or to bounce off Brian's idea would be  
25 less angst by not inserting a definition that we've

1 come up with but to use the official definition. So  
2 I think that would be one thing that I think would  
3 cause less angst for folks.

4 And interpretive, that word does mean  
5 that you are interpreting the law for us, the  
6 pre-existing laws. I don't see a statement in here  
7 saying that it was approved by the AG or that the AG  
8 looked at it. As you know, I do case reviews. I  
9 think that would be really important to write down if  
10 that's been reviewed by the Attorney General when  
11 this is done because this isn't just an FAQ. Like  
12 you said, this is a more involved process. This is  
13 not the same.

14 CHAIRWOMAN KEELS: I don't know, though,  
15 if the IG has that disclaimer.

16 MEMBER ZAMUDIO: But we could say that,  
17 that it has been reviewed. So that as an employer,  
18 someone does go to that website and says, "Hey, are  
19 you allowed to do this," we can say, "Look, the Board  
20 put out this. You guys are the experts in the law  
21 and the legislation and the Attorney General did  
22 review it." So I think that would be important to  
23 put in there.

24 MS. EMRICH: I can't make that  
25 determination right now.

1 MEMBER ZAMUDIO: I mean, they are  
2 reviewing it, right? We would just be saying that.

3 CHAIRWOMAN KEELS: I'm assuming that  
4 somewhere in the process is written down on what an  
5 IG goes through, I would assume, but I don't know  
6 that for sure, so we would need to find out.

7 MEMBER ZAMUDIO: I think it would make  
8 people feel more comfortable if they're like other  
9 people have looked, it's not just someone trying to  
10 restrain us or, you know... other people have looked  
11 at this as well from a legal perspective, that might  
12 be helpful. So do we agree to change or to remove  
13 the definition or just that line?

14 CHAIRWOMAN KEELS: We agreed to remove  
15 the line that referred back to setting but to retain  
16 I believe the rest of that as a way to explain where  
17 when we talked about acute care practitioners....

18 MEMBER DIPIAZZA: Not acute care  
19 practitioners but the patient who requires acute  
20 care, not practitioners.

21 MEMBER ZAMUDIO: Are we going to use the  
22 professional definitions like the ones you quoted,  
23 Jody, from the program?

24 MEMBER DIPIAZZA: From NONPF, I thought.

25 MEMBER ZAMUDIO: I still don't know what

1 we voted on. I'm just trying to clarify.

2 MEMBER MINIARD: What we voted on was to  
3 move forward with the IG, to remove the sentence --  
4 wait, keep the first paragraph, then it would say,  
5 "For purposes of this Interpretive Guideline, the  
6 term acute care," and then you explain blah, blah,  
7 blah, the most time sensitive, individually-oriented  
8 diagnostic and curative actions whose primary purpose  
9 is to improve health. A proposed definition of acute  
10 care includes the health system components or care  
11 delivery platforms, used to treat sudden, often  
12 unexpected urgent or emergent episodes of injury and  
13 illness that can lead to death or disability without  
14 rapid intervention." That's what I thought we voted  
15 on.

16 And then on the Decision-Making Model,  
17 there may be we need to revise that, and we talked  
18 about many different ways that we could do that,  
19 where we could have links to definitions from NONPF  
20 or I don't know, something in the -- I don't know how  
21 that works, but we voted on that, on the IG, is what  
22 I understood, not changing, just removing those  
23 sentences.

24 MEMBER GAGER: Which is a combination of  
25 the Decision-Making and the IG.

1 CHAIRWOMAN KEELS: Correct.

2 MEMBER DIPIAZZA: Right.

3 MEMBER MINIARD: Yeah, we have both,  
4 FAQs, Decision-Making Model and IG.

5 CHAIRWOMAN KEELS: We're going to have so  
6 many resources, people won't know what to do with it.

7 MEMBER SIEVERS: Which is not good  
8 always.

9 CHAIRWOMAN KEELS: They all say the same  
10 thing, that's the key.

11 MEMBER BOLTON: And they do define the  
12 scope.

13 CHAIRWOMAN KEELS: Yeah, that's part of  
14 the conversation. Okay, we'll move on, yeah? Is  
15 anybody -- Do we have any public comments? Anyone  
16 fill out a yellow form for public comments? Does not  
17 appear so.

18 Brian, did you want to say anything else  
19 about the CRNA title?

20 MEMBER GARRETT: The American Association  
21 of Nurse Anesthetists put -- the AANA put out within  
22 the last year a Position Statement on titles and  
23 descriptors and it has caused some discussion at the  
24 national level.

25 I just want to officially state from the

1 President of the state association, because I'm not  
2 on the association anymore -- I quote-unquote retired  
3 a month ago, the pay is great -- that they do not  
4 have an official position and they don't have any  
5 agenda items tied to anything to do with that  
6 Position Statement at this time, just to be clear on  
7 that.

8 CHAIRWOMAN KEELS: I did think the  
9 content of the statement was important, though, in  
10 that there are many titles that are used to describe  
11 APRNs, like mid levels, physician extender and then  
12 some non-state approved titles as well. So I think  
13 it's important to have those discussions.

14 I don't know what, if anything, the Board  
15 can do to help that. A lot of it comes from the  
16 billing coding world and sort of practices and  
17 language, but it was making the point that it's  
18 archaic and not reflective of our practice.

19 MEMBER GARRETT: They're talking about  
20 mid level and things like that, I say that we don't  
21 officially -- not sponsor, those aren't the words  
22 that we are using anymore. Had a whole list of  
23 titles and descriptors and things like that, and I  
24 have all that on my phone.

25 MEMBER ZAMUDIO: Who was making that

1 statement, Brian?

2 MEMBER GARRETT: AANA.

3 CHAIRWOMAN KEELS: Oh, AANA, right?

4 MEMBER GARRETT: So one of those things  
5 it talked about, though, he gave a list of  
6 descriptors and titles and accepted descriptors such  
7 as mid level practitioner is outdated -- and I don't  
8 even know what that word is -- but the current  
9 healthcare system and it talked about a few other  
10 words -- oh, CRNAs should not be referred to as mid  
11 level practitioners, nonphysician extenders,  
12 independent practitioners, allied health care  
13 practitioners.

14 CHAIRWOMAN KEELS: We can e-mail this to  
15 you so you can review it. I thought it was an  
16 important discussion. I thought it was very well  
17 written and as we have those discussions back at our  
18 organizations... So thanks for bringing that up.

19 Next we are going to schedule our 2020  
20 meetings, so grab your phone. And we're meeting  
21 quarterly; is that right? Three times, so like every  
22 four months. So our next meeting would potentially  
23 be on... when's the Board retreat?

24 MS. EMRICH: It's in April.

25 CHAIRWOMAN KEELS: So what looks good to

1 you guys? February 24th? March 2nd? March 9th?

2 MEMBER ZAMUDIO: February 24th.

3 CHAIRWOMAN KEELS: Pardon me?

4 MEMBER ZAMUDIO: February 24th. That  
5 would be the four months.

6 MEMBER MINIARD: Can't do that.

7 MEMBER BOLTON: Can you do the 2nd?

8 CHAIRWOMAN KEELS: Can we do March 2nd?

9 MEMBER ZAMUDIO: As long as my partner  
10 doesn't deliver early, yes.

11 CHAIRWOMAN KEELS: When is the June  
12 Board?

13 MS. EMRICH: It's on the 17th of March.

14 CHAIRWOMAN KEELS: So March 2nd. Then  
15 April, May, June. Do we want to keep it on  
16 June 29th?

17 MEMBER SIEVERS: When is AANP?

18 CHAIRWOMAN KEELS: I don't know. It's  
19 June 23rd through the 28th. So June 29th, is that  
20 pushing it? Is that a yes? Okay. July 6th?

21 MEMBER SIEVERS: That's fine.

22 MS. EMRICH: Coming off the July 4th  
23 weekend.

24 CHAIRWOMAN KEELS: Is that okay? Okay.  
25 So going into November, the 23rd....

1                   MEMBER BOLTON: Before or after  
2 Thanksgiving is the question.

3                   MEMBER MINIARD: That is Thanksgiving  
4 week. I think so.

5                   MS. EMRICH: It is.

6                   CHAIRWOMAN KEELS: Would you prefer the  
7 16th?

8                   MEMBER BOLTON: Yeah, let's do the 16th.

9                   CHAIRWOMAN KEELS: Okay, November 16th.  
10 I love it when we can make decisions. So March 2nd,  
11 July 6th, November 16th.

12                   Anything else? Any other things we  
13 should be thinking about?

14                   Well, thank you for all of your input and  
15 your suggestions, recommendations. Conversation has  
16 been really good, lots of things to think about. I  
17 appreciate it. We are adjourned. Thanks, guys.  
18 Safe travels.

19                   (The meeting was concluded at 2:16 p.m.)

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CERTIFICATE

I do hereby certify that the foregoing is a true and correct transcript of the proceedings taken by me in this matter on Monday, October 28, 2019, and carefully compared with my original stenographic notes.

*Cynthia L. Cunningham*  
Cynthia L. Cunningham

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