ADVISORY COMMITTEE ON
ADVANCED PRACTICE REGISTERED NURSING
---
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.
---
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

ARMSTRONG & OKEY, INC.
222 East Town Street, Second Floor
Columbus, Ohio 43215-5201
(614) 224-9481 - (800) 223-9481
Monday Morning Session,

---

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

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

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

MS. EMRICH: Lisa Emrich, Board Staff.

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

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

MEMBER SIEVERS: Sherri Sievers, FNP.

MEMBER ZAMUDIO: Michelle Zamudio,
Certified Nurse Midwife.

BOARD MEMBER KLENKE: Lisa Klenke, Board
Member.

MEMBER BOLTON: Pam Bolton, acute care
and CNS.

MEMBER MINIARD: Jody Miniard. I'm an
acute care nurse practitioner representing faculty.

MEMBER GARRETT: And Brian Garrett representing the CRNAs.

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

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

MEREDITH: Meredith from OAAPN.

JENNIFER: Jennifer, OAAPN.

MR. DILLING: Tom Dilling, Board Staff.

MS. ROSSELET: Robin Rosselet, APRN.

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

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

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

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

MS. ELMORE: Kelly Elmore, CRNA with UC
in Cincinnati.

CHAIRWOMAN KEELS: Thank you. Welcome.

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

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

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

We'll come back and have general
information and updates. And then we'll tackle the
draft of the Interpretive Guidelines. Then we'll
have some more public comments. And then we will
have some discussion around APRN-CRNA title and
schedule our 2020 meetings.

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

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

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

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

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

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

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

So I feel that the IG and FAQ will be valuable and help answer some routine questions and to demonstrate to chief stakeholders that APRNs are well positioned to move forward with full practice
authority which will still be based on our population focus.

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

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

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

In fact, the Attorney General opinion
stated clearly that nothing requires a nurse 
practitioner to be certified in acute care in order 
to provide services to patients because we all 
provide acute care services, but at some point, the 
acute issue may become so critical and life 
threatening, that those with acute care certification 
are the ones that are qualified to care for that 
patient.

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

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

For instance, there was a statement made 
that no other state regulates specialty practice. So 
if we're talking that specialty practice describes a 
specialty certification that an APRN gains expertise 
in within the population focus, this is true. States
do not regulate that specialty certification within a population focus like oncology or cardiology or urology if those certifications exist, right.

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

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

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

So those were some comments that I reflected on the transcript and I'm hoping that that
helps sort of frame our discussion as we move forward because I have a feeling a lot of it is going to be on the IG as it tends to be.

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

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

I did e-mail him directly and I asked him about that. And his response was that it is simply an example showing the differentiation that the confusion can cause. It was in no way highlighting what an acute care NP versus a primary care NP can do in a practice.
CHAIRWOMAN KEELS: Thank you for clarifying that. I appreciate that.

Any other discussion?

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

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

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

And then I did notice that he recommended a Decision-Making Model as well for four different states. So I think he did point out we're one of 16 -- Ohio's one of 16 that have a required
collaborative agreement for this period in time.

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

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

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

MEMBER SIEVERS: I just noticed that in these recommendations on what we should do going forward, that it wasn't explicit that he was saying that the Board should further define. It was more based on some mitigation strategies with education and working with the institutions. It did say that
review the state's scope of practice, not that there
should be anything really specifically that he
recommended coming out of there.

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

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

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

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

CHAIRWOMAN KEELS: Oh, I'm sorry.

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

I wasn't sure what we were supposed to
get out of it. I read the thing, I did a little
research on her. And I think her takeaway was that
there's threats to the license for FNPs in mental
illness treatment which we were touching on a bit. I wasn't sure what we were supposed to take out of that.

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

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

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

MEMBER SIEVERS: Yeah, and I agree. And one thing it brought to my attention was that this -- what we've been discussing really doesn't address going across different certifications. It doesn't
address the NP family practice and what is their
ability to care for mental health or women's health
or -- so I wasn't sure if that was something we were
going to go down and that's why this was brought up
or -- you see what I'm saying?

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

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

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

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

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

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

Next up, I think Jesse, are you
representing OAAPN?

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

CHAIRWOMAN KEELS: And Josecelyn is...

all right. Come on up.

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

CHAIRWOMAN KEELS: Oh, Angela, please come up.

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

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

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

As you know in October of 2018, Senator Portman passed a bill for allowing CNSs and CNMs to be able to be part of the MAT treatment across the nation if the states would allow it. The issue we
got into was not actually with Ohio Revised Code or
rule, I should say, was the federal SAMHSA agency did
not open up their website to allow CNSs and CNMs.

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

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

CHAIRWOMAN KEELS: Did you get yours?

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

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

MR. MCCLAIN: Yeah. Well, it's okay.
The education was free and nobody could pass on
further education even though it's not formal
education technically in a school setting. But you
can't pass up free education, so it was nice to learn
and I'm stilling trying to talk my collaborator into
going it because in northeast Ohio, we have a big
problem.

CHAIRWOMAN KEELS: How long is it valid
for?

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

CHAIRWOMAN KEELS: Okay.

MR. MCCLAIN: Go ahead.

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

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

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

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

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

So the plan was then to start basically
asking legislators what are you comfortable with,
what do you think, you know. So right now we have a
sub bill that we got back on Wednesday or Thursday
that we're kind of reediting and drafting. It's not
technically a transition to practice, but the idea is
to have the SCA for maybe 2,000 hours, and then after
2,000 hours, the SCA is retired.

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

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

Right now by their law, they cannot do
the x-rays at certain centers because there's not a
physician on-site. And we had a few members, APRNs
in rural Ohio where they were having trouble getting
x-rays. They had reached out to their Senator. I
think it was a Senator who was going to try and put
it in the budget bill as just cleanup language, but
that never actually got completed.

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

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

MR. MCCLAIN: Yes.

CHAIRWOMAN KEELS: Is that right?

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

So, yeah, so the substitute bill when
it's finally correct will get dropped by
Representative Brinkman and go back into the Health
Committee hopefully for more hearings and then
hopefully a vote and move on. That's the plan.
MEMBER ZAMUDIO: I have a question. So a lot of the opposition that I have heard revolved around supposition, well, this could happen and the sky could fall and we could have all these kinds of things happen. When talking to the supposition more at the state level, have they looked at the information from the overwhelming number of states who already have removed that and looked at those outcomes?

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

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

Again, we’re not getting rid of collaboration. We’re getting rid of the written mandate that you have to have someone. We’re still
expecting and there isn't anyone at this table or in
the state that's still not going to professionally
collaborate every day.

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

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

MEMBER ZAMUDIO: Thank you.

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

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

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

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

So I appreciate the intent. I just don't think the goal's going to be there. But lumping us
in with RNs, you know, it's just not ideal. And I think it's, again, an evidence of a juris doctorate from Long Beach, California not understanding or someone in Texas, and I think it was Michelle who brought up that -- how it works in Texas. That's a restricted state. I'm not too comfortable with Texas law, but according to AANP's website, they're a restrictive, supervised state. So I'm not shocked that they don't have APRNs on committees deciding scope of practice, you know.

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

Miller did comment the NONPF white paper about primary care is not limited to preventive maintenance care of the well person but includes continuous care for patients with stable, acute or chronic conditions. And I think we get into this, all right, what kind of patient it is; where I think we need to start thinking about what it is that APRN is treating in that patient.
Again, working in neurology, I may be consulted to adjust the patient's seizure medicines when they're in the ICU for ARDS but I would be the first one to tell you you don't want me touching a patient with ARDS, but I'm not handling anything to deal with that.

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

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

So we admitted we have a scope of practice Decision-Making Model three years ago almost to the date. I feel like we're using it. In the three years you guys have been arguing this -- well,
many of you, some of you have changed -- have been
arguing this point -- the sky -- not to use a cliche
again -- the sky has not fallen. You know, patients
are not being harmed. APRNs may or may not be
reported, but like the world is not coming to an end
in Ohio. If there were safety issues, rest assured
we would hear about it, the Board would hear about
it. That's just not happening.

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

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

You said not all APRNs go through a
credentialing process, but I would argue the ACNP-FNP
issue isn't an issue outside of those hospital systems. And even in rural hospitals, we have APRNs that are chief medical officers in some of these rural hospitals. They're running the show. Trinity over in Dennison, Ohio, Eric is the CMO of that hospital.

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

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

And I just feel like more regulation isn't the answer. Answering the questions, sure, we all have to do that. We hired a lawyer just to answer FAQs at OAAPN. The Board of Nursing, that's gonna be what it is, and I don't think this
Decision-Making Model or this Interpretive Guideline is going to prevent questions from still being flooded in. So that's my comments, take it or leave it.

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

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

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

I feel it's working. It's not that I'm against it. I just don't feel like this is needed. We have something that's working. It's not going to
answer the questions. They're still going to e-mail the questions. I feel what we have is working and it's okay to walk away.

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

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

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

Hospital systems maybe got scared and became a little more restrictive, you know, and changed their hiring policies which is okay, they have every right to do that. And I'm not saying hospitals can't do that. I'm not saying employers
can't do that. I just don't feel the Board of Nursing should be doing that. That should be a hospital system to be worried about it. I don't think the Board should restrict it when we're not really sure what the APRNs are -- you know, their intent is.

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

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

You know, doing something just because we've been talking about it for three years isn't ideal either. Oh, we have to do something, we talked about this. No, it's okay to say, you know what, we need to move on, we have bigger issues in Ohio.
Yeah, they're going to send in questions anyway, we're moving on. That's wisdom to know when to move on. I think it's time to move on.

CHAIRWOMAN KEELS: Pam.

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

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

MR. MCCLAIN: But I mean, that nurse knew enough to ask whether or not that was in their scope,
and I think that's where -- I mean, they sent out the
questions but they didn't send out their answers or
when the questions came in or when the answers went
out.

MEMBER BOLTON: Right.

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

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

MR. MCCLAIN: Uh-huh.

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

MR. MCCLAIN: I think that's how it was
originally written, as to be broad and to give that
empowerment to the hospital systems and employers. I
agree, but I don't think that question is going to be any better answered with those colorful graphs is my argument.

MEMBER BOLTON: Okay.

CHAIRWOMAN KEELS: Jody.

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

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

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

And I think that as faculty, that is my responsibility, and I solely see that, but I can speak from my institution and my students, that I
talk about this a lot. I meet with students before they come in, are you sure this is what you want to do because if you want to be in this, you want to do this when you're done. If you think you want to do this, you're in the wrong program, you need to switch programs.

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

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

And during that meeting, we had said over and over that this is simply an Interpretive
Guideline. It's not law or rule. It is still the APRNs' responsibility to understand their scope. It's just to help them, right. So I think that was kind of taken out of context.

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

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

Because OAAPN is talking a lot about what APRNs in the State of Ohio are saying, but I've never seen a true -- like have they ever surveyed their members about what they feel about maybe not this attachment A, but what do they feel their understanding of scope of practice is?
Because I've never -- I'm an OAAPN member and have been for years, probably going on 15 or 16 years, but I've never received anything about that. So speaking for everyone, I'm just a little bit confused as to how -- what the -- kind of what Pam said, what is a better thing because I'm not sure that this is really working as well as people are saying it is.

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

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

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

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

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

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

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

CHAIRWOMAN KEELS: Brian, did you have a question?

MEMBER GARRETT: Yeah. Just on the
outside looking in as an educator, and so correct me
if I'm wrong, but for undergraduate education, it's
very prescriptive -- it's more prescriptive on what
the education would be, but for graduate education,
they defer to the accrediting bodies.

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

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

And there's several ways to do it. They
can either have Interpretive Guideline and FAQ or
like the other guy said, get their prescriptives and
making sure that they have done certain things or a
continuing education credit thing or something like
that.

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

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

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

So it's not necessarily that the schools
are the issue. It's the accrediting body. And we
have a specific gap here and we have to fill that.
So, again, I'm just a process person on the outside
looking in, and we have to get that filled because I
teach professional aspects courses for anesthesia
education, but it is very prescriptive. It's down to what....

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

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

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

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

MR. MCCLAIN: Right.

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

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

And then maybe it would decrease the questions. And it would be more beneficial, I get CEU credits for it, and then I don't have to do the
one on nursing that I -- my wife and I go, "Why are we doing this?" My wife is a nurse practitioner, by the way. "Why are we doing this?" I would like to have one that's to me. How cool would that be, right? That's where I was going with that. Sorry.

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

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

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

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

(Multiple people talking at once.)

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

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

MR. MCCLAIN: But to fix this problem,
all right.

CHAIRWOMAN KEELS: Actually... Sherri.

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

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

I think that the flip side of that, you know, I have many of your students, and they still do come out confused. I had an acute care student that applied for an outpatient clinical job, and we just don't put our acute care folks there because they're not in that scope at all.
And so I think it's the employer responsibility to have clear job descriptions and postings that require the -- I would never allow a Family Nurse Practitioner to be in a surgical trauma or ICU at our institution.

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

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

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

And here's an example that you're still going to get questions, I just love No. 5. I had a
certificate to prescribe and where do I do that. So clearly you're going to have people who are just not understanding, right?

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

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

MEMBER SIEVERS: Sorry.

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

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

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

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

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

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

CHAIRWOMAN KEELS: Lisa.

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

One of my concerns is the lack of knowledge and education particularly when there's not an APRN who's very articulate on scope of practice
that may be assisting with making some of those decisions. Some of the I think opposition that you may hear may be the lack of knowledge.

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

MR. MCCLAIN: Absolutely.

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

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

It's very different if you're in the Cleveland Clinic or you're a small rural hospital like I am, but in smaller community hospitals, I can
tell you they struggle because there's not the
ease to determine. So they may artificially
narrow the scope of practice just because it's
comfortable for them.

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

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

CHAIRWOMAN KEELS: Anything else?

MEMBER ZAMUDIO: Just a quick point.

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

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

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

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

So we have to keep in mind the overall picture here. You're talking about Interpretive Guideline for CNPs. The Decision-Making Model is for all of us. That is a huge distinction.
So I think one of the decisions should be are we going to have these Interpretive Guidelines for CNPs only which would pigeonhole a lot of us or do we need a Decision-Making Model like the one we have last updated in 2017, although we've been doing this for a while, it was updated in 2017 that addresses all nurse practitioners and maybe some education to fill that gap.

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

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

MEMBER GARRETT: So just a suggestion for the group name for Jesse -- my being a solution guy, so what if OAAPN came up with a specialty specific CEU that's mandatory that is specific to your specialty, my specialty. And then OAAPN partners help write that and then the Board of Nursing, if you
have an NP or an CRNA to... or discipline with the
Board, you could say, look, you didn't complete, do
all this, and they say I didn't know, I didn't go to
the website or have the FAQ, so both sides get what
you want.

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

MEMBER ZAMUDIO: It's a good one.

CHAIRWOMAN KEELS: Pete, did you have a
question?

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

No one's disagreeing as a neuro CNS that
you can't take care of the neurological needs of
someone in the critical care, but would I want you to
intubate me or manage my drips, right? I wouldn't
want to do that.

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

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

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

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

    And it was your comment, Michelle, that
made me think about this. Are we making an
assumption that everyone who comes to this
Decision-Making Model has a certain set of knowledge.
And with that knowledge that comes forward, it's
really going to drive how those questions are answered.

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

MEMBER ZAMUDIO: I agree.

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

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

MEMBER BOLTON: Okay. And you may be
right, and I don't remember all of how that was
brought forth. In here, its procedure, task or
activity is within the scope of practice. So it's
making in my interpretation, and I would need the
Board to correct this, it's once you've determined
what that scope is, then is this particular
procedure, task or activity appropriate to that
scope.

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

MEMBER BOLTON: Correct.

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

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

MEMBER MINIARD: I just want to make one
comment to Lisa and Pete, that I think that we have
to be -- I think that, again, I would second, Pete, that we do need some sort of Interpretive Guideline or FAQ or something that's more specific to the scope of practice of APRNs in the State of Ohio.

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

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

MEMBER SIEVERS: One final thing that does involve Jesse.

CHAIRWOMAN KEELS: Doesn't involve?

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

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

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

So we're not addressing the complete issue of scope of practice for all APRNs, and I think that is like the top thing in my mind that's falling short. So being a CNS, I didn't know if you could speak to that and where you see yourself with this guideline.
MR. MCCLAIN: I mean, I'm an adult CNS per my national certification, and that certification no longer exists outside of just renewal, so it does create a problem. Obviously the top of the page says for nurse practitioners, so obviously it doesn't apply.

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

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

And I agree, I mean, it would be nice to have the Decision-Making Model that we already have.
that applies to all APRNs rather than this subset
because it does seem like a target on FNP, you know,
rather than a target on acute care because I have
acute cares that are working in outpatient settings
with stable patients. And then you get into that
whole question of, all right, should they be doing
that; well, what are they treating.

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

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

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

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

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

MR. MCCLAIN: There's critical care
scenarios.

MEMBER DIPIAZZA: But it's very specific
to critical care, right. So going into that, you
know I can manage critical care population. The way they've set up our programs for FNPs and acute care, adult geri, acute care pediatric, adult geri, I mean, it's just created its own problem in itself, but I think that's why this is so specific to acute care and FNP and it doesn't include midwives and CNSs and CRNAs. Just my observation.

CHAIRWOMAN KEELS: Lisa, then Jesse.

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

MR. MCCLAIN: This graph, though, creates a question for your hospitalist NPs. You know, a hospital that has a psych floor that has an obstetrics floor that has an acute care floor or critical care floor, you know, you read this and it's like, oh, my gosh, if I want to work as a
hospitalist, I better have my acute care
certification, my psychiatry psych NP certification,
my women's health certification.

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

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

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

So to me, I thought the graphs were
trying to -- to me, they do -- that if you're a
primary care certified NP, you have the scope of
practice that you are certified in and educated in
and then you continue to learn in -- through clinical
experience and education within your scope within
your population.

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

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

Then the next question is, well, I have
to get my acute care to go to the ICU even though
it's not setting specific. You know, I have to go in
there to hand off -- go to the ICU even though I'm
not handling their acute care condition.
Should I be going to the women's health floor? Should I be going to the psych mental health floor? This discussion has created more questions than has helped the situation.

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

MR. MCCLAIN: Agree.

MEMBER DIPIAZZA: -- who have made those decisions.

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

MR. MCCLAIN: Triage.

MEMBER DIPIAZZA: -- acute abdomen, I'm consulting general surgery. So, I mean, in the practice of hospital medicine, that's where I feel like the Interpretive Guideline would really benefit the Advanced Practice Nurse working in the hospital setting because it could help with further direction for the administrators that are making the decisions that aren't accurate, nor reflect what we should be doing.
CHAIRWOMAN KEELS: Any further comments, Jesse?

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

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

MR. MCCLAIN: Sorry. Happy to answer anything.

(Multiple people talking at once.)

MEMBER BOLTON: Thank you, Jesse.

CHAIRWOMAN KEELS: Thank you very much.

Right, go get a drink of water.

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

Do we want to do -- I see Tom is here.

Do you want to do legislative reports and then we'll break for lunch?

MR. DILLING: Sure. It will be quick.

CHAIRWOMAN KEELS: Does that sound okay?

Stay on time.

MR. DILLING: Yeah, I think Jesse has already given a legislative report. I did get to meet with the OAAPN earlier this week, and they came in and explained similar to what Jesse explained as
to what they were doing with the bill and how they were adjusting the original legislation based upon interested party comments and on proponent/opponent positions. So we'll see what happens at the end of the year with that bill.

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

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

There is a Committee -- there's a couple Committees, it's confusing, as to whether or not you should continue on as the Nursing Board or any type of professional Board, and that's like a bigger type
of issue, and we're not going to be called in front
of that Committee for a year or two, I guess.

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

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

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

That's something that, too, could
potentially be solved in House Bill 177, but I think
really the fact that it's there today is a -- more of
a political thing than actual functional thing. So
maybe this helps the politics if there's a Committee
that, you know, is informed that not much is
happening in those Committee meetings. The need is there in the same way.

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

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

You actually are doing things here. And quite frankly, I'll add in my own opinion, this was some of the best dialogue that I've ever seen at any Committee that I've been involved in, both at the Medical Board and the Nursing Board. Is that part and parcel of having taken three years to get to this
point? Changing in different people and so forth?

I'm sure there's a little bit of truth in everything, but it does go to show that when you work in a collaborative way, you bring things out in a transparent manner that often leads to the best decision-making at least, again, in my opinion.

That's about it for legislative report right now.

CHAIRWOMAN KEELS: Any questions for Tom?

MEMBER BOLTON: Thanks, Tom.

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

CHAIRWOMAN KEELS: Thank you.

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

(At 11:30 a lunch recess was taken until 12:30.)
CHAIRWOMAN KEELS: We're back. Thank you, guys. Thank you for coming back, everyone. Next on our agenda are the general information and updates, so next up is renewal. Lisa.

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

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

MEMBER BOLTON: I had one of those.

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

MEMBER MINIARD: That's why I did it.

MEMBER SIEVERS: So you're sending specifically to these folks?
MS. EMRICH: Yes, we have been sending e-mails to APRNs that have not renewed. Now here's another one, 1,191 are the number of current APRNs who have neither renewed their RN and then, therefore, have not obviously renewed their APRN. So that's about 1,800 total APRNs who have not yet renewed.

CHAIRWOMAN KEELS: So tell your friends.

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

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

If the renewal application is not complete as of midnight, October the 31st, the
license will lapse and you will not be authorized to
practice unless you reinstate the license. So
just... I cannot emphasize -- October 31st is a
Thursday, coming up.

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

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

CHAIRWOMAN KEELS: The program actually
shut it off.

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

MR. DILLING: Just along those lines, not
to put us on the spot, I apologize to Lisa, because
when I was at the ONA Leadership Summit, something
came up, an APRN afterwards made the similar comment.
She was more specific to could there be a button that
pops up at the end that says Press Here To Take You
Back To This Page. And if that was there, she felt
like that would make it so much easier so just in
addition to the theme there on that.

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

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

CHAIRWOMAN KEELS: Thank you.

MS. EMRICH: I have over the past few
months, we've been working with the Department of
Administrative Services and all to look at
enhancements as we call it to the E-license system.
I think the button back to the CRNA would be a good enhancement.

MEMBER MINIARD: To remind you.

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

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

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

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

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

CHAIRWOMAN KEELS: He gets the good catch award.

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

Anita, she printed off what the actual response was, if people want to see this. I
scratched out the person's name, but I can pass this around if you guys want to take a look.

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

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

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

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

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

CHAIRWOMAN KEELS: I believe so.

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

CHAIRWOMAN KEELS: Sure. It makes sense.

Do you want to read it?

MEMBER GARRETT: Sure. It says regarding the appearance of generally APRN's scope of practice
is not determined by the setting in which the APRN practices.

CHAIRWOMAN KEELS: Yes.

MEMBER GARRETT: What about CRNA?

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

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

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

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

Similarly, APRN licensure renewal is
based on current valid RN licensure and proof of
having maintained one's national certification. This
necessarily includes meeting all CE and any other
requirements necessary to maintain that particular
national certification.

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

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

4723.804 OAC and APRN CSA would
necessarily include a statement of services to be
provided by the APRN. Regarding specific procedures,
treatments, et cetera, have you had a chance to
review the attached APRN Decision Model that assists
APRNs? It assists APRNs in determining if a
particular procedure is within their scope and may be performed consistent with standards. It is attached for convenience -- it says that twice. It is attached for your convenience and it is attached for your convenience.

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

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

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

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

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

CHAIRWOMAN KEELS: Any other comments about the questions that -- the sample of questions because the Board gets more than just that in front
of you, but it was sort of a representative sample.

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

MS. EMRICH: The responses, no.

MEMBER ZAMUDIO: Oh, but the questions?

MS. EMRICH: No.

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

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

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

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

MEMBER ZAMUDIO: Okay, thank you.

MEMBER GARRETT: Just to clarify, just
take a task of intubation, obviously because it's
common to all of us, doesn't matter where it's at as
long as it's for that patient population that you're
managing, right? It doesn't matter where it's at in
the hospital; is that what that's saying? I'm trying
to understand your role, so....

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

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

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

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

CHAIRWOMAN KEELS: Yeah.

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

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

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

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

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

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

CHAIRWOMAN KEELS: Lisa.

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

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

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

MEMBER GARRETT: Yeah, the e-mail was a general e-mail to all APRNs, and we've been asked at
times to put ourselves, well, if you're inside these
courts these walls, you can do it, but if you're in
these four walls, maybe, maybe not. I'm not saying
that's a pass. I'm just saying that's discussions
that occurred. It didn't seemed like a general list
for all APRNs where it's not limited to any
geographical setting in a facility or something like
that.

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

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

CHAIRWOMAN KEELS: A baby in the NICU,
right.

MEMBER GARRETT: Right.

MEMBER DIPIAZZA: The airway.

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

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

CHAIRWOMAN KEELS: Is it in the Momentum.

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

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

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

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

I'll read off of yours. So, again, this is just a draft, and for those who don't have a copy,
questions include: What are Ohio's requirements for APRN licensure?

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

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

Which APRN license and designations authorize the licensee to prescribe?

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

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

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

I am a CNS whose national certification is in child adolescence psych mental health. This certification examination and its resulting national certification are now retired and no longer available. Seeking the current national certification in psych mental health across the
lifespan is not my career plan. May I continue to practice as long as my national certification is maintained?

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

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

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

(Multiple people talking at once.)

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

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

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

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

I am aware of the licensure exemption section in 4723.32, Ohio Revised Code, that is applicable to any person acting in an emergency.
Since I indeed hold an APRN license, how is this applicable to my APRN practice?

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

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

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

CHAIRWOMAN KEELS: Does this pertain to this?

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

CHAIRWOMAN KEELS: You want to take an FAQ?

MEMBER GARRETT: If I can take an FAQ.

CHAIRWOMAN KEELS: Yeah, go ahead.

MEMBER GARRETT: The CRNA specialty is the first specialty that is going to require you to get your doctoral degree, and 90 percent of programs are holding this over. Ohio is kind of the last
holdout. So the traditionally doctor-prepared nurses are then in academia or in a research setting. And now you're going to have APRN CRNAs who are not prepared going into the hospital.

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

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

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

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

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

CHAIRWOMAN KEELS: Yeah, before APRNs
become doctorally prepared, how is that used in the context of the clinical side.

MEMBER MINIARD: It's not.

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

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

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

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

MEMBER GAGER: I think you can encompass
DNPs out practicing with the same question.

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

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

MEMBER GARRETT: -- doctoral-prepared
nurse.

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

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

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

(Multiple people talking at one time.)

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

MEMBER GARRETT: In the professional
organizations or other... their system can guide them there.

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

MEMBER MINIARD: Yeah.

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

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

MEMBER MINIARD: Yeah.

MEMBER SIEVERS: More directive.

MEMBER MINIARD: Yeah, that would be nice.

CHAIRWOMAN KEELS: Probably won't capture all clinical scenarios, but if you can -- but the answer to the question we read does encompass a lot of questions that may come, like where do I start and how do I figure this out which is what we're trying to do with Interpretive Guideline but perhaps FAQs might be either more helpful or together would be really good, and we're going to get to that in a second.
I do want to make a quick announcement that Lisa can, the Board website is going to be updated. I don't know if you all were aware of that. So I saw a demo a little while ago and it looks really nice. It feels like it's easier to navigate.

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

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

MS. EMRICH: Early next week.

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

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

So I'm assuming everybody's had a chance to review. So why don't we go around the able and everybody sort of individually provide some feedback
for a few minutes, not too long. I might have to use
the gavel if we go too long, so we can get some --
see where our areas of consistency are and where our
areas of diversity are. Do you want to start?

MEMBER GARRETT: No.

CHAIRWOMAN KEELS: Pete, do you want to
start?

MEMBER DIPIAZZA: No, I didn't really

have any comments. I think that we need an
Interpretive Guideline. I know there's a lot of
hangup around the graphs or the pictures that were
provided. I like them because it's a nice visual,
and I'm a visual kind of person.

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

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

MEMBER DIPIAZZA: I mean, no, I don't. I
thought Lisa did a great job of lowering the lines down.

MS. EMRICH: It was actually Chantelle.

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

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

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

CHAIRWOMAN KEELS: Thanks.

Angela.

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

MEMBER DIPIAZZA: No, you're fine.

MEMBER GAGER: I still think there's a lot of gray in here. Where does red stop and orange begin, and what defines that? And I just -- I don't know, I think it's just going to create new questions. So I like more of a decision-making tree and the FAQs versus graphs. I think it's a little more concrete rather than I feel a vague visual representation. But I do think we need something to
answer questions across the Board, not only for practicing APRNs but for employers, for all of us.

CHAIRWOMAN KEELS: Thank you.

Sherri.

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

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

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

CHAIRWOMAN KEELS: Can you read that for me?

MEMBER SIEVERS: The paragraph says, "The term acute care encompasses a range of clinical
health function including emergency medicine, trauma
care, pre-hospital emergency care, acute care
surgery, critical care, urgent care and short-term
inpatient stabilization." So those to me are all
locations because the patient that might be under the
umbrella of emergency medicine can be very vast.

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

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

MEMBER GAGER: Can I add something to
your statement?

MEMBER SIEVERS: Yes, please.

MEMBER GAGER: I think that this part
also, so much of this overlaps. You can have various
key issues develop in a primary care setting and you
are going to intervene in that as you pass that
patient on to the appropriate setting or the
appropriate provider and that's where this gets gray.

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

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

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

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

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

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

MEMBER SIEVERS: That's what it was.

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

MEMBER SIEVERS: Right.

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

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

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

CHAIRWOMAN KEELS: Probably not.

MEMBER SIEVERS: -- and answers students' questions or does it make it more confusing. And
worse, is it going to be used against someone with
good intentions who was trying to do the right thing
but because it's gray it can always be gray to a
negative and not always gray to support us in what
we're trying to help people do the right thing.

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

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

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

CHAIRWOMAN KEELS: Okay, great, thanks.
Michelle.

MEMBER ZAMUDIO: So I did a lot of
preparation for this part. I want to start with
saying I agree with what's been said so far, that we
do need something. I do think we need a
Decision-Making Model, and I use those words from the
Consensus Model from all of the research articles.
They all recommended DMM, one set a DMT,
decision-making tool, so we do need something to
clarify it.

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

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

I do agree with Sherri, the graphs are
only fodder for the attorneys. That is going to be
presented in a court, it's going to be blown up on a
screen and to be honest with you, not everybody
prints in color, okay. So this is going to be black
and white when it's printed off, right.

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

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

So I think this could quickly become
obsolete if we use those eight models -- or I mean
eight graphs there. So I don't think the graphs are
helpful. I do think we need a Decision-Making Model.
I do think ours needs to be changed and updated. I
think we should avoid pigeonholes again for the
attorneys.
We do have a lot of layers of checks and balances, but I like Erin's idea that this isn't about checks and balances, this is about helping us too as NPs. Like, this is to help us. That's what we are trying to do, our charge on this Committee, is to help other NPs look at that website. So I think we should do something to help provide clarification.

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

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

The World Health definition that's listed, it could describe somebody in labor on some of those. I don't think that that should be in anything that we do. I think it should stay more focused on the legislation and the rules and laws than necessarily providing a definition that you guys
might get in school or something, but I don't think that's appropriate to put in this guideline.

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

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

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

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

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

MEMBER ZAMUDIO: Absolutely. I love that. I like the idea that they can click on their link, right, so they're not printing off the IGs,
they're not thinking about where the -- the lines are, but they can actually look in the rules. I think that's very helpful to them. Whether you're an experienced provider or a new graduate, I think that would be helpful. The OAAPN version that they put forth, it was kind of a yes/no....

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

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

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

Lisa.

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

And I like Pam's comment earlier, the current Decision-Making Model, which might be the gap
that we talked about, the very first question is, is it within your scope of certification. Well, if they can't make that decision, then they can't follow the Decision-Making Model. And so I wonder if the Interpretive Guideline provides the context to support the Decision-Making Model if we don't expand the Decision-Making Model.

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

Then the only other thing, in terms of the attachment, I know that the attachment is intended to identify those gray zones, and if anything, I think we should recognize that it's not an easy decision and allow nurses to know this is
intended to help guide, but it's -- a patient situation is so fluid and changes so easily, that there may be times when while you're waiting for handoff to somebody who has more expertise to manage that patient, you'll find yourselves in a situation with trying to manage the situation as opposed to the whole patient.

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

CHAIRWOMAN KEELS: Yeah. Thank you.

Pam.

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

I also think that a graph would be helpful, but I think a couple things. When I look at some of the individual comments, one talked
specifically about chronic conditions. I almost 
think that we need a graph that looks at acute, 
chronic, stability, instability.

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

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

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

CHAIRWOMAN KEELS: Thanks so much.
Jody.

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

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

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

I like the idea of a decision-making tool or model. Maybe if you revise that, work off the current one, put current links to these comments about -- from NONPF about an acute nurse practitioner can take care of a chronic -- it says chronic -- chronic, complex or deteriorating patients and then what the statement is for NONPF about FNPs, you know, stable, primary care, you know.
And maybe you would just have links to those statements and you just click on that. Is this within your scope of practice; if you're an FNP, click here. And then they can -- that to me makes more sense than graphs and language in the front because I would agree with the comment that Sherri made I think about it's very setting specific in that language that's on that first page, and I think that's going to create a lot of issues.

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

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

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

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

MEMBER SIEVERS: But emergency medicine --

MEMBER MINIARD: It does go on to list sites.

MEMBER DIPIAZZA: It doesn't say settings. It says encompasses a range of clinical
health care functions including... It doesn't say settings.

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

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

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

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

MEMBER SIEVERS: -- I think it's having people that aren't always -- they might be acute care certified, but they're not always in a life and death situation. They are down here which this is just as vague for your folks on the opposite end that are in some specialty clinics. Somebody could say, well, that patient's green because they're in an outpatient clinic and they're all good and your people shouldn't be in there.
CHAIRWOMAN KEELS: So if we remember why we were looking for that definition, we were trying to articulate where a primary care certified person's care management of that patient probably ends and is handed off, and it's when that could lead to death or disability without intervention.

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

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

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

CHAIRWOMAN KEELS: So we've become hypersensitive to anything that might reflect back on settings.
MEMBER MINIARD: I like the beginning of it too.

MEMBER SIEVERS: I agree with you.

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

CHAIRWOMAN KEELS: Good points, guys.

Brian.

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

And you could put on the next page what is the responsibility of the APRN-CNP related to the role as far as accountability and responsibility as an FAQ. I just -- when I hear people talk, the word interpretive, it gets everybody anxious. And it's a
guideline that isn't quite as -- are we really
interpreting anything or are we just guiding them to
the current information.

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

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

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

I see there's a lot of similarities, so
maybe redo the graphs where it's here's what excluded
instead of included because I see a lot of color and
very little white. And if you flip it around and
delineated to that, that's just teaching adults and
teaching exclusionary stuff. Well, we have the
exclusionary and inclusionary, well, there you go.
Everybody is all happy. So it's just something....

CHAIRWOMAN KEELS: Good point.

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

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

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

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

MEMBER SIEVERS: But I think we're still
trying to put everybody in a box and there's a lot of
different scenarios. So I like Jody's idea to have
kind of the question and then the link which allows
them -- they have to work through a set of questions
to say was I trained in this? Do I have education?
Was this part of my certification? Was this in the content outline for my test? And if they get any no's....

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

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

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

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

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

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

I like having this all in front of me.
I like the definition of acute care for the purposes
of the acute care certified practitioner to help
provide that sort of guidepost there. I like that
there's accountability and responsibility for the
individual sort of pulled out.

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

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

    MS. EMRICH: You're the Chair.

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

    MEMBER BOLTON: Second.

    CHAIRWOMAN KEELS: It's been seconded.

All those in favor....

    (All respond aye.)

    CHAIRWOMAN KEELS: Okay, so thank you for
trying to do that. I really do appreciate that.
Question 2, I think everybody is on Board with FAQs, so I think -- I know Lisa and her staff wants to get through renewal time and we'll be able to work more on that and perhaps have a draft for our next meeting. So I like the FAQs, and I think that will be very helpful.

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

MEMBER MINIARD: Can I make a motion?

CHAIRWOMAN KEELS: Yes, make a motion.

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

CHAIRWOMAN KEELS: Is there a second?

MEMBER BOLTON: Second.

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

MEMBER SIEVERS: I have a question.

MS. EMRICHT: So just to clarify, on the draft IG in front of you, we are going to remove from that first indented paragraph, which is actually the third paragraph, we're going to remove the last sentence which is cited from Hershon Brisco, correct?
MEMBER MINIARD: Right, starting with the term acute care encompasses.

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

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

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

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

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

MEMBER MINIARD: Yes.

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

MEMBER MINIARD: It's in the National
Organization Nurse Practitioner Faculty white paper further notes that primary care is not limited to preventive maintenance for the well person. On the other hand, the acute care NP provides care for patients with unstable, chronic, complex, acute and critical conditions.

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

MEMBER ZAMUDIO: Yeah. The certification program --

(Multiple people talking at once.)

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

MEMBER DIPIAZZA: No, go on.

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

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

MEMBER DIPIAZZA: I don't know about that.

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

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

MEMBER MINIARD: Unstable.

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

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

MEMBER DIPIAZZA: Right. And so I think really just going one step further and making it very
clear what we're saying here is acute is they're going to die if you do nothing with them.

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

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

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

MEMBER DIPIAZZA: I'm looking at it just from the FNP side. This is what defines where my
role ends in the care of this individual.

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

MEMBER BOLTON: You know....

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

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

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

MEMBER ZAMUDIO: It's a good point.

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

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

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

(Multiple people talking at once.)

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

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

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

MEMBER ZAMUDIO: What's chronic? How long?

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

CHAIRWOMAN KEELS: Would you propose that sentence to define?

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

MEMBER BOLTON: I wonder if we should take a back door to this. Maybe we should try to create that Decision-Making Model and then let the
Decision-Making Model decide what needs to be defined and what doesn't.

MEMBER MINIARD: That's a good idea.

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

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

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

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

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

MEMBER BOLTON: That would drive them there. That would drive them to their competencies, drive them to their test exam. I mean, when I was
trying to determine what scope was for my
institution, that's where I went, you know. And I
did seek the Board's assistance because....

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

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

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

Is there something we're gaining
specifically by the Interpretive Guideline? Maybe
this is more explanation before we have a vote. And
then I saw somewhere in the voting we have a period
of discussion too; isn't that right?

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

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

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

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

In the past, these IGs have really been
prepared for RN and LPN kind of practice because they
needed some more information about how to apply laws
and rules to very specific practices. This is the
first one we've had as far as APRNs, that it seems to
be requested and appropriate. So it's about taking
existing law and rules and applying it to the CNP
scope of practice and how did the laws and rules
about national certification population folks, all of
that is applied from the laws and rules down.

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

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

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

CHAIRWOMAN KEELS: Do you want Lisa to address that?

MS. EMRICH: Sure.

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

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

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

MEMBER SIEVERS: What about a Decision-Making Model?
MS. EMRICH: The Decision-Making Model, the Board has reviewed and approved those.

CHAIRWOMAN KEELS: Lisa.

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

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

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

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

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

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

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

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

CHAIRWOMAN KEELS: Thank you.

Michelle.

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

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

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

MS. EMRICH: No.

MEMBER ZAMUDIO: -- for the --

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

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

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

CHAIRWOMAN KEELS: The wording IG
contains -- is nothing new. It's already out there. It's just pulled into one document.

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

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

MEMBER BOLTON: Yeah, it references.

CHAIRWOMAN KEELS: Angela, did you have a comment?

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

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

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

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

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

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

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

MEMBER GAGER: Well, birth control
options. FNPs, I work with several FNPs who do IUDs.
I don't do an IUD. I don't have supporting
physicians that work with me. I don't have the
training. At one point, I was being trained to do colposcopies, but that requires the training, the continuing with that certification, so there's an additional skills and certifications you can get within your scope.

MEMBER BOLTON: Perfect. Those are great examples --

(Multiple people talking at once.)

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

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

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

MEMBER BOLTON: Yeah, I know. Thank you.

CHAIRWOMAN KEELS: Good point.

MEMBER SIEVERS: You just sparked a question for me. So if it's not enforceable, could the group live with the content and not calling it an Interpretive Guideline? What would be the negative for us, for our practice, for the people that we manage, our students, the APRNs in Ohio for not calling it an Interpretive Guideline but accomplishing the same end goal which is to provide clarity?
MEMBER BOLTON: Can I ask a question?
MEMBER SIEVERS: Yes.
MEMBER BOLTON: What's adverse to Interpretive Guideline?
MEMBER SIEVERS: What -- what Michelle alluded to as being -- how it is impacting folks negatively. While the Board cannot enforce it, I think because of what it is, and correct me if I'm wrong if there's legal folks that can weigh in, that it carries a different weight.
MEMBER MINIARD: But isn't that just a --
MEMBER GARRETT: It doesn't matter how people are perceiving it. It's like we said last time when we asked for the Interpretive Guidelines, what was the Interpretive Guideline last time?
CHAIRWOMAN KEELS: Pete.
MEMBER DIPIAZZA: You know, I wanted to say so that's why we need the Interpretive Guideline, though, because all of these health systems have interpreted it -- they've hyper-reacted to the Momentum article, and that's why having Interpretive Guideline would be really helpful because now it's more, for lack of a better word, official from the Ohio Board of Nursing that the Ohio Board of Nursing has come out with these Interpretive Guidelines that
allow us to practice more freely or in a way we
should be practicing.

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

Jody.

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

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

MEMBER GARRETT: All I'm asking from last
time, if we keep the word Interpretive Guideline, I
don't have a problem, but it just needs to be what
you just said in bold letters right underneath it:
Interpretive Guideline is... not blah, blah, blah
because they're not going to go to the other part of
that. We all know how we are, we're not going to go
to the other part of the website, we're not going to
go look it up, we're going to go right here and then
we're good.

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

CHAIRWOMAN KEELS: Thank you,
Mr. Process.

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

MEMBER SIEVERS: Is there anything else
we could call it?
CHAIRWOMAN KEELS: No, not if we do it in this form, but Lisa has a handout and we sure can address that.

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

CHAIRWOMAN KEELS: There it is.

MEMBER MINIARD: Period. Bolded at the top.

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

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

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

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

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

MEMBER DIPAZZA: They don't represent all of the stakeholders.

MEMBER ZAMUDIO: No, no, definitely. I'm not saying that. I'm certainly not -- I had some significant problems with the one they put forth too. What I'm saying, to avoid what's been going on, if you look at our process so far, it's not very effective and that is that it keeps coming back to
us. We're responding. A month later, it goes back. A month later, it comes back. Either meet more frequently or let's just get this done.

CHAIRWOMAN KEELS: Brian.

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

CHAIRWOMAN KEELS: Do we have to make another motion?

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

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

CHAIRWOMAN KEELS: Oh, well, thanks.

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

CHAIRWOMAN KEELS: Sorry about that.

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

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

MS. EMRICH: Well, we can preface this with either the companion documents or we can even insert it in here.
CHAIRWOMAN KEELS: The motion was that we move forward with an IG with suggestions that have been made to help.

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

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

CHAIRWOMAN KEELS: Jody?

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

MEMBER ZAMUDIO: I've come and gone.

MEMBER MINIARD: How far they have come
in the last year to even have anything remotely like this....

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

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

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

MEMBER DIPIAZZA: It's on the site.

MS. EMRICH: Yeah, it's a statement about the Board -- a statement about APRNs working to the full extent of their licensed authority.
MEMBER SIEVERS: Right. Could that not be what we're talking about and it's something this Board publishes and has their name on?

MEMBER DIPIAZZA: It's on there already.

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

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

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

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

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

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

MS. EMRICH: Right, exactly.

MEMBER DIPIAZZA: What she's referring to
is the Practice of Nursing Scopes of Practice
document that you guys have published already.

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

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

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

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

CHAIRWOMAN KEELS: For a Decision-Making
Model.

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

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

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

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

And no one here is setting rules or
legislation. We're simply giving guidance. If
someone chooses to misinterpret that and use it to
regulate NP practice, that's on the employer. It's
not going to come from the State or the Board of
Nursing.
I think we have to erase that idea that what we're doing here with IGs and scope of practice is trying to limit practice. We're trying to make practice better. We're all fighting to get independent practice. We're not fighting to regulate your practice. We're fighting to give you guidance in your practice so it makes it better for all of us.

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

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

MEMBER MINIARD: Yes.

MEMBER ZAMUDIO: So removing our own definitions that we've came up with would make it more palatable or to bounce off Brian's idea would be less angst by not inserting a definition that we've
come up with but to use the official definition. So
I think that would be one thing that I think would
cause less angst for folks.

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

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

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

MS. EMRICH: I can't make that
determination right now.
MEMBER ZAMUDIO: I mean, they are reviewing it, right? We would just be saying that.

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

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

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

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

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

MEMBER DIPIAZZA: From NONPF, I thought.

MEMBER ZAMUDIO: I still don't know what
we voted on. I'm just trying to clarify.

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

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

MEMBER GAGER: Which is a combination of the Decision-Making and the IG.
CHAIRWOMAN KEELS: Correct.
MEMBER DPIAZZA: Right.
MEMBER MINIARD: Yeah, we have both, FAQs, Decision-Making Model and IG.
CHAIRWOMAN KEELS: We're going to have so many resources, people won't know what to do with it.
MEMBER SIEVERS: Which is not good always.
CHAIRWOMAN KEELS: They all say the same thing, that's the key.
MEMBER Bolton: And they do define the scope.
CHAIRWOMAN KEELS: Yeah, that's part of the conversation. Okay, we'll move on, yeah? Is anybody -- Do we have any public comments? Anyone fill out a yellow form for public comments? Does not appear so.
Brian, did you want to say anything else about the CRNA title?
MEMBER GARRETT: The American Association of Nurse Anesthetists put -- the AANA put out within the last year a Position Statement on titles and descriptors and it has caused some discussion at the national level.
I just want to officially state from the
President of the state association, because I'm not on the association anymore -- I quote-unquote retired a month ago, the pay is great -- that they do not have an official position and they don't have any agenda items tied to anything to do with that Position Statement at this time, just to be clear on that.

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

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

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

MEMBER ZAMUDIO: Who was making that
statement, Brian?

MEMBER GARRETT: AANA.

CHAIRWOMAN KEELS: Oh, AANA, right?

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

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

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

MS. EMRICH: It's in April.

CHAIRWOMAN KEELS: So what looks good to
you guys? February 24th? March 2nd? March 9th?

MEMBER ZAMUDIO: February 24th.

CHAIRWOMAN KEELS: Pardon me?

MEMBER ZAMUDIO: February 24th. That

would be the four months.

MEMBER MINIARD: Can't do that.

MEMBER BOLTON: Can you do the 2nd?

CHAIRWOMAN KEELS: Can we do March 2nd?

MEMBER ZAMUDIO: As long as my partner

doesn't deliver early, yes.

CHAIRWOMAN KEELS: When is the June

Board?

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

CHAIRWOMAN KEELS: So March 2nd. Then

April, May, June. Do we want to keep it on

June 29th?

MEMBER SIEVERS: When is AANP?

CHAIRWOMAN KEELS: I don't know. It's

June 23rd through the 28th. So June 29th, is that

pushing it? Is that a yes? Okay. July 6th?

MEMBER SIEVERS: That's fine.

MS. EMRICH: Coming off the July 4th

weekend.

CHAIRWOMAN KEELS: Is that okay? Okay.

So going into November, the 23rd....
MEMBER BOLTON: Before or after Thanksgiving is the question.
MEMBER MINIARD: That is Thanksgiving week. I think so.
MS. EMRICH: It is.
CHAIRWOMAN KEELS: Would you prefer the 16th?
MEMBER BOLTON: Yeah, let's do the 16th.
CHAIRWOMAN KEELS: Okay, November 16th.
I love it when we can make decisions. So March 2nd, July 6th, November 16th.
Anything else? Any other things we should be thinking about?
Well, thank you for all of your input and your suggestions, recommendations. Conversation has been really good, lots of things to think about. I appreciate it. We are adjourned. Thanks, guys. Safe travels.
(The meeting was concluded at 2:16 p.m.)
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