Proceedings

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ADVISORY COMMITTEE ON
ADVANCED PRACTICE REGISTERED NURSING

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MEETING
before the Advisory Committee on Advanced Practice Registered Nursing, at the Ohio Board of Nursing, 17 South High Street, Suite 660, Columbus, Ohio, called at 10:00 a.m. on Monday, March 2, 2020.

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Advisory Committee on Advanced Practice Registered Nursing:
Erin Keels, APRN-CNP, Chair
Peter DiPiazza, APRN-CNP, Member
Sherri Sievers, APRN-CNP, Member
Michelle Zamudio APRN-CNM, Member
Jodi Mielard, APRN-CNP, Member
Angela Gager, APRN-FNP, Member
Pamela Bolton, APRN-ANCNP, APRN-CNS, Member
Also Present:
Lisa Emrich
Chantelle Sunderman
Anita DiPasquale

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Monday Morning Session,
March 2, 2020

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CHAIRWOMAN KEELS: By my phone it's 10:00, so we'll go ahead and get started. Good morning, everyone. Welcome to the Ohio Board of Nursing APRN Advisory Committee.

The charge of this Committee is to advise the Board regarding the practice and regulation of Advanced Practice Registered Nurses, and may make recommendations to the Committee on prescriptive governance.

My name is Erin Keels. I'm the Chair of this Committee. I would like to welcome everyone. We're going to have some introductions.

Before we do that I'd like to remind everybody to silence your phones and your pagers, and anything else that may be distracting. And then I'd like to ask the Committee to introduce themselves.

Go ahead and tell us your name, where you're from, your APRN role, and your role on the Committee.

To my left.

MS. EMRICH: Lisa Emrich. I'm Board Staff Program Manager.

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1  MS. DI PASQUALE: I'm Anita DiPasquale, Board Staff.
2  MEMBER GAGER: I'm Angela Gager. I'm a Family Nurse Practitioner. I teach at Washington University, so I am part of the faculty advisory.
3  MEMBER SIEVERS: Sherri Sievers. I'm a Family Nurse Practitioner representing APRN practice from Cincinnati.
4  MEMBER ZAMUDIO: I'm Michelle Zamudio also from Cincinnati. I work with the University of Cincinnati's College of Medicine, and the residency program at the Christ Hospital in Cincinnati.
5  MEMBER BOLTON: I'm Pam Bolton. I am an Acute Care Nurse Practitioner from Cincinnati, and I represent the employer.
6  MS. SUNDERMAN: Chantelle Sunderman, Board staff.
7  CHAIRWOMAN KEELS: And again, I'm Erin Keels. I'm a Certified Nurse Practitioner from Columbus, and I am the Board representative for this Committee.
8  Now, who do we have visiting with us today? Would you like to introduce yourself?
9  MR. SNYDER: My name is Eric Snyder, I

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am Southeast Region Director for OAAPN.

MS. DRING: Jennifer Dring, OAAPN.

MS. GABELE: I'm Christina Gabele, Emergency NP and Family NP from Akron. I teach at Walsh, and work in the ER in Akron.

MS. SULLIVAN: I'm Tori Sullivan. I'm a student at Capital University.

MS. WELLS: Betha Wells. I'm also a student at Capital University.

MS. CLARK: Charlie Clark. I'm also a student at Capital University.

MS. SIEVERS: Dina Sievers, student at Ohio State.

MS. DUBACH: I'm Jessica Dubach, I'm staff at ONA.

MR. DELILLE: Eli Delille, I'm a student at Marshall University.

MS. HUFFMAN: Kate Huffman with the Ohio Hospitals.

CHAIRWOMAN KEELS: Thank you. Welcome. Member DI PIAZZA: And I am Pete DiPiazza. I apologize for being late. I represent the FNP's in primary care.

CHAIRWOMAN KEELS: Hi, Pete. So if you wish to speak during this Committee, we have time for

1 (Pages 1 to 4)

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We have worked to remain informed of important legislative efforts, and advise the Board on certain APRN issues such as recertification process -- or relicensure process, excuse me.

And I'm very proud to work with this Committee. I think we have gotten a lot of work done, and I'm looking forward to this year and working on more things.

All right. So any comments from the Committee?

(NO response.)

CHAIRWOMAN KEELS: All right. So next on the agenda is the public comment section. Anybody in the gallery have public comments to make?

(NO response.)

CHAIRWOMAN KEELS: Okay. Thank you.

All right. Next is APRN Advisory Committee application period.

MS. EMRICH: There are a couple positions whose terms expire in 2020. There will be an application process similar to what you went through before.

Pete, I believe yours and Michelle's and Jody's are up this year, so you'll want to -- we will email you when those applications are available, and then they will be -- for anyone else who would like to apply, those will be available this month; should be.

CHAIRWOMAN KEELS: So those positions are an APRN Faculty Member, a Certified Nurse Midwife, and an APRN in primary care.

MS. EMRICH: Correct, understanding that yours, Michelle, doesn't expire until July.

MEMBER ZAMUDIO: I had a question about that. So if I stepped in just to help because someone else stepped out, is that a second term under -- like the agreements that I read, it said you can reapply.

Can I still reapply since I stepped in partway through?

MS. EMRICH: Yes, you're filling an unexpired term, an existing term. That's what you are doing.

MEMBER ZAMUDIO: Okay. Thank you.

CHAIRWOMAN KEELS: Great. Okay. So next up would be the five-year review, but Holly is not with us yet.

MS. EMRICH: I sent her a note.

CHAIRWOMAN KEELS: Okay. I thought we would have more public comments.
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<td>1. MEMBER DI PIAZZZA: We're ahead.</td>
<td>1. The other changes, as we go, the Board has consistently changed any reference to &quot;individual&quot; to &quot;patient&quot; when it does refer to the patient, so you'll see a change in that word, the verbiage.</td>
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<td>2. CHAIRWOMAN KEELS: That is a first in the history of this Committee.</td>
<td>3. And the other significant change is that when it comes to treatment of pain in rule -- it's in the same rule -- I'm on page 11 -- that we have added oncology and hematology certified APRNs as those who may potentially exceed 120 MEDs in those certain circumstances.</td>
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<td>4. MEMBER SIEVERS: Can I step back just real quick? So will her spot be open at the same time as these other two even though it's not on the same timeline?</td>
<td>5. So we recognize that they would be working with pain patients, specifically. And that was discussed previously at the Advisory Committee.</td>
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<td>6. MS. EMRICH: I think the appointment date will take effect the day after her current term expires.</td>
<td>7. CHAIRWOMAN KEELS: We also -- terminal condition.</td>
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<td>8. MEMBER SIEVERS: But the application period will be for all of them?</td>
<td>9. MS. EMRICH: In rule -- the definition of terminal condition, this is on page 2, was adopted to mirror the same definition that the Medical Board has adopted. And this comes into play when treating pain.</td>
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<td>10. MS. EMRICH: Yes, I think we'll do all of them at the same time. It just makes sense to do it that way.</td>
<td>11. CHAIRWOMAN KEELS: And then consequently, this algorithm was updated to reflect that rule back to the definition of terminal.</td>
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<td>12. MEMBER SIEVERS: Correct.</td>
<td>13. MS. EMRICH: Yes, because of the rule</td>
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<td>14. MS. EMRICH: It will be the same, yes.</td>
<td>15.</td>
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<td>16. I can speak to the -- aside from the memorandum that's from Holly Fischer, included in your packet are just two separate pieces of rules.</td>
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<td>17. One is 4723-8-08, and this particular rule was effective February the 1st of this year, so I just wanted to include it in your packet.</td>
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<td>18. And the most significant thing about this rule, it was a technical change that was needed because it impacted APRNs who were receiving their initial APRN license during a renewal period.</td>
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<td>19. I don't know if you recall on that last renewal period, if you received your initial APRN license last July 1st, it was good only through October the 31st of that same year, and you had to renew with no fee.</td>
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<td>20. But the rule change -- and that was really a holdover from the implementation of House Bill 216.</td>
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<td>21. So we changed it so that any new initial license issued within that renewal period that begins July 1st will go through that whole two-year cycle, so they don't all have to renew again. So that will be helpful.</td>
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<td>22. The next rule that became effective February the 1st is 4723-9-10, which is actually the prescribing authority rule, and the most -- there's a few significant changes within this rule that we needed to accomplish this past year.</td>
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<td>23. One was the exclusionary formulary is now in rule. It is no longer just this document that is approved or adopted every -- it's in rule, so any change in the exclusionary formulary would require a rule change, okay? And that was required.</td>
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<td>1.</td>
<td>1. change, our prescribing flow chart was updated to -- at the bottom, the next to the last -- in the last open square, white square, it represents the terminal condition as defined in rule.</td>
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<td>2.</td>
<td>2. CHAIRWOMAN KEELS: 4723-9-10(A)(13).</td>
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<td>3.</td>
<td>3. That's the only change that was made to this.</td>
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<td>4. MS. EMRICH: Holly is on her way.</td>
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<td>5.</td>
<td>5. CHAIRWOMAN KEELS: Thank you. Do we want to just wait for her? Do you want to talk about CPG?</td>
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<td>6.</td>
<td>6. MS. EMRICH: Yes, we can do that.</td>
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<td>7.</td>
<td>7. MEMBER ZAMUDIO: I just have a -- is this the appropriate time to ask a question about the algorithm for prescribing?</td>
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<td>8.</td>
<td>8. MS. EMRICH: She may want to wait for Holly to come for -- Holly may want to hear your comments or questions.</td>
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<td>9. CHAIRWOMAN KEELS: Take it out of my done pile list.</td>
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<td>10.</td>
<td>10. MEMBER ZAMUDIO: I'm sorry.</td>
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<td>11.</td>
<td>11. MS. EMRICH: In the Sunset Committee for CPG and the APRN, we're required to respond to the Sunset Review Committee.</td>
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<td>12. This is the legislative kind of committee to look at the continuation or whether it's</td>
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necessary to continue with certain committees. And
Tom, on behalf of the Board, provided testimony, and
we have given you copies of that.
Consistent with what the CPG had
recommended, we are suggesting or recommending that
it be Sunset, the CPG, simply for the reasons stated
in the testimony and the questionnaire.

The exclusionary is in rule, the CPG
members themselves have said that they are not
inclined to add anything to the exclusionary
formulary at this point because it's really a matter
of standard of practice and the individual's
practice. So we feel there are other safety
measures.

MEMBER SIEVERS: What are we looking at
for timeline? What is the next steps there with Tom?
MS. EMRICH: Tom would follow up with
that. It would be a statutory change, and it would
not be -- I'm waiting to hear back what happens next.
We can't -- it doesn't automatically
happen, so --
MEMBER SIEVERS: Right. About a month,
six months?
MS. EMRICH: Time frame, I have no idea.
CHAIRWOMAN KEELS: Just trying to plan

your life out.
MEMBER SIEVERS: I have a meeting in a
couple weeks.
MS. EMRICH: That will still be held.
CHAIRWOMAN KEELS: Would Tom be able to
speak to that when he comes today?
MS. EMRICH: He may. We can ask him.
And of course, we also spoke to the work of this
Committee, and the value of this. So very good.
MEMBER ZAMUDIO: Question. So was the
exclusionary formulary put into rule because the CPG
was going away, or had we always planned to put it
into rule?
It seems if we're ever going to change a
formulary, now we have to go back and change rules
just to add or subtract a medication. I mean, do we
need to have that in rule?
MS. EMRICH: Yes. It was really a
requirement of JCARR.
MEMBER ZAMUDIO: Okay.
CHAIRWOMAN KEELS: And now it's in rule,
so it's going to be very, very challenging to make it
nonexclusionary, which is a good thing for APRNs,
right?
MEMBER ZAMUDIO: Right.

CHAIRWOMAN KEELS: But to your point, if
something does come up, I would assume that it would
get referred to this Committee if the CPG --
MEMBER ZAMUDIO: Like a safety with a
med?
CHAIRWOMAN KEELS: Yeah. And I can't
imagine that would happen unless it went across like
all three Boards or something.
MEMBER BOLTON: How will new drugs be
handled?
MS. EMRICH: Those are all items that
would have to be addressed. And/or they are
addressed like any other new drug now.
You still don't prescribe it unless it's
within your scope, and you can prescribe new drugs
now, it's just more of a retroactive review. But
there's nothing in rule now that prohibits an APRN
from prescribing a new drug before it's reviewed
by CPG.
CHAIRWOMAN KEELS: So it's much more
permissive within your scope.
MEMBER BOLTON: Excellent.
CHAIRWOMAN KEELS: I think that was
actually a good step.
Hi, Jody.

MEMBER MINIARD: Sorry.
CHAIRWOMAN KEELS: How are you?
MEMBER MINIARD: Sorry.
CHAIRWOMAN KEELS: It's okay, parking
and drive.
MEMBER MINIARD: There was an accident
in Cincinnati. I was stuck for like 40 minutes not
moving, and I'm like well, this is not good.
MEMBER ZAMUDIO: I know, I almost went
down the side of the road. I didn't, but I thought
about it.
CHAIRWOMAN KEELS: I'm glad you could
join us.
MEMBER MINIARD: Sorry I'm late.
CHAIRWOMAN KEELS: Right now we're
waiting for Holly to join us so she can review the
five-year review highlights. We are down to No. 6.
MS. EMRICH: Okay. I can speak to 6,
too.
CHAIRWOMAN KEELS: Okay.
MS. EMRICH: So having gone through, as
Program Manager involved directly with licensure this
last APRN renewal period, we looked at some things
that are maybe helpful through the next cycle of
renewals.
MEMBER ZAMUDIO: Okay. Got it.
CHAIRWOMAN KEELS: So those are already in effect.
MEMBER ZAMUDIO: Right.
CHAIRWOMAN KEELS: But then we do have a rule review, five-year rule review of 8 and 9.
MEMBER ZAMUDIO: Got it.
CHAIRWOMAN KEELS: Which Holly has joined us to talk about.
MS. FISCHER: Good morning. How is everybody this morning? Nice to see you.
CHAIRWOMAN KEELS: Good. Thank you.
MS. Fischer: Yes, so this year the rule Chapters that are scheduled for five-year review, which is the minimum time period that we're required to look at them, include Chapter 4723-8, 9, and 23; relates to dialysis, 8 relates to the standards of practice for the Advanced Practice Registered Nurses, and 9 is prescriptive authority. Chapters 8 and 9 were substantially revised after House Bill 216. And then there have been more changes especially to Rule 9-10 in the prescribing role because under the legislation it changes.
So even though we have a five-year rule review, it's definitely not been five years since we went into these chapters to look at changes.
The time frame for this process this year is based on your meeting schedule and our Board's meeting schedule, would be that at the April Board retreat, the Board would take a first look to see if it has -- the members of the Board have any changes to these chapters.
I have a memo that identifies changes coming from staff, things that look like they need to be cleaned up a little bit. So I will cover those with the Board at the April retreat.
Then at the May meeting, typically we would have a first draft of language. Then your group will meet again July 6. So by that time, this Committee's recommendation should be finalized to get to the Board members so that they can look at those changes at the July meeting if there are any.
We also have an intervening interested party meeting which is open to the public, and certainly all members of the Committee are welcome to attend. That's tentatively scheduled for June 22nd, so it will be before the July meeting.
So it would be best if we could get a recommendation from this group by the July 6th
meeting so the Board can consider the
recommendations.
The next step would be that I would file
the proposed changes with the Office of Common Sense
Initiative which is a branch of the Lieutenant
Governor's office, or it's also known as CSI.
Then they take a look at this. They
look at the adverse effect of any changes in the
rules as a whole. And then they need to send a memo
to us, and then we need to respond to that memo.
At that point in time we can file the
rules with the Secretary of State and JCARR, and we
do that usually in mid October.
There's a very limited window for
filing, and it's all based on when we want to
schedule the rule hearing, and there's a filing date
deadline for each rule that exists. So it's usually
around mid October.
Then we would have the public rule
hearing in conjunction with our November Board
meeting, usually the first day of the Board meeting,
which would be November 18th.
Then the rules would be subject to JCARR
final review, a JCARR hearing, and then a final
cross check.
then they would be
recommended that one hour be this, or we can say one
hour qualifies if it's in this area, or it could be
more than one hour.
So we're throwing it out there. We have
a lot of options. We could also add it -- instead of
adding it to 8, we could add it to our continuing
education rule, as I mentioned, for the RN.
So it's something I wanted you to think
about, if you have any opinions on that.
MEMBER ZAMUDIO: So Holly, is it sexual
assault or sex trafficking? Because they are
different.
MS. FISCHER: They are different, and
this would be geared toward sexual assault victims,
the victimology, how to identify, assess, and treat
those kind of people that have been through those
traumatic experiences.
MEMBER ZAMUDIO: I would hope that we
would include trafficking since Ohio is pretty high
on that list. And it's a national initiative to
identify those individuals. It's a form of assault,
but it's a different issue, and I think all
healthcare providers, not just APRNs, so I think RNs
 licensure would be a good time to add it.
MS. FISCHER: We have added that for
effective February 1st, 2021. So that's the whole
process in a nutshell.
So Chapter 8 -- this is on page 2 of the
memo that you have received. You can see we
don't have a lot of identified changes at this time.
If legislation is passed, particularly,
you know, the CRNA, pending House Bill 224, or other
pieces of legislation, then we would need to go in and change Chapter 8, and probably Chapter 9.
So what we have now is just what exists at this point
in time.
One of the considerations would be to
consider adding additional continuing education for
Advanced Practice Registered Nurses and identifying
and dealing with treating victims of sexual assault.
Some of this is emanating from a
study -- a work group, I should say, that involves
multiple state agencies, and is an outcome really of
Dr. Strauss' investigation, so what can agencies do
to better prepare their practitioners to identify and
treat victims of sexual assault.
So the CE could be added as part of the
RN 24 hours. It could be an additional hour. It
could be part of the APRN hours. It can be something
that is recommended. So out of the 24 hours it's
trafficking, and it's in Chapter 14. So it
references it up to one hour of CE in trafficking
counts towards your CE.
It's not mandated that you get the one
hour, though, it's that one hour will qualify for it.
So it's a distinction. If you have 24 hours, you
have to decide, okay, are you going to mandate that
one be in that area, and that change has not been
made.
So this would be -- we could do a
similar pattern, one hour or more could qualify, but
when you're only talking about 24 hours and there's
so many topics to consider, mandating it is, you
know, something that I guess -- then it takes away
from another hour and another subject.
MEMBER ZAMUDIO: So it would be
inclusionary like it would count towards your 24, but
not mandated.
MS. FISCHER: That's what we're here to
talk about, and whether or not that would be an RN,
or APRN, or both. But currently we don't have
anything except for -- either the trafficking, which
as you mentioned, is different.
CHAIRWOMAN KEELS: I feel like at the
very least it should be a recommendation that it
would be counted, somebody like that.

But I could see -- so I'm in neonatal
pediatrics, women's health. Even -- it seems like
sexual abuse goes across all populations. It would
be valuable to have that education. I don't know
whether it should be recommended or required or not.

MEMBER ZAMUDIO: So the other thing we
could do is link in our responsibility. I get a lot
of questions about what our responsibility is as
mandatory reporters.

And so I mean, maybe we should address
that. If you're going to have -- part of the CE
could be what is our role when we suspect that, who
is a mandatory reporter, how do you do it. I get a
lot of questions about that from resident physicians,
physicians, and faculty as well.

CHAIRWOMAN KEELS: Other comments?

MS. FISCHER: Is there any feeling at
this early point as to whether or not this is
something that would be better added to the RN 24
hours, or the APRN, or both.

MEMBER ZAMUDIO: I think RN.

MEMBER BOLTON: I think RN.

MEMBER GAGER: I agree as well.

MS. FISCHER: Is it the feeling it would be best in the form of a recommendation, it will
qualify for, but not mandatory?

MEMBER SIEVERS: If you don't mandate it
people won't do it.

MEMBER BOLTON: I think it should be
mandated.

MS. FISCHER: So it should be one of
the 24 shall be in this area, but not for the APRN 24
hours, just the RN 24 hours?

MEMBER ZAMUDIO: We would have to --

MS. FISCHER: Of course you would have
to do it.

MEMBER ZAMUDIO: I think it's important,
the RNs are at the bedside. A lot of times they are
directly with the patient, checking in at the
clinics, et cetera, so I think it's appropriate.

MS. EMRICH: Just a question. We can
have this -- maybe this discussion later. There's no
differentiation currently between mandatory CE for RN
and LPN, so would we require them both maybe, if it
was to go that route?

MS. FISCHER: I mean, that would be
something to consider as well.

CHAIRWOMAN KEELS: So this Committee is
recommending to require this as an RN CE for
relicensure, and this recommendation would then go to
the Board.

MS. FISCHER: Okay.

CHAIRWOMAN KEELS: Is there another
comment.

MEMBER SIEVERS: Just that I agree with
Michelle. The RNs are the ones that are doing the
safety screening -- are you guys doing that? So when
they are with a patient they say do you feel safe in
your home, and they are the ones documenting in Epic,
those screenings, so I think training would be good.

CHAIRWOMAN KEELS: And of course, then
we'll be required to complete it as well.

MEMBER SIEVERS: Right. They are
probably doing a lot more frontline screening than we
even are.

CHAIRWOMAN KEELS: But then as a
provider you're doing face-to-face, and if you get
that information --

MEMBER SIEVERS: But it would be good to
have education on how they handle that, and recognize
that, and throw questions to the patient.

CHAIRWOMAN KEELS: Okay.

MS. FISCHER: Okay. The other
legislative activity included the temporary licenses

for military members and their spouses.

Ohio's a little unique in that for
nurses we have always had temporary license permits,
and we don't condition that on being a member of the
military, so it can be open to anyone.

So these permits are issued to people
getting licensed by reciprocity, or we used to -- I
guess we call it endorsement, too, but this is not
something that we have implemented in the past for
the APRNs coming from other states.

So we would probably cross reference the
temporary permit possibly in Chapter 8, but we could
also do this in Chapter 2, which is the Chapter that
deals with military licensees and applicants.

So I wanted to bring that to your
attention, if anybody has questions about it.

MEMBER ZAMUDIO: So when they are
addressing the military licensure, does the rule
specify the military member, veteran or active, and
their spouse? Does it address the word dependent at
all?

Because I know there are dependents of
military who have tried to get licenses, and it's
been a very difficult process for them.

MS. FISCHER: I don't think so, I think
it's just spouses. I think --

MEMBER ZAMUDIO: I wish they had used

the word dependent.

MS. FISCHER: If you look -- has Tom
done his legislative report?

MEMBER ZAMUDIO: No.

MS. FISCHER: So on page 2 it kind of
gives you a little outline on the status of that, but
I've never seen dependent in conjunction with that.

MEMBER ZAMUDIO: To their children who
were maybe like couldn't get that -- but in Ohio, I
guess they could still do the expedited.

MS. FISCHER: Anybody can get a temp in
Ohio, and again, not conditioned on military status.

MS. EMRICH: It's in Tom's summary from
the last Board meeting.

MS. FISCHER: Does anyone right now,
before I move on to Chapter 9, have anything that
they have identified thus far they want to talk about
as a change in Chapter 8?

CHAIRWOMAN KEELS: Michelle, did you say

something about 8-08?

MEMBER ZAMUDIO: I thought it was 9.

Right now are we talking about like the -- you mean

the graph?

CHAIRWOMAN KEELS: No, Chapter 8.

MEMBER SIEVERS: It's everything.

CHAIRWOMAN KEELS: Advanced Practice
Registered Nursing, nurse certification of practice,
Chapter 2723-8.

MEMBER ZAMUDIO: Which handout are we

on?

MEMBER SIEVERS: It's not there, it's a

whole chapter.

MS. FISCHER: Does everyone have their
new lavender rule books? So it's really the whole
chapter that we look at. And if you have this copy,
it starts on page 99 of this book. This is where the
chapter starts.

CHAIRWOMAN KEELS: Sherri.

MEMBER SIEVERS: So we have House
Bill 177, but let's just assume -- let's take that
out and just look at the rules as they are.
I'm wondering if there's any tweaks that
could be made with the standard care arrangement that
is in rule and not in law?

One thing as an employer -- and I look
to Pam, maybe, and your other folks that have
institutional SCAs, is the two-year review -- so
we're coming up on that right now.

And the administrative burden that's
going to be put on our institution to redo 450
standard care arrangements is unreasonable.

I mean, it is -- and we did get the idea
that we could do like an out of station, but it still
is a resigning of something by all these people and
trying to get those signatures.

So I don't know how you all do that, but
other similar states like Kentucky, they have a
one-time -- it's in place until either party cancels
or revoked it.

And of course you would redo it if there
was a change, either an addition or deletion, because
we're notifying the Board, but if there are no
changes to it, that it could remain in existence
without a renewal two years.

The other thing I get tons of questions
on, and I'm not really sure how to explain it, is the
coalition with no more than five people who are
prescribing.

So I'm picturing the clinic where, you
know, you have a physician -- there's no number to --
and then I saw that was one of the FAQ questions --
about how many people can you be in a collaborative
agreement with, and there was no number.

But you can't be -- they all can't be
prescribing at the exact same time. So you have a
group of people, say you have six on in a day, you
know, do you say you don't prescribe at this moment
because I'm going to prescribe? I think it's very
confusing to people.

MEMBER ZAMUDIO: Definitely.

MEMBER SIEVERS: And really, I don't
understand the rationale behind it. If there's no
limit to the number of people you can have on your
SCA, if we could consider removing that limit for
prescribing.

MS. EMRICH: That's in statute.

MEMBER SIEVERS: Okay.

MEMBER DI PIAZZA: And I believe the
Board, at one point when this was first introduced,
when we increased the numbers, talked about it, it
being really scheduled, you know, how many nurses are
scheduled at one time.

MEMBER ZAMUDIO: It doesn't say that.

MEMBER SIEVERS: That's prescribing.

MEMBER DI PIAZZA: But they commented
looking at -- you know, think about how many are
scheduled at one given time, because if they are
scheduled and you're an Advanced Practice Nurse,
you're likely prescribing at any given time. That's what I recall.

CHAIRWOMAN KEELS: And your collaborating physician could be any number of collaborating physicians on your standard care arrangement.

MEMBER SIEVERS: But I think it assumes that you only ask questions or collaborate if you have a question about medication.

Our folks, the way our inpatient preferences it, it's kind of a team thing, and so I think -- I don't know that it covers -- but if it's in statute, it's a moot point.

CHAIRWOMAN KEELS: It's a very, very --

MS. EMRICH: It used to be three.

MEMBER SIEVERS: Two year --

MS. EMRICH: Two year. I think that's in rule.

MEMBER SIEVERS: So maybe just looking at pieces of some of those things, just trying to reduce the administrative burden on people.

CHAIRWOMAN KEELS: So that's a good point. And it would be interesting to understand what are those things that are only in rule that can be manipulated.

MS. FISCHER: It's kind of like every single thing you bring up, you've got to carefully check.

CHAIRWOMAN KEELS: Right. It's the statute.

MEMBER ZAMUDIO: You could say everybody can't hit the Epic sign button at one time.

MEMBER SIEVERS: But if it's in statute -- but those are some things that I think I would like to go back myself and try to look through, not for discussion today, but -- so if we have those, we just bring them --

CHAIRWOMAN KEELS: To our next meeting, and then --

MS. FISCHER: Yeah. If you can send them in to -- so Erin and Lisa have them, they can send them out to the group, so that when you get to your meeting everybody is fully informed.

The five prescribers, like Lisa said, it is in statute, but I, at the moment, can't figure out exactly where it is.

MS. EMRICH: .431.

MS. FISCHER: What paragraph?

MS. DI PASQUALE: It's in A.

MS. EMRICH: It's toward the bottom of the --

MEMBER BOLTON: And Sherri, just from the employer's side, I agree with you. I think it's very hard for medical staff -- especially for individuals, I just think it's very difficult for medical staff to do that as well. You want to have them updated LCA, so I would agree with you.

MEMBER SIEVERS: And it's in line with what -- some of the other states have kept some sort of agreement, like Kentucky.

MS. EMRICH: It's in the second paragraph of A1.

MS. FISCHER: So that one, there's little that we can do because of that. Now, the other one, Lisa, the two-year review period, that's also -- that's in 8-04, but is that in statute?

MS. EMRICH: It might be.

MEMBER DI PIAZZA: While you folks are looking, I just -- maybe a recommendation for the institutions that are looking at reappointment.

Most the institutions reappointment is every two years, so just doing it at reappointment, because they are already completing paperwork, might be helpful to smooth out the process.

MEMBER SIEVERS: The only issue with that is not everybody is on the same cycle.

MEMBER DI PIAZZA: You have to get them on the same cycle.

MEMBER SIEVERS: And you're constantly doing that.

MEMBER DI PIAZZA: At reappointment you get them on the same cycle. So some may have completed it six months ago, but now they are in cycle and they just renew it, a new one.

MEMBER SIEVERS: But the administrative people who support that then, it never ends. They would rather do it one time and be done because of the -- how we --

MEMBER DI PIAZZA: I don't know if that will be an easy change.

MEMBER SIEVERS: That's a thought for sure.

MS. EMRICH: We believe that it is only in rule.

MS. FISCHER: I think it is, too. I can't find it in law, so let's say we propose to discuss changing that every -- minimum of every two-year review. What would the alternative be, that it's only reviewed? I don't know, every four years?

Or it does not need to review unless changes are
made?

MEMBER ZAMUDIO: Right.

MEMBER SIEVERS: I think that.

MEMBER ZAMUDIO: Yes.

MEMBER SIEVERS: That's what we're doing currently. There may be more things, that just came to mind.

CHAIRWOMAN KEELS: I think now is the time to bring up questions so they can cross reference to statute.

My other question is, sort of thinking about the political piece of it, because if we work on making the standard of care arrangement a little easier, does that disrupt our efforts to remove it through House Bill 177?

MEMBER DI PIAZZZA: Right.

CHAIRWOMAN KEELS: I'm trying to think of unintended consequences.

MEMBER SIEVERS: Good point. And I haven't talked to anyone about it, I was just using that as sort of an example if there are things like that that are not in statute with those people.

MEMBER DI PIAZZZA: It might be worthwhile running by OAAPN and --

MEMBER SIEVERS: I can do that.

from nurses and APRNs learning in other areas, and I didn't know if the Board had kind of like a threshold before they say you know what, we're going to have to go back and increase the required CEs.

MEMBER ZAMUDIO: I don't think there's any evidence that shows a certain number of CEs making you safe or not safe. I wouldn't recommend adding to the requirement.

MEMBER DI PIAZZZA: No, I'm just concerned about taking away from learning that's pertinent -- not that sexual assault is not pertinent to their learning, but worried about taking away some of maybe the clinical CEs.

MEMBER ZAMUDIO: You can always do more.

MEMBER DI PIAZZZA: You could.

CHAIRWOMAN KEELS: But you don't require it. Like we said before, it's not mandatory.

MEMBER ZAMUDIO: But I have a question for Holly.

MS. EMRICH: APRNs have to maintain their national certification. You have to get lot of CEs for that.

MEMBER ZAMUDIO: This is probably for Lisa or for Holly. So back to the 8-08. And I know it's already in -- it's there, we can't change things, but I had a question just for clarification.

Where it talks about, on page I, under A-I-A and B, documentation satisfactory to the Board of our continuing education, and the fact that we have maintained our certification, what documentation is that?

Do we need to actually send you copies, or just when we renew that little box that says we have completed or CEs?

MS. FISCHER: Right.

CHAIRWOMAN KEELS: But you could be audited.

MEMBER DI PIAZZZA: It just said documentation. I thought you're going to have to send that then.

MEMBER MINIARD: I just have a comment. So when you renew your certification, you actually have to document and you have to say who --

MEMBER ZAMUDIO: And check the box.

MEMBER MINIARD: You actually have to put in what it is, who the sponsor is, so you can't just go on Joe Schmo's CE, it has to be a certain -- ANA or ANCC, or AANP, or some things like that?

MEMBER DI PIAZZZA: And some are required to be able to speak of the objectives of the
CE as well.

MEMBER MINIARD: I just renewed mine a few days ago, so it was very painful.

MEMBER ZAMUDIO: And that will satisfy that requirement?

MEMBER MINIARD: Yeah, it will for sure.

CHAIRWOMAN KEELS: From accurate recordkeeping, it will be helpful.

MEMBER MINIARD: Well, I did it.

CHAIRWOMAN KEELS: Anything else about Chapter 8 right now?

MEMBER ZAMUDIO: That's not open to any changes right now, this is just interpretive clarification?

MS. FISCHER: What?

MEMBER ZAMUDIO: So as part of this five-year review on 8-08 on the second page under C, I think writing the failure of the licensee to receive an application for renewal does not excuse them from the requirements, I thought that was pretty demeaning to say that's not an excuse.

I think if we said something to the effect of license holders bear sole responsibility for meeting these renewals, it's probably just semantics, but I thought that really sounded kind of demeaning to the provider saying well, that's not an excuse.

I understand the thought behind it, though, like we want to tell them us not writing to you doesn't mean you don't have to respond to it, so that was one thing.

And then in E where it said that they may be subject to disciplinary action in accordance with that section of the Revised Code, who provides the disciplinary action, is it the Board, or their national, or both?

MS. FISCHER: That would be the Board.

MEMBER MINIARD: The Board.

MEMBER ZAMUDIO: I just thought if we're going to revise this -- because it says does not excuse. These are professionals, I thought that sounded kind of demeaning.

MEMBER MINIARD: Just for the national certification question, you can let your national certification lapse at any point, certifying body --

MEMBER ZAMUDIO: They don't do anything.

MEMBER MINIARD: They don't care. Then it's just up to you if you want to renew it, and then you have to -- depending on the timeline, you either have to retest --

MEMBER ZAMUDIO: And then you have to send that renewal to the Board.

MEMBER MINIARD: Right. That's later on in, in the same thing, within 30 days of recertification then the national certified body says you need to contact -- for me it's ANCC. So you have to contact your national certified body, and have them send something directly to the Board that verifies your recertification.

MEMBER ZAMUDIO: So this makes it our responsibility for them to do something?

MEMBER MINIARD: Yes. So for example, like I said, I just renewed, so I'm waiting -- they have to go through and look at everything and make sure it's good.

But once they get yes, you're good, then I need to tell them to send something to the Board of Nursing, so it's a separate thing I'm responsible for.

MEMBER ZAMUDIO: Do people call you to see if it got there? How do we follow up on that?

CHAIRWOMAN KEELS: You check the Board website, and then if it's not there, you call them.

Just clarifying some of this for people.

MEMBER MINIARD: You have to remember to go back and have them send it. because they will not send it just automatically.

MEMBER ZAMUDIO: I just thought if we were changing like what documents had to be sent to the Board, when we would do that, for people reading it.

MEMBER BOLTON: And that depends. Some certifiers are a little better.

MEMBER MINIARD: And --

MEMBER BOLTON: It depends on the certifying organization.

MEMBER ZAMUDIO: Okay.

CHAIRWOMAN KEELS: Other comments on 8?

As you review these and have questions, or comments, then please do email them to Lisa and I; not to the group, but to Lisa and I. And then we'll pull them together and they will be in your meeting packet for the next time, because we cannot meet offline. Just remember to email the stuff.

MS. FISCHER: Let's move to Chapter 9.

It's on page 113 of the new rule book. The first -- well, the first thing that we have relates to Rule 9-10.

And this is a very technical point, but it's something that really just struck me when I was
looking in preparation for this meeting. And it relates to the definition of terminal condition. So I realize that we had changed our language to mirror that of the Medical Board with respect to exceeding the MED limits. And I'm not going to go into all the hows and whys the Medical Board changed their definition, but we did the same. So we changed the definitional section. But unlike the Medical Board, we have this other statute that says that that definition is in 2133.01, so what I think we need to do, it's a small change, but we need to change the reference to terminal condition to define it specifically in the MED components which are -- I think it's K7 -- I and K, the terminal condition means this. And then when you're talking about the Schedule 2 prescribing limits, terminal condition means as defined in 2133.01, because that's what the law says. So I don't want to belabor the point, but it's just sort of a technical correction.

MEMBER ZAMUDIO: Right.

MS. FISCHER: And then the other big thing is that we still don't have rules related to the detoxification component of medication assisted treatment.

The Medical Board's rules -- it got delayed, delayed, delayed, so they still don't have their rule yet, and we were waiting on that. So what I have given you today as part of the package is just a copy of the most current Medical Board language, and this language is for physicians. There's also a separate chapter for PAs.

That's attached to the memo.

CHAIRWOMAN KEELS: It's attached to the memo?

MS. FISCHER: Yeah, it's attached to my memo. And the changes are the underlying language, that's the additional language. And basically they have a whole rule, which is 4731-33-02, where everything is underlined that's brand new. And you can see it's very complex, it's pretty dense.

CHAIRWOMAN KEELS: I was surprised how specific it is.

MEMBER ZAMUDIO: Right.

CHAIRWOMAN KEELS: But that's what the Medical Board approved.

MS. FISCHER: That's what they filed with the office of CSI. And this wasn't -- I don't think this was filed until December, so --

CHAIRWOMAN KEELS: As the final, or draft?

MS. FISCHER: No, it's just -- they originally thought this would be final and approved and done by the end of 2019, but it still hasn't left the office of CSI.

So this is what you've got right now, and it's kind of tricky, because -- I don't know how much time to spend, you know, working with this, in that it's not anything yet, it's just a proposal, but I wanted you to have it.

If you see this and see something striking, obviously for APRNs -- it's going to be modified for APRNs, but if you see a big component you think is missing, or -- this will be a time we could share that with the Medical Board.

Since they have filed it with CSI, the CSI comment period is closed, so technically you can't, you know, file a comment. But they could withdraw it and refile it if it's significant.

I know that's an awful lot to look at, but if you could take some time, and if you see some things, send them to Lisa and Erin so they can put your comments together for a packet for the July meeting.
neonatal side, we'll see a mom that's been tested at
the beginning of the pregnancy, but not towards the
end, and she's converted or she's been infected.

MS. FISCHER: So what I'm going to do in
the meantime is follow up and talk to the Medical
Board and see if they have a sense where this is
going.

And timing-wise, if I could draft a rule
like this for APRN but have it available for the July
meeting -- but it depends on what the Medical Board
says.

I don't want to go through the time.
It's very laborious to translate it to APRN language,
and then it's going to be completely regretted and
start over. But at the same time, we need to draft
something.

So I thought this is the best we could
do for now. Take a look at their language. Let me
know if you see something that strikes you like the
time frame, can we clarify that, clean it up a
little. That's a good point.

MEMBER ZAMUDIO: Is this an appropriate
time to address the algorithm in 9, 9-10?

MS. FISCHER: Yeah, 9-10 is completely
open for review. There were a couple changes made

last year.
We have the new updated flow chart that
reflects some of that, mostly just because it's in
cross-references, the subparagraph numbers changed
and that kind of thing.

MEMBER ZAMUDIO: I didn't know if this
was something that was maybe cut off at the bottom.
If you get to the very bottom of the algorithm it
says is the patient -- prescription for inpatient
use, there's an arrow to the side, but it leads to
nothing, it's like out in the open. Was that cut
off?

CHAIRWOMAN KEELS: No, I think it means
to go up and then up -- it's over and then up. I
thought that, too.

MEMBER ZAMUDIO: I thought that is kind
of a little blank area, it leads to a blank.
MS. FISCHER: It's -- yes, and then it
goes up.

MEMBER ZAMUDIO: I think we need to just
fix that little intersection on the algorithm there
so there's something at the bottom of the arrow or
something.

MS. FISCHER: Actually, there's two
little arrows there.
Is Tom coming?

MS. EMRICH: I just emailed him. We could move ahead or we can --

CHAIRWOMAN KEELS: So we'll try to get Tom Dilling down here so he can give us a legislative update. I did want to ask if everyone has visited the new website?

MEMBER DI PIAZZZA: Yes.

CHAIRWOMAN KEELS: I think it looks great.

MEMBER MINIARD: It does.

CHAIRWOMAN KEELS: And Lisa and I were talking about that earlier today, and made a recommendation to see if there's something under APRN practice resources that we could say -- or that we could cross link, or at least reference you back to the APRN Advisory Committee and the material so you don't have to go hunt for those, because the Committee said the materials did say they are available, but they are under Contact Support.

But if we can just do CE, whatever, it's not even a hyperlink -- or if it's a hyperlink, that would be even better. But I think it looks fantastic.

Lisa, do you want to talk about LPN renewal?

MS. EMRICH: Sure. Just a reminder, LPN renewal will begin on July the 1st of 2020. We have about 630,000 LPNs that will be up for renewal. And we anticipate that to go as smooth, if not smoother, than the RN did last year.

But again, we think the fee schedule that's published, and then the additional messaging that we're going to be sending, will be helpful.

CHAIRWOMAN KEELS: And that just reminded me. As I was on the Board website looking at the upcoming Board meeting materials, the APRN work force statistics are posted from the last year's renewal period where we answered those surveys. So I'll call your attention to that if you're interested.

MS. EMRICH: And then those will be provided to the Committee the next meeting, too. Of course, they are going to be --

CHAIRWOMAN KEELS: They are available now, too. Summary of APRN practice questions is included in your packet and online for your review.

Lisa and her staff provided us with the most recent questions that they received from APRNs as an FYI for us to sort of have a general understanding about what APRNs in the community are -- have questions about that we can work to help make that a little bit easier for them.

MS. EMRICH: Some of these you'll find in the draft document as well. I think there's some similar ones. I think we --

CHAIRWOMAN KEELS: Yeah, it seems like each time we meet there are some general themes that come up again, that we can then move into the draft documents to help proactively steer people. Any questions or comments about that?

And not to be -- this is in no way punitive because we always want people to email questions to the Board, because the worst question is the one that is not asked, right?

So I would -- I was still struck by the fact that someone who is certified in women's health was helping to manage a pediatric patient, not a nonfemale pediatric patient.

And there was also -- there was another adult gero certified person, I think, that was wondering if they could treat pediatric patients, which then goes to the developmental age parameters.

So at what point does the pediatric patient become the adult patient, which is what we're trying to do to help. Right? Okay.

MEMBER ZAMUDIO: Erin, were these questions already answered on the website, or are these just the questions?

MS. EMRICH: They are not on the website. These are email questions that we received.

MEMBER ZAMUDIO: Do we get the answers that they got, or no? I was curious about the answer to No. 1, what the Board wrote.

CHAIRWOMAN KEELS: Oh, about injury during insemination?

MS. ZAMUDIO: Yeah, about the common studies that they do.

CHAIRWOMAN KEELS: Do we have the answer available?

MS. EMRICH: We can provide that.

MEMBER ZAMUDIO: I think --

CHAIRWOMAN KEELS: It would be helpful for us to see the answer.

MEMBER ZAMUDIO: That's a great question.

MS. EMRICH: I don't know if there was more context provided to the question.

CHAIRWOMAN KEELS: We'll definitely want to keep it anonymous.
MEMBER ZAMUDIO: Absolutely. I thought that was a good question more so than even addressing a different population. Like the other one in the draft document was can you do something for a newborn or a male. I thought this is really good for scope of practice, because it's a common thing done by a nurse midwife and --

MS. EMRICH: This is more of a procedural.

MEMBER ZAMUDIO: Yeah, I thought that was good. And if we're on this, can I just go to this first, and then we'll --

CHAIRWOMAN KEELS: So we're going to move on from the questions.

MS. EMRICH: Unless there's more discussion.

CHAIRWOMAN KEELS: Okay.

MS. EMRICH: Just item E, just that the ODH updated its form for the medical clearance, so we just wanted to provide that to you, so for those of you who are involved in the return to play.

MEMBER SIEVERS: We had sent recommendations, not me, but my institution, a while back to ODH, because what our concussion people tell us is that sometimes there's an intermediate -- it's a gradual return, they are restricted to some activities.

I notice they still did not include any sort of intermediate -- you know, it's not an all or none. Like they might be allowed to go back to something noncontact, but they can't go back to full participation with maybe football, but they could do track or something. They do have like a graduated thing, and it's still not included.

CHAIRWOMAN KEELS: And of course --

MEMBER SIEVERS: There's nowhere to write any comments about the specific -- when we did that, the ODH -- no one ever got back with me.

CHAIRWOMAN KEELS: Is that something that House Bill 177 could include? Because I know it seeks to add an APRN on this that can clear, right?

MEMBER SIEVERS: It would be good for -- I mean, it's more of an overarching kind of issue, but it makes me wonder if they consulted with folks who are doing the actual clearance. But I guess you can just write in a note or something.

CHAIRWOMAN KEELS: All right. Thanks for that comment.

NCSBN APRN roundtable.

MS. EMRICH: Just an FYI. Erin and I are both attending that. It's April the 7th.

CHAIRWOMAN KEELS: So through the NCSBN, they have pulled together APRN educators course and even practice.

MS. EMRICH: Certifying bodies.

CHAIRWOMAN KEELS: Certifying bodies all come together and discuss pertinent issues. This years the agenda looks very interesting around education programs, competency, how to measure competency, some content around legislation initiative. So we'll report back.

MEMBER ZAMUDIO: Can you let us know what they -- if anyone talks about the educate them and help them find their own site approach to some of the education that we see?

I'm not intimidated with phone calls, but I know a student right now who can't graduate because she can't find her own way. She has gone through enormous steps to try get a faculty -- someone who educates physicians for a living.

I thought can you imagine if we told a medical student, yes, you can graduate. Good luck to you in residency, find your own patients. I think it's abhorrent that they have to find their own site.

So if somebody can mention that to them. The rest of us in the community are fatigued, you know, with the questions.

MS. EMRICH: Are you reporting that to the accrediting body?

MEMBER ZAMUDIO: Reporting what?

MS. EMRICH: The clinical site issues.

MEMBER ZAMUDIO: No, that they can't find a clinical site.

MEMBER SIEVERS: It's loosely interpreted by the schools, let me say that.

MEMBER ZAMUDIO: So we get probably -- this is not to offend anybody here, obviously, but it is a fatigue factor, and now there are entire offices that are forming at universities and within hospitals to try to place students, but that's on the student to find them and to know they exist and to find a site. And it is difficult.

CHAIRWOMAN KEELS: And I think it would -- program to program, so I know I work with one program that places and another program that does not.

MEMBER ZAMUDIO: Maybe they could collaborate.

CHAIRWOMAN KEELS: But the accrediting
I mean, you can't make people precept students, and there are a lot of not well accredited institutions that actually pay preceptors, you know, but that's very difficult to do from a budgeting perspective at a state university.

MEMBER ZAMUDIO: I think if the preceptors are actually doing their job, it is a huge undertaking. I mean, I think they should be compensated just saying that.

But it is a significant amount. I invest in them. I mean, I'm all in; you're coming to every meeting with me, I'm talking to you, you're going to the CEIs with me, so it is a big undertaking.

So I think it should be done with compensation. But that said, them finding a preceptor doesn't mean they have found an educator. So I like that you're vetting them.

CHAIRWOMAN KEELS: Yeah, because the Board does not regulate graduate programs. I don't know what can be done through this Committee other than just bringing awareness.

MEMBER ZAMUDIO: We need good ideas.

MEMBER MINIARD: It is something we talk about on the national level --

CHAIRWOMAN KEELS: Challenging.

MEMBER MINIARD: -- every meeting. So it's a known problem.

CHAIRWOMAN KEELS: All right. So the remaining item is legislative report, and I think --

MS. EMRICH: I haven't heard from him.

CHAIRWOMAN KEELS: He's probably in a meeting.

CHAIRWOMAN KEELS: And let's see what else. We can skip down to No. 10. And just as a reminder, our remaining meetings for 2020 are July 6th and November 10th. We'll clarify with everybody, validate that everybody has that on their calendar.

Are there other topics that were not on the agenda that folks would like to discuss?

MEMBER ZAMUDIO: Are we waiting for Tom for the Sunset thing?

MS. EMRICH: Legislative report.

MEMBER ZAMUDIO: Okay.

CHAIRWOMAN KEELS: Then you can ask him about the Sunset CPG.

Do we need to take a five-minute break?

MS. EMRICH: Sure. Let's take a five-minute break for those of you who need to.

(Recess taken.)
CHAIRWOMAN KEELS: We'll get started.
So thank you, Tom, for joining us. And we're going
to turn it over to you for the legislative report.

MR. DILLING: Okay. I think maybe I'll 
start with the -- since we last met, I appeared at
the Sunset Review Committee on behalf of the Board,
and the APRN Advisory Committee and the CPG.

They don't give you a schedule at the
end of the year, you get a phone call and say can you come, we need somebody on such and such date, right?

However, I had prepared the CPG stuff.

We had had -- for like six months we thought we were going to get called in, and then didn't or whatever.

So whatever.

The -- we were not concerned as far as
the Sunset Review Committee reviews all types of agencies and committees of agencies and so forth, looking for is there something that's redundant or
out of date, so forth.

But again, we didn't fear like somebody was gunning for the APRN Advisory Committee, especially since it's just been a couple years old.

On the other hand, for the CPG, we had talked about the CPG previously and said we got this call and, you know, what do you think about it?

And I talked to people behind the
scenes, too, you know, in terms of it, and so we went in there with an -- answering their questions, but
saying nobody sees the need for the CPG anymore in
the sense that it's an exclusionary formula, and
reviewing new drugs, but none of these are ever going
to be deleted or added to the exclusionary
formulas as far as anyone sees.

If they really needed to, we still have
the APRN Advisory Committee we can go through, you
know, the Board can go through rulemaking, statutory
changes. There's all these different routes, you
know, available.

And then added to that, it was that the
Medical Board had a PA equivalent of the CPG, and
that was recently eliminated in the statute as well.

So basically went in there and fell on our sword, and
they were more than happy to -- this is really --
that makes my day when somebody comes in and says, you know, their time has come.

Then I also presented for the APRN
Advisory Committee, which you have the written
materials and that, was positive about what the
Committee was doing and its helpfulness to both the
Board and the State. And they seemed to have the --

be fine with that.

There really wasn't, you know, questions
asked in terms of, you know, the continued existence
of the Committee, continued work. So that's about as
exciting as it was, if you catch that.

CHAIRWOMAN KEELS: So Sherri was
wondering about the timeline. Now that we have made
the recommendations to Sunset and CPG, what will happen.

MR. DILLING: So they make a report at the end of the year.

CHAIRWOMAN KEELS: End of 2020?

MR. DILLING: Yeah, and that's the
official report. That doesn't stop them from going in and doing something, you know, ahead of time.

It's a good question, because we hadn't been going through it for anything else.

So that is something I can go and visit
and share and ask, you know, hey, is it okay if we speed up that process, and then you can report it was done, you know, at the end of the year, or do they like to play credit at the end. I haven't explored
that as of yet.

CHAIRWOMAN KEELS: To Sherri's point, I think the people's schedules and travel would be good
to know when that would take place.

MR. DILLING: Absolutely. I think the
CPG would love it to be gone, right, the next day.

Of course, you also have these other bills that we'll report on as well, the House Bill 177 and so forth.

I don't see that being a political issue
or problem. I think this is, again as we have
discussed previously, CPG, the cleanest way is to do it through this process, then nobody has to get too
concerned about it from a political perspective. But
I'll check on that and see and report back.

CHAIRWOMAN KEELS: Thank you.

MR. DILLING: In terms of other
legislation on, the mover is House Bill 224. So, you
know, that's a good thing. And the Bill moved out of the
House.

There was, I think -- I believe that the
CRNAs were supportive of the bill. Certainly wasn't
as introduced, but supportive of the process in that
there were changes made.

The OSMA and the anesthesiologists took
a neutral position, and that's usually the best that
you can hope for in these type of bills. And so that helped move things along.

And now it's being heard over in the
That's the way I basically read it. And the expansion of the authority has been to clarify their CRNA's ability to write these orders and have other people fill them out.

The clinical support functions that they are allowed to direct others to do, I think it might be a little bit clearer in terms of the listings of some of the other things that are -- they are allowed to do, and then the respiratory care area, it's clear that the CRNAs are now allowed to, you know, direct, supervise certain respiratory care functions, which again makes a lot of sense based on their training, education, or what they do.

However, historically the CRNAs were excluded, and again, I think that that was more of a technicality because somebody had an issue with people who were being supervised, supervising others, and I think it was just kind of an over read of the situation. But clearly this allows for it, and that's a good step forward.

In terms of House Bill 177 and standard of care arrangements, I don't know, we're like on draft 8, 10, you know, something like that, version.

Now some more changes were made.

The 2,000 hour requirement for people that hadn't done a year and were coming in from another state or whatever, it's -- there was an addition that says one year or 2,000 hours, which is reflective of basically what the 2,000 hours was supposed to represent, it just makes it easier to delineate, especially from our perspective, when we are looking at applications coming in here.

We do not want to get into the business as far as I understand, as far as everybody else's understanding goes, of trying to go review documentation that says, you know, have at least 2,000 hours, it's basically, I think, being set up where somebody says I've been working for such and such a date over these amount of hours, a couple people sign it and send it into the Board and we move on.

CHAIRWOMAN KEELS: Is that 2,000 hours for initial practice regardless of if it was in another state, or initial practice within Ohio? So I'm thinking about a new graduate versus somebody who has been practicing say in Indiana for ten years.

MR. DILLING: It's the new graduate, I believe, yeah. And anybody who doesn't have, you know -- again, the year is more of a definitive point than the 2,000 hours.
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Don't want to get into a situation where somebody says yeah, I did my 2,000 hours. But you graduated four months ago. Yeah, I've been working really hard.

CHAIRWOMAN KEELS: A lot of hours.

MR. DILLING: Again, the 2,000 hours, as I understand, was chosen because it basically equates to the one-year. So this makes it more of a hard and fast law getting to any of that.

And, you know, it's still some -- somewhat of a big change that's being proposed. And I believe to some degree, now it becomes a little bit more complicated, not from any changes in the bill, but that the PAs have recently introduced a practice bill, whereas usually it's hey, we like what the APRNs are doing, so we would like to, you know, be the same way.

And this has been the first foray of theirs into no longer being supervised in the same way as with the physicians. It's a very bold proposal, but again, sometimes bold proposals are made just in order to catch people's attention, and to engender some discussion about, you know, different items.

So I think that that's left to be heard here when they enter Committee sessions again and start hearing on that bill.

But from a political perspective, if it wasn't easy for the OSMA to say okay, let's talk about what you all want, APRNs, it's certainly going to be more difficult to do that when well, let's talk APRNs, let's talk PAs, and, you know, what the world -- how the world is changing.

It's a little bit more massive for certain people to digest, and I think that that -- that doesn't necessarily serve to clarify things.

You could potentially ask more specific questions about education and training, and what does everybody want to do, and how things are changing and so forth, but that's usually not a process with these type of bills.

CHAIRWOMAN KEELS: So has the PA -- that's actually now a bill that has been introduced?

MR. DILLING: Yeah, I'm sorry, I don't have -- I think that was prior to the issuance of this, and that's the 400s, and I'll be coming out with my March report for the Board here in another week or two, and that will be posted up and I'll for sure have that.

A lot of my time and energies here recently have been spent more on this House Bill 263 and Senate Bill 246. House Bill 432, which are the licensing reciprocity bills, and 263, is the -- what I'll call the criminal convictions aspect component of it. And those have been moving and having a lot of hearings, and we have been trying to have some input into that. And the House Bill 263 moved out of Committee, but it's not moved out of the House as yet.

The 246 and 432 have had plenty of hearings, and now we have gotten into a situation where kind of had clashing testimonies and people that are representing associations have testified and explained why they believe that there's licensure and why there are certain standards in Ohio, and why they support Ohio's standards, and the differences with other states.

And that is not as easy as viewing it as a driver's license where, you know, everybody drives under the same rules with the same amount of education and training.

And when that happens -- that's happened in the past and in other bills, you know, when we talked about whether or not there should be certain -- like global licensing and consolidation and things like that, I didn't think that the associations would stand by, and kind of just watched the landscape change so dramatically without weighing in.

We are, as Boards, weighing in, and I think we have a common messaging for the most part, but the legislature today is more impactful when it's coming from, I think, the actual associations and the professionals themselves.

I think that they at least claim to understand the licensing aspects of it, you know, whether or not that is totally clear, but there's certainly maybe greater lines that are drawn.

I would tell you that the idea of this, I don't know what you call it, occupational licensing is what they term it as, sometimes you'll hear the term universal licensing, it's kind of a -- I call it reverse federalism.

It used to be everybody stood up for the State's rights and our ability to, you know, this is how we're going to protect Ohio citizens, we're going to require this and that, and nobody, you know -- we don't want the whole -- the nation to decide for us.

And now it seems like there's a lot of legislation that goes around and knocks off state by Page 76

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And now it seems like there's a lot of legislation that goes around and knocks off state by...
state by state, and it's all very similar.
And what you do is you get like this
common -- these common statutes or these common standards, and it's maybe a little bit easier for
some occupations than it is for some professions.
And while maybe in the year 2020 we
should be closer to maybe more common standards and
more common understandings, the way that these licensing laws have birthed and lived over the years makes it that there are differences at least between certain states.
And so when the occupational -- or the professionals come in from the associations they are saying -- they are pointing out certain states that are very different, you know, on the scale from others. And so that's causing people to take pause and notice.
I've been reading some things here
recently about from some of the proponent groups where, like down in Florida, they are hearing this type of bill now. There are only two states, I think, that have it currently -- it's Arizona and Pennsylvania, that as law.
And those are fundamentally the same,
the difference being, I think Arizona you have to move into the State, actually physically be there before it kicks in.
But in Florida, they seem to have understood this differentiation between certain professions from others, and are more focused on more universal licensing standards for occupations like hair braiding, interior design, you know, things like that, that might lend itself to lesser number of hours, lesser testing, more common standards from the start, and ones that are being heard in individual bills, you know, maybe even here in Ohio where we don't have them.
So that is what, in part, we are arguing, too, is that, you know, there should be some differentiation made, thinking about hey, before you license somebody or create a licensing board, you know, what's happening in other states and what should those standards be, you know, that there are differences in those questions.
There's also -- and again, it's not reflected here, but since the last Board meeting we had a search goal assisting bill that was introduced, and, you know, you have certification boards I believe in surgical technicians and surgical assistants, and here in Ohio there are people that are practicing in those areas without licensure, the idea being that they are performing more rote tasks and not practicing medicine or nursing or some other profession in and of itself, they just say hand me this or do this.
Then there are people who will explain to you that perhaps there are some people that are doing more than that. And there's certainly a desire to do more than that on the part of some. But again, that's a good one to take a look at.
It comes every two years, but it seems like one session it will say let's be licensed by the Nursing Board, and this one says let's be licensed by the Medical Board. They try, you know, different routes and so forth.
But I thought the scope of practice that was being offered up here was quite broad, more so than I've ever seen before, and it really was about hey, we as the hospitals and the professionals, we'll determine how far this stuff goes, and where it ends, and where it stops, and things and so forth.
You know, to me it's a jaw dropper.
I'll be interested to see how that is viewed. But again, gosh, it seems like that dates back 15 years on these types of bills have been coming through.

I think that's a good overview of what's happening over in the Statehouse. I'm certainly open to any of your questions and concerns you might have.
CHAIRWOMAN KEELS: Well, I became aware of the acute -- the Advanced Practice Respiratory Therapy role because the Ohio State University is now offering a graduate degree in that, in collaboration with the College of Nursing, for some shared education on the PPPs, and faculty approached me to accept their graduate students for clinicals.
It sounds to me like they are patterning their scope of practice after the physician assistants, so it's a broad across the lifespan generalist education with a focus on cardio respiratory, and so they are doing it as the head of National Certification and head of a legal scope of practice in Ohio, and so I asked Tom if he had heard any information about that.
The RTs roll up under the Medical Board for regulation, and so I guess this would come through there, and I don't know what you've heard.
MR. DILLING: No, you and I have to have a talk about what your conversations were, you know, specifically with -- or what you heard back, you know, from them.
The Medical Board told me that they had
gone to and spoken -- "they" the program had talked
with the Medical Board. And yeah, it's almost as if
the Medical Board thought it was kind of like oh,
that's a nursing thing, you know. It was like no,
you license the respiratory care therapist. Oh,
yeah.

CHAIRWOMAN KEELS: And this is the first
program of its kind in the entire country. This role
is not anywhere else.

MR. DILLING: Right. So there was --
yeah, it's -- certainly the timing has been
coincidental in terms of you asking about it.
Yes, supposedly the only -- the first
advanced practice respiratory care, but please
understand, it is respiratory care, and you need a
license to practice respiratory care. And you have a
defined scope of practice for respiratory care, and
you're licensed as a respiratory care therapist.

There is no statutes or anything
creating an advanced practice rule either in
respiratory care or nursing, you know, in that way.
Yes, preceding the National Association
for Respiratory Care coming up with model guidelines
and recommendations for scope, regulation, you know,

of this practice and, you know, what are the
differences and so forth. That recently came out
within the last month, and those are published. You
can go online and see what they are doing.
There in turn comes the chicken before
the egg, or whatever the conundrum here, of -- you
know, from a regulation standpoint. If you're going
to actually be practicing something, you need to be
licensed.

And you see even in our statutes and
others, there are exceptions to the requirements for
licensure for the most part and students and that.
And they have a good group of attorneys and others
over at Ohio State, and I'm sure they are following
all the rules and so forth with respect to that, but
perhaps they want to, you know, move forward.
I've also, at the same time asking about
that, heard that respiratory care is facing some
questions about the desire on the part of some to
have respiratory care assistance at the same time,
and that not necessarily being welcomed by the
association on that side of things.
So this happens, too, in some scope
issues. People like to move up their scope and
concentrate on that, but when someone comes into
their territory, then it's, you know, quite a
different thing, you know, in terms of scrutiny on
questions and so forth.

So it seems to me, things going on in
that area -- and quite frankly, some of it too might
have to do with, you know, hospitals are now
utilizing personnel in this area in terms of clinical
support functions for what happens in certain
situations, whether it be emergencies or otherwise,
you know, and the need for the respiratory care,
which we all like to breathe, it's a very important
thing.

Stay on top of that, right. So we'll
find out a little bit more about that, but this is
one of those things where lots of times, you know,
scope issues are birthed over in the educational
setting.

25 years ago I was telling Lisa, I told
the Medical Board keep sending me over to the
Statehouse, we ought to all be overdone -- at Ohio
State schools, you know, that's where it's -- all
these changes are happening before they get over
here.

CHAIRWOMAN KEELS: So I digress back
to 177. So it's still in the House, still being
debated with the recent change, is that right?
MR. DILLING: Yes. I mean, it's had
some hearings and that, and I'm sure it will have
some more, you know.
All scope issues are, I would say, kind
of hot. People want to hear about different things.
But now you've moved on to -- with the CRNAs, you
know, apparently.
Once that's happened then, you know,
there's good and bad to that. Then you become the
spotlight, you become the focus, and both proponents
and opponents can concentrate, you know, in that area
as well.

So that's where it's at, and that's
basically why I said, also, now we have the PAs
moving in, and it maybe just shines a larger light
upon some of those issues.

CHAIRWOMAN KEELS: Okay.
MEMBER ZAMUDIO: So this kind of came up
when I was reading this Sunset review on this
Committee, as well as I guess it's timely because
we're talking about the applications to be on this
Committee.
And I'm curious what your interpretation
is, and Lisa's as well. On 4723.493 under (B), it
people, then what is that statute telling me to do?

MEMBER ZAMUDIO: That's the same question I had, because how do you decide?

MR. DILLING: Because these things are directory. That's how the law interprets them. And the direction here, as I'm reading the whole of the statute and so forth, was that bodies, multiple, send in these people.

You got a number of them, and the Board sits down and selects, you know, the grouping. And the Board has done this in a transparent process, and you know, has commented, as I understand, to try to get some breath to the Committee so that that better advises them, you know, from different areas.

But the statute says it definite enough in terms of what groups will be represented, you know.

MEMBER ZAMUDIO: Yeah, it doesn't say, it just says they shall appoint them according to the recommendations.

MR. DILLING: But aren't there somewhere in the statutes that says you shall have one CNM, you should have --

MEMBER ZAMUDIO: Yeah.

MR. DILLING: So that keeps people into

encouragement in the statute that certain bodies that aren't named, but described, put in names.

MEMBER ZAMUDIO: Like the American College of Nurse Midwives would submit someone.

MR. DILLING: But it doesn't set for the process that says there are seven positions and so they are going to give us seven names, and those are the ones we're going to pick.

If more about here is names, maybe you'll have 14 names, maybe you'll have 21, maybe you'll have 7, utilize those in selecting that point group.

If nobody does send it in, then you're going to have to drum them up, you know, find people and go select them involuntary servitude if necessary, you know, make -- get the Committee together.

MEMBER ZAMUDIO: It says if it does not receive any recommendations it's to use its own advice. So what do you do?

I mean, to me this is saying that really you should go with the recommendations of the organizations, but if they don't make any, then who do you choose.

MR. DILLING: If they recommend 15 a -- keeps people in a certain direction. You know, that's consistent with how many other groups are appointed, and that's not necessarily at the Medical Board level, these are things that are done throughout the State.

MEMBER ZAMUDIO: No, I was just more specific about this Committee, because I know the -- our role is to represent -- like the nurse midwives, for example, you would want a breath of people, and those organizations are going to know who they want to recommend or represent them, so would it be incumbent upon the Board, where it says the Board shall appoint, to use those recommendations, or could you say no, even though someone is recommended we're not going to appoint them, and go to, let's say a directory of midwives or CRNAs and pull from them?

MR. DILLING: If we didn't have people from that area appointed or whatever, then we're thrown into that situation. That has not occurred as of yet.

MEMBER ZAMUDIO: So right now we're doing it according to the recommendations, but if there's none received, then the Board will use its own advice; is that right?

MR. DILLING: Yeah. But again, we
have drilled down to perceive any necessity to come up with rules to say if nobody has come forward, the Board will try again and — you know, for two more months and shall go look, we — MEMBER ZAMUDIO: This happened, right? MR. DILLING: Yeah, we have a number of advisory committees that are from outside the Board that aren't necessarily created by statute. And so we go out and we say to the grouping of them, nurse educators, their associations and so forth, send out notice to the ONA, OAPI, hey, we're recruiting, it's recruiting time of the year, send us in some names. MEMBER ZAMUDIO: But not for this Committee. This Committee is a statute. MR. DILLING: Yeah, I'm just telling you that on occasion for, like dialysis or somebody, it's come back and we don't -- here again, nobody is volunteering to be the physician -- MS. EMRICH: APRN? MR. DILLING: Yeah, that supervises a dialysis tech, they got other things that they want to do and that, so then we go out and — I don't call up my friend and say hey, are you doing anything for the next year? Would you like to come in?

No, we go back and say we're going to start it again, and we go start — pick up the phone and start talking to different groups and say can you find us somebody, and most of the time they find us -- MEMBER ZAMUDIO: I was just curious about your and Lisa's interpretation, because this situation actually happened. The midwife spot wasn't filled. Remember, we started later because there wasn't someone. So I'm curious, when I read this, so what it's saying is the Board shall appoint according to any recommendations, and it says that exact verbiage, and it says if it doesn't reach a recommendation, then it can do it on its own advice. And in that situation you would call ACNM or whatever, and solicit applications, is that correct. MS. EMRICH: We have an application process, and the application process includes providing, with your recommendation, a recommendation from whichever organization is recommending you. I think the process works. MEMBER ZAMUDIO: Do you appoint according to the recommendations?

That's why I wanted to get to this should be recommended.

MR. DILLING: So help us with that, go out everybody.

MEMBER ZAMUDIO: That was such a bad situation to be in the.

MR. DILLING: The more names, the better, I think.

MEMBER ZAMUDIO: Thanks. Appreciate it.

CHAIRWOMAN KEELS: Anything else for Tom? Thank you.

MR. DILLING: Thank you.

CHAIRWOMAN KEELS: We're at noon, so we're going to take a break for lunch, 45 minutes as scheduled, and we'll come back at 12:45. And then we will review the draft document, as it is known, and have public comments. Okay? All right.

(Lunch recess from 12:00 to 12:45.)

CHAIRWOMAN KEELS: Go ahead and get restarted. Welcome back from lunch. For all of those that are hanging in with us, thanks for coming back. Some people skedaddled.

So next up is the draft document. That's what we're calling it, the draft document.

You know, big kudos to Lisa and her Staff who are...
started with role, and then designation. You know, we have been struggling really a lot with there are four roles, and then the population based certification, or population based foci, has been used in statute as specialties. So trying to give definition to that so people are clear when you see that word, what that means.

I talked to Lisa. One of my suggestions would be, in this introduction area, is maybe have a little bit more information around how continuing education, ongoing experience and training continues to expand your scope within your population focus.

You know, you're different as a novice as you are when -- than when you're several years down the pike, because you have a lot more experience and education and training and expertise, which then, in fact, can increase your scope, which you're permitted to do within your organization, or what your collaborating physician will ask you to do.

But it's still within your population, so it doesn't jump you out of your population, but it's within your population. Pam has it -- she's thinking. No? What is your thought?

MEMBER BOLTON: I just want it to be extremely clear, because I think that could cause

statute and rules, pulls in a little bit of the Consensus Model, simply because the Consensus Model is congruent with existing statute and rules, and basically to see if this is somewhere close or an aspect of what might be helpful to APRNs and the general public.

It is applicable to all types of APRNs as well, so that's the other positive thing about it. So with that said -- and it's provided to you as a starting point for discussion.

CHAIRWOMAN KEELS: And I like that you titled it in such a way that you could kind of scroll down and find the topic that you're sort of interested in.

We talked about adding some live links to take you to pertinent pieces of the legislation. It would be really time consuming and challenging to do links everywhere though, from what I understand.

MS. EMRICH: And the Word document does have a lot of things linked. Did it come through on the pdf?

MEMBER BOLTON: Yeah, I just tried to pull it up and it came right in.

MS. EMRICH: Good.

CHAIRWOMAN KEELS: So I liked how it some interpretation that might go down a different track.

The other thing I'm thinking about is what about that provider that goes from one specialty to another? I mean, I don't want them to assume that if they have, you know, ten years in this specialty, and they go to another specialty, that they are equivalent.

CHAIRWOMAN KEELS: Specialty meaning population, or you're talking about --

MEMBER BOLTON: Like if you are in pulmonary or -- I mean, that's a different -- it's not -- it's good to have that experience, but I see that kind of as a novice again; you know, not novice in the term of new graduate.

CHAIRWOMAN KEELS: You're a novice within that patient subspecialty, actually, right?

MEMBER DI PIAZZA: You're fine. You had used the word scope, and I think it's more of the clinical skill, right?

MS. EMRICH: And expertise.

MEMBER BOLTON: Thank you, Pete, that's what --

CHAIRWOMAN KEELS: It does, but I say that only because in statute, scope is defined by
your education and experience.

MEMBER DI PIAZZA: The population is
your scope, not the skill set. Does that make sense?

MEMBER BOLTON: Correct. But your skill
set is based on your education.

MEMBER DI PIAZZA: Right.

CHAIRWOMAN KEELS: It all needs to come
back to that so that you continue to evolve.

MEMBER BOLTON: I think it's going to be
a couple sentences, and it's going to need some
clarity.

MEMBER SIEVERS: You bring up a really
good point, and I was hoping maybe this is where we
could start, because it's the first paragraph.

It says that it's congruent with the
Ohio laws and rules of the Consensus Model, but the
point you just made was it's not.

These definitions -- and I think it's --
I was very confused having -- when I read it, to go
back to think about is this Consensus Model
definition or is this law-rule definition, as far as
foci, specialty, designation, all those terms.

CHAIRWOMAN KEELS: So back in our
original conversations we talked about that the
Consensus Model came out after the law, the Ohio law,

and that it was felt to be congruent, meaning the
same, but that the words are different.

So in the Consensus Model they use role,
population based foci, specialty, to mean what you
specialize -- really a subspecialty or specializing
within that population. In Ohio law we use the word
designation.

MS. EMRICH: And that word was
introduced after HB 216, that it became designation
at that point.

CHAIRWOMAN KEELS: Instead of role.

MEMBER SIEVERS: I guess that's my
point.

CHAIRWOMAN KEELS: But they have the
same meaning, which is what we're trying to say in
here. Designation and role have the same meaning;
specialty certification or population based
certification has the same meaning as specialty.

MEMBER BOLTON: So could we define that
in here?

MEMBER SIEVERS: Or do we need the
Consensus Model stuff if we're -- the language? I
think that's going to be confusing.

We can have the underlying concept of
it, and the idea, but if you already are having to

say -- if you're reading the Consensus Model and you
see the word specialty, it means foci and it means
oncology, if you're in the law and you see the word
specialty it means education and certification, like
CNS.

That to me is not congruent, and they
are going to send them down a track where I don't
know what they are talking about.

CHAIRWOMAN KEELS: I'll get to you guys
in a second. This Committee agreed to follow the
Consensus Model, and so I think we do need some of --
literally one paragraph about the Consensus Model.

I think the language could be made more
simple, so I'd like to use the words plain language
or simple language because, you know, sometimes you
read these and it feels a little bit legalese, and a
little confusing, so we may need to just -- so maybe
if we make it a little bit more plain, Sherri, that
might help you.

MEMBER SIEVERS: Do you see what I'm
saying though?

CHAIRWOMAN KEELS: I do. But that has
been the crux of these discussions for two years, is
the mass confusion around what does that mean and,
you know, so on and so forth.

So I think if we can get that defined in
a way that people kind of understand that that is
what this means, this is what that means.

MEMBER SIEVERS: But I guess by defining
it, you're going to have to -- maybe we have a better
way, but when you see specialty in the Consensus
Model it means foci like oncology blah, blah, blah.

MEMBER MINIARD: No, it doesn't.

CHAIRWOMAN KEELS: Specialty in the APRN
Consensus Model mean --

MEMBER MINIARD: You have a specialty in
cardiology, a specialty in --

MS. EMRICH: It's a level beyond what
your national certification is in.

MEMBER SIEVERS: Right, a foci.

MEMBER MINIARD: No, population focus is
acute care, family.

MEMBER SIEVERS: See, I'm already
confused and I'm --

MEMBER DI PIAZZA: There's advanced
cardiology certification.

MEMBER SIEVERS: But they are calling
that specialty. But specialty in the eyes of the law
is --

(Multiple people speaking.)
MEMBER ZAMUDIO: So my thought was, at the beginning, if everyone's interpretation, or their definitions between the model and the law, are different, why not start with definitions, and put definitions at the top?

And then I strongly recommend and feel that we should include the ORC definition of the APRN, because it includes that word nursing specialty, it says 4723.01, and it says it includes formal education, training, and clinical experience. So that would solve all that.

MEMBER BOLTON: Within the population foci.

MEMBER ZAMUDIO: Whatever it says.

CHAIRWOMAN KEELS: It doesn't say that in statute, but that's what we're trying to clarify here.

MEMBER ZAMUDIO: That's 4723.01, so it's not in statute, but if we put that in the rules, I think all the definitions could you say population equals this. But why do we have to mention the Consensus Model? We agree to follow it without putting it in here, can't we?

MEMBER BOLTON: Can I ask a question?

CHAIRWOMAN KEELS: Pam has had her hand work. I don't know if this was Lisa -- it looks like a whole team of people. But I loved it. I thought this was a really great -- like you said, a great place to start.

When I look at the beginning -- and I heard what Sherri was saying. I know we agreed that we were going to follow the Consensus Model.

Our laws don't necessarily follow the Consensus Model, and if you think about it, it's kind of a shame that the Consensus Model is 12 years old and our laws predated that.

CHAIRWOMAN KEELS: Michelle, I'll stop you there when you say the law doesn't follow the Consensus Model, because we agreed it did.

MEMBER ZAMUDIO: I mean for things like compact and --

CHAIRWOMAN KEELS: We don't follow all the recommendations.

MEMBER ZAMUDIO: That's what I mean.

CHAIRWOMAN KEELS: But they regulate the license.

MEMBER ZAMUDIO: They are not matched up completely.

CHAIRWOMAN KEELS: We're working towards compacts.

MEMBER ZAMUDIO: I mean, I feel like the Consensus Model was -- I mean, I think we owe homage to that group who put this together, who truly tried very hard to make this a unified document to guide Boards of Nursing, and I feel like we are -- if you look at the document, which talks about the degree of implementation by the State's Board of Nursing, we are one of the highest there.

And so I think we need to -- we need to have mention of the Consensus Model in this document because we are following that.

We aren't doing it all 28 points, I think we're in 22, 24, if I remember correctly, but we are -- it's definitely a part of who we are and how we look at advanced practice nursing. And leaving that out of the document I think would be -- it would be reckless.

MEMBER ZAMUDIO: But you're beginning with a comparison.

CHAIRWOMAN KEELS: Jody, response?

MEMBER MINARD: I would agree with Pam because I think, one, we did agree to follow the Consensus Model here as a group, and, two, I would agree with Pam's comments about, you know, this is
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<td>1. not just some -- it is a guideline. It's not rule,</td>
<td>1. MEMBER ZAMUDIO: We're working on it,</td>
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<td>2. it's not statute, it's something that was created.</td>
<td>3. that's the message.</td>
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<td>3. It is 12 years old, but it has been</td>
<td>4. CHAIRWOMAN KEELS: We are working on it,</td>
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<td>4. followed by many other states of nursing who have</td>
<td>5. but the rule -- the statute stood before the</td>
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<td>5. since then obtained independent practice. So it</td>
<td>6. Consensus Model, and so I go to Lisa and then Sherri.</td>
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<td>6. gives a very -- a consensus across the APRN role</td>
<td>7. MS. EMRICH: Just more a point for</td>
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<td>7. across the United States.</td>
<td>8. clarification. The Consensus Model, regulation which</td>
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<td>8. So I think it is -- and not to mention</td>
<td>9. is the Board, is only one fourth of that whole</td>
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<td>9. the members of the groups who -- the member -- the</td>
<td>10. appliance there.</td>
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<td>10. elite people who created this document says a lot</td>
<td>11. It's also about congruent, it's about</td>
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<td>11. about -- I just think it says a lot about a lot of things,</td>
<td>12. the model for a national education of APRNs, the</td>
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<td>12. and I think it's really important to have the Consensus Model in</td>
<td>13. accreditation of APRNs programs, as well as the</td>
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<td>13. there, because I think most people -- I mean, it's something as a</td>
<td>14. Nursing Board that regulate the APRNs. And when I'm</td>
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<td>14. faculty, we teach our students about the Consensus Model, okay?</td>
<td>15. talking about congruent, I'm talking about how the</td>
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<td>15. I mean, we don't say this is rule or</td>
<td>16. Board regulates the APRN.</td>
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<td>16. this is statute, but we do kind of -- we do give that</td>
<td>17. CHAIRWOMAN KEELS: We could probably put</td>
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<td>17. to them as a guideline as to what it means to become</td>
<td>18. a word around that, maybe regulation is congruent, maybe?</td>
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<td>18. a nurse practitioner for example, right?</td>
<td>19. MEMBER ZAMUDIO: I think just starting</td>
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<td>19. So what does it mean? Because a nurse</td>
<td>20. with the definitions, too.</td>
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<td>20. and a nurse practitioner are very different roles.</td>
<td>21. MEMBER SIEVERS: That's what I was going</td>
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<td>21. So in one of our classes that we have that is all</td>
<td>22. to suggest. I just Googled congruent. An agreement,</td>
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<td>22. about, you know, becoming a nurse practitioner, and</td>
<td>23. but then the other definition is coinciding exactly</td>
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<td>23. what does that mean legally, what does that mean for</td>
<td>24. when superimposed.</td>
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<td>24. practice for you, we do talk about the Consensus</td>
<td>25. And so for people to think that the law</td>
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<td>1. Model. So I think it's more formally known than a lot of people think</td>
<td>1. and the -- Consensus Model is one in the same, that's</td>
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<td>2. it is.</td>
<td>3. where I get really worried, because somebody sees</td>
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<td>3. CHAIRWOMAN KEELS: Michelle had a point before.</td>
<td>4. Consensus Model is congruent with the law, then they</td>
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<td>4. MEMBER ZAMUDIO: What was it? So I</td>
<td>5. think I can just look at the Consensus Model.</td>
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<td>5. wasn't saying we don't mention it at all, we don't</td>
<td>6. So maybe a different statement there.</td>
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<td>6. use it, we don't follow it, I'm just saying the way</td>
<td>7. And like Jody's, maybe a little bit more explanation</td>
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<td>7. it's laid out by reference, it's going back and</td>
<td>8. about what we're really trying to say about the</td>
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<td>9. Model this, Consensus Model, state law, Consensus</td>
<td>10. MEMBER PIAZZA: I have a question</td>
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<td>10. Model, laws and rules.</td>
<td>11. actually for Lisa. Is there any concern that</td>
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<td>11. Beginning with definitions may be</td>
<td>12. putting -- I like the idea of definitions.</td>
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<td>12. helpful. And the definition of the APRN that's in our current rules</td>
<td>13. Is there any concern about putting</td>
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<td>13. -- and then when it says the APRN Consensus Model is congruent with</td>
<td>14. definitions in there that it will appear to be less</td>
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<td>14. Ohio laws and rules, that almost should be flipped around.</td>
<td>15. of a guideline and more of interpreting?</td>
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<td>15. We're trying to make our Ohio laws --</td>
<td>16. MEMBER MINIARD: That's a good question.</td>
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<td>16. the rules congruent with the Consensus Model. It's</td>
<td>17. MEMBER ZAMUDIO: I don't understand.</td>
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<td>17. not there yet, but we could allude to the fact that</td>
<td>18. MEMBER PIAZZA: Because the</td>
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<td>18. that's our aspiration or something. It's not completely congruent.</td>
<td>19. guidelines aren't meant to interpret the law.</td>
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<td>19. CHAIRWOMAN KEELS: Remember that the Board is congruent</td>
<td>20. MS. EMRICH: This is not considered an</td>
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<td>20. because the Board is regulating the independent -- Yes and no, I</td>
<td>21. interpretive guideline, this is an informational</td>
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<td>21. understand what you're saying. I'm sorry.</td>
<td>22. sheet. It's not as formal, but that's why I think</td>
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<td>22.</td>
<td>23. the words and information used is taken mostly from</td>
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<td>23.</td>
<td>24. existing law and rules.</td>
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<td>24.</td>
<td>25. So, you know, we could actually not have</td>
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<td>25.</td>
<td>26. the APRN and Consensus Model paragraph in here and it</td>
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MEMBER SIEVERS: That might be best.

CHAIRWOMAN KEELS: I think, however, we still have the APRN Consensus Model posted on the website, so it feels like it just lives there, right?

So it feels like there needs to be some reference to it in some way.

MEMBER BOLTON: Guideline around that.

The other thing is, I was wondering if the -- one of the links could be -- one of the things, the State has 28 different components and tells -- at the bottom it has the summary score of each state.

I'm trying to find it and I'm struggling to find it. But it tells how many of these various indicators are actually being implemented at the -- each of the state levels at the Board of Nursing.

That might be something that we could show someone how significant or which components the Ohio Board of Nursing is --

CHAIRWOMAN KEELS: Are you talking about the APRN consensus map?

MEMBER BOLTON: No, it's not a map.

CHAIRWOMAN KEELS: Are you talking about the document that Lisa pulled together?

MS. DI PASQUALE: It's the SPBN document and it says this state has adopted -- congruent with or has adopted, but not these three things.

MEMBER BOLTON: It's worth 28 total points, and we're like 22 or 24.

CHAIRWOMAN KEELS: I've seen that.

MS. DI PASQUALE: But it's --

MEMBER SIEVERS: It is a SPBN document.

MEMBER SIEVERS: This one?

MEMBER BOLTON: Yes.

MEMBER SIEVERS: But this drives the map. This is what the map is based on.

MEMBER BOLTON: But what -- I think what is good there is it gives specific information.

MEMBER ZAMUDIO: I think that would be good. Maybe a link to that, so that nurse practitioners -- for somebody who is new, they could look for that.

CHAIRWOMAN KEELS: So we agree that we need to work on the two paragraphs to make that more plain, and to define terms.

And then I asked for some information to add some information around experience and education for training and continuing education.

MEMBER ZAMUDIO: Can I request that we specifically look at the 4723.801 for the definition of APRN?

CHAIRWOMAN KEELS: You want to have that --

MEMBER ZAMUDIO: Yeah, where it says -- because it uses -- I know it uses that word specialty, which is obviously controversial, but it is what is in there right now in the rule.

And so it does say formal education, training, and clinical experience. To be honest with you, when I was kind of word-smithing some of the earlier documents looking at other people coming in to be licensed in Ohio, it says "or" on there, they can be trained, or educated, or experience.

I'm like no, we want to claim this. It should be an "and", and we should leave this in here. It's our current one, and it's good and it recognizes clinical experience, is what we have right now.

CHAIRWOMAN KEELS: Okay. Anything else on those first two paragraphs? So we'll get another draft out on that one.

Under APRN Licensure, any comments around that? I thought that was helpful to have. I was thinking of putting myself in the position of being a new APRN to Ohio, and this is a great resource to let me know exactly what needs to be done.

I was wondering if -- I think you put it in there, but standard care arrangement, do you have to have a standard care arrangement in order to practice?

MEMBER DI PIAZZZA: It's in here. It's in here under the scopes of each.

MS. EMRICH: And you don't have to have it to be licensed, you have to have it for practice.

CHAIRWOMAN KEELS: Good point. Strike that. Nothing on licensure.

MEMBER SIEVERS: Wait, one question. Do we want to call out out-of-state, because isn't there one more course they have to take? I get that question all the time.

MS. EMRICH: The two-hour online rule.

MEMBER ZAMUDIO: Where is that.

MEMBER SIEVERS: And a link to maybe -- well, that would be hard. I know we used to have a link to the courses. It means to call out out-of-state, they have to have one more additional two-hour.

MEMBER DI PIAZZZA: Is that for their RN license?
CHAIRWOMAN KEELS: No, APRN. There's a module in Ohio.
MEMBER SIEVERS: If you had the pharmacology but not had state specific things, and I think there's -- I can't remember who has the course.
MS. EMRICH: Well, are you talking about the online, so that -- we had a person had to go back through for 2016 after transition, or are you talking about the three-hour course?
MEMBER SIEVERS: Three-hour.
CHAIRWOMAN KEELS: If you are moving in from, say Indiana, you need to complete that online module.
MEMBER MINIARD: For a new licensee?
CHAIRWOMAN KEELS: For a new licensee coming into Ohio. That's a good point. Okay. Moving on. APRN education programs are not regulated by the Board.
MEMBER MINIARD: I think "not" should be in all caps.
CHAIRWOMAN KEELS: I do like questions or concerns should be addressed to the accrediting agency or the Ohio Department of Higher Education. I like that. Approve national certifying organizations.

MEMBER ZAMUDIO: I mean, just the word nursing specialty bothered me. I mean, I'm sure we can come up with something there.
MEMBER SIEVERS: That's specialty in the law is the --
CHAIRWOMAN KEELS: I just wonder if when we do definitions, you'll have to do specialty/population.
MEMBER ZAMUDIO: Yeah, that's good.
CHAIRWOMAN KEELS: We may have to do that, see how it works.
MS. EMRICH: And this is actually consistent with the way it's used here, the national certification is correct. But it's currently correct.
CHAIRWOMAN KEELS: Yeah, it's just that word specialty.
MEMBER MINIARD: Something different.
Population or -- something shorter than that.
MEMBER BOLTON: I love the links, Lisa.
They are all working and they are wonderful.
CHAIRWOMAN KEELS: Certifying examination. Any feedback on that? APRN designations, scope of practice, Nurse Practice Act, it took me a minute to remember what NPA stood for.

MEMBER MINIARD: The only thing I could say -- I'm sorry, can I backtrack?
MEMBER SIEVERS: I think I'm going to say --
MEMBER MINIARD: The thing that we brought up earlier about how I think there should be something in here, because a lot of people don't know this, even when you recertify, it says right there, but that you need to require that your certification sends -- verifies your certification with the Ohio Board of Nursing, because -- within 60 days of your certification.
CHAIRWOMAN KEELS: Good point.
MS. EMRICH: Certifying organization --
MEMBER MINIARD: It's in the law we just read. I don't know the numbers as well as they do, but --
CHAIRWOMAN KEELS: Using Michelle's previous language, it is the sole responsibility of the APRN to ensure that the certifying body has provided primary source verification.
MEMBER MINIARD: Right.
CHAIRWOMAN KEELS: Good callout. I still have staff that forget that.
MEMBER MINIARD: It's just another reminder. I think it's a good -
With the CRN for 244, will anything of this change in this paragraph?
MS. EMRICH: I would have to --
CHAIRWOMAN KEELS: See what the final --
MS. EMRICH: I'm not even going to go there until we actually have something substantial, something, the final product.
MEMBER MINIARD: A helpful document.
CHAIRWOMAN KEELS: And then Michelle, CNM scope of practice.
MEMBER ZAMUDIO: I'm not good with it, but I agree, you know.
CHAIRWOMAN KEELS: It's congruent.
MEMBER ZAMUDIO: It is congruent. I don't know if there's a way -- I think I word-smithed that on a different page here, but to say -- here it is -- that it's recognized that nurse midwives provide care for unborn children.
I'm a little worried about this because we have new fetal care centers and other opportunities for newborn care, so under the CNM
intubating.

MS. EMRICH: I differentiate a
gestational and delivered fetus from a newborn.

MEMBER ZAMUDIO: It's true. But
somebody could say hey, if you're not doing that, why
are you resuscitating that baby, it's been born?

So most states allow up to 28 days
including or surrounding -- all of our -- and I
realize that's a whole topic for another day, but we
do provide newborn resuscitation, we do provide
immediate newborn care.

And I think in a lot of the hospitals,
not going back to looking -- have written immediate
newborn care, so we have to educate them well, we're
not allowed to do that.

So just some kind of statement that
although I'm not allowed to take care of that
newborn, that newborn can actually sue me for not
taking care of it.

MEMBER MINIARD: Can I ask a question?
So I'm confused at what you are saying. So are you
or are you not providing immediate care?

MEMBER ZAMUDIO: So nurse midwives may
provide that care, and they should provide that care.
In Ohio that's not addressed at all.

So it wouldn't be expanding scope to say
that it's recognized that we may provide
stabilization of a newborn or immediate care of a
newborn.

MEMBER MINIARD: So there's nothing in
statute that says you can't?

MEMBER ZAMUDIO: No prohibitory
language. It just says newborn, and like that part
has always just bothered me, because are you not
taking care of a newborn?

CHAIRWOMAN KEELS: So what you would
like to add is something around initial care, which
includes resuscitation and stabilization?

MEMBER ZAMUDIO: Right.

CHAIRWOMAN KEELS: Particularly in
emergencies?

So why the publication?

MEMBER ZAMUDIO: Right.

CHAIRWOMAN KEELS: Because then there's
a whole perinatal guideline that comes out what CNMs
may be doing based on level of care.

MEMBER MINIARD: This is an ignorance
question, because I don't work in pediatrics, but
like you guys were saying, so what does your national
organization say is the timeline of immediate
postnatal care?
MEMBER ZAMUDIO: So it doesn't define immediate because it allows us to care for newborns. And when I was in practice in another state it was up to one year of life, all the vaccines, physicals, everything. Now, obviously -- and that's many -- so our education includes --

MEMBER MINIARD: So there's no standard for that?

MEMBER ZAMUDIO: Right. Our education includes newborn care. Out of your four semesters, 25 percent was newborn care.

MEMBER MINIARD: I know the education piece of it, but I was asking, like is there any definition by -- like the first 20 days of life, the first week of life?

MEMBER ZAMUDIO: Many states use 28 days, but there's none I'm aware of that -- I have a knowledge deficit. I can look for that and see if we have a defined time period.

CHAIRWOMAN KEELS: But what does Ohio statute say?

MEMBER SIEVERS: I can read it. A nurse authorized to practice as a certified nurse midwife in collaboration with one or more physicians, may provide the management of preventive services, and those primary care services necessary to provide healthcare to women antepartally, intrapartally, postpartally, and gynecologically, consistent with the nurse’s education and certification, and in accordance with the rules by the Board of Nursing.

MS. EMRICH: And then there's some additional prohibition.

MEMBER SIEVERS: Right, about --

CHAIRWOMAN KEELS: Mr. Dilling.

MR. DILLING: I don't mean to totally interrupt you, good discussion, but for purposes of legality and so forth, these are all really good questions, and perhaps we could go and do some research into it and take this up at a different time.

I don't want people to understand the law or scopes of practice in a way in which authority is not granted you. But because somewhere in the law it says you can't do something, even though that authority might not be expressly granted, is okay.

Now, I'm not saying anything that's described here is not okay, I'm just saying we need to take a closer look at what makes it okay and, you know, how to phrase this.

These are excellent questions, but we are still in Ohio working within a collaborative arrangement. Certain things can be done in collaboration and under the direction of others, it's a care team that is doing things.

There are exceptions to licensure requirements for emergency situations like resuscitation that allows for things to happen, and rather than bore you even further now with getting into those, which I think would be problematic at this time, I would suggest that this probably is an area that needs to go back and be looked at.

CHAIRWOMAN KEELS: Find out what the statutory limit is.

MEMBER ZAMUDIO: Well, but I disagree that it's a bad time to do it, Tom. This is why we're here. We want to have an opportunity to write things like this.

And I can quote you all the prohibitory language both for prescribing and for practice, but we're writing FAQs based on those, so we do need to look at that, and saying a statement saying it's recognized that this is what kind of --

CHAIRWOMAN KEELS: I think Tom needs to be saying that we need to go back to our --

MEMBER ZAMUDIO: But with our input.

CHAIRWOMAN KEELS: We need to know what the limits are in Ohio.

MR. DILLING: I see the conversation getting into areas where now we're commenting and answering questions in an incomplete manner, whereas I was totally into this is great, this is why there was an Advisory Committee.

And there's been some great discussions, and I think that you've honed a couple of the questions. I'm just saying this body is not set up at this moment in time to pursue some of the legal questions further.

MEMBER ZAMUDIO: That's why I'm bringing it up.

MEMBER BOLTON: I would like to suggest that he go back to Holly and those who can draft what we would want to say there, and then bring it back to us and then we can have further discussion.

MEMBER ZAMUDIO: I mean, that's my job,
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<td>is to give the input to request things like that.</td>
<td>be able to truly take care of patients from beginning</td>
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<td>MEMBER BOLTON: It's a great thought, and I think we do need to research it further. But rather than continuing a conversation, I think bring some language back and we can then approve it.</td>
<td>to end, you know what I'm saying? So what you find is that the CNS who is not certified typically will serve more like an educator, policy developer, you know.</td>
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<td>CHAIRWOMAN KEELS: Good point. Moving down to CNS scope of practice. My question is on the second bullet; CNS may provide and manage the care of individuals and groups with complex health problems and provide healthcare services that promote, improve, and manage healthcare within the nurse's specialization, consistent with the nurse's education and in accordance with rules adopted by the Board.</td>
<td>It's not that they don't encompass the rules of the CNS, but they cannot bill for those services. So they are not going to be managing care in a situation where they would bill.</td>
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<td>Should that say education and certification.</td>
<td>That does not mean -- because we have CNSs in CT surgery where the billing is global, and they are seeing them. So it crosses both paths.</td>
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<td>MS. EMRICH: No, because the scope of practice in .43, for this particular designation of APRN, it says education, not certification.</td>
<td>Certification, noncertification. And she would not be there if she didn't have acute care certification, you know what I'm saying?</td>
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<td>CHAIRWOMAN KEELS: But do CNSs meet that?</td>
<td>CHAIRWOMAN KEELS: My point was that a couple pages ahead, we said in order to be licensed you had to have the national certification, and it just stood out to me that it wasn't included in that sentence, but I understand why.</td>
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<td>MS. EMRICH: They have to have national certification to practice, and their national certification is within certain areas, like acute care and all.</td>
<td>MEMBER BOLTON: Does it need to be clarified that there are CNSs who were grandfathered, and those who had certification? I don't know, is that too much?</td>
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<td>CHAIRWOMAN KEELS: I felt like it was in here somewhere.</td>
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<td>CHAIRWOMAN KEELS: But there's a general, in case they don't have like a population focus.</td>
<td>MS. EMRICH: We have chosen -- more out of as time has gone on, those grandfathered CNSs are fewer and fewer, so really we have just stopped mentioning it so much unless it comes up on an individual basis. We're going at it --</td>
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<td>MS. EMRICH: And not all CNSs have national certification.</td>
<td>MEMBER BOLTON: Might be they are --</td>
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<td>CHAIRWOMAN KEELS: Right, they were grandfathered at some point.</td>
<td>MS. EMRICH: I can tell you 99 percent</td>
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<td>MS. EMRICH: Right.</td>
<td>are certified, because as time goes on there's just going to be fewer and fewer, because we're talking about a person that was grandfathered in 2000.</td>
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<td>CHAIRWOMAN KEELS: So does that need to be some sort of bullet explanation, or no?</td>
<td>CHAIRWOMAN KEELS: So no more information needed then. Are we ready to move from CNS, Pam?</td>
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<td>MEMBER BOLTON: Oh, boy. Yes.</td>
<td>MEMBER BOLTON: I'm good.</td>
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<td>CHAIRWOMAN KEELS: Pam.</td>
<td>CHAIRWOMAN KEELS: Then we have CNP.</td>
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<td>MEMBER MINIARD: Be careful, he's going to stand back up.</td>
<td>Pretty much taken straight from statute. And that is just the certification examination, which we may want to put in the words specialty/population.</td>
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<td>MEMBER BOLTON: You're allowed, Tom.</td>
<td>MEMBER MINIARD: I think that's probably a good idea just to use the -- put the slash --</td>
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<td>MS. EMRICH: And I should say we do not -- this is not scope. Certification has never been a question raised by CNSs. This is not a high -- nothing as compared to what the CNP question is.</td>
<td>CHAIRWOMAN KEELS: Put it in the very beginning and --</td>
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<tr>
<td>MEMBER BOLTON: The other pieces here, if you are a noncertified CNS, and correct me if I'm wrong, you cannot bill?</td>
<td>MEMBER MINIARD: Always put the &quot;slash population&quot; so it's always there.</td>
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</table>
WEBSTER: Aka this, aka that.
MEMBER MINIARD: So you don't know what that was, and go back to the definition page. Never mind.
MS. EMRICH: Some are past retired and are no longer available. But I just put currently.
MEMBER MINIARD: Can I make one comment about that? I can see this causing some confusion for ACNPs who are -- it was a former certification through ANCC, that if they don't have the adult gero acute care certification, that that would create issues for them under the law. I can see you getting a lot of questions about that.
MS. EMRICH: The adult?
MEMBER MINIARD: It's ACNP. It's adult acute care nurse practitioner. And you could maybe just put former -- I mean, because it's still a certification that you can renew, and you're not required to go back and get the AG ACNP. For example, I'm an ACNP.
MEMBER SIEVERS: Maybe say no new exams or --
MEMBER MINIARD: Yeah, there's a lot -- I know a lot of people who are just ACNPs, because that was only in the last five or six years that the AG ACNP came up.
MEMBER GAGER: That's primary care, too. It's you can recertify, but you can't --
MEMBER MINIARD: Good point, because there's a lot of them, too, so it would be maybe former.
MS. EMRICH: Just a former.
MEMBER MINIARD: No new certification exams for those, because I could see you getting a lot of questions, well, my certification isn't listed under there.
CHAIRWOMAN KEELS: So something like some certifications have been retired, and then --
MEMBER MINIARD: For example, adult nurse practitioner, and acute care nurse practitioner, without the gero are included.
MEMBER BOLTON: They are global.
CHAIRWOMAN KEELS: Okay. Prescriptive authority. I don't have the link. I'm assuming this links to the formulary?
MS. EMRICH: Or the rule link --
CHAIRWOMAN KEELS: The rule would be linked. Did we want to -- and I know this is a lot of work on your part, the rules and law enforced by the Board of Pharmacy and DEA, did we want to have a link to those pertinent pieces?
MEMBER MINIARD: That's a good point.
CHAIRWOMAN KEELS: Because I think a lot of people don't --
MS. EMRICH: They should.
CHAIRWOMAN KEELS: Remember, I need to know what the Medical Board and the Pharmacy Board and the DEA -- maybe less about the DEA.
MEMBER MINIARD: Or tell lawyers how to register.
CHAIRWOMAN KEELS: It's linked to the rule, which then gives the direction.
MEMBER DI PIAZZZA: You said it already, so we're good.
CHAIRWOMAN KEELS: The next bullet, prescribing must be consistent with the APRNs' scope and standard care arrangement and consistent with the standards of practice. I thought again we may want to -- APRN specialty/certification.
MEMBER MINIARD: Or "slash population", you want to keep it --
CHAIRWOMAN KEELS: Whichever word we end up with that makes it more clear.
MEMBER MINIARD: I think most of us know it as a certification, but I think it would be better to use the terms used in the Consensus Model.
CHAIRWOMAN KEELS: Probably because there are certifications in that nonregulated specialty in that Consensus Model.
MEMBER MINIARD: Correct.
CHAIRWOMAN KEELS: Back to my pyramid in my mind. Then there's that nasty little prescribing with five APRNs at a time.
MEMBER SIEVERS: Statute.
MEMBER BOLTON: There's an extra space in there.
MEMBER MINIARD: There is.
CHAIRWOMAN KEELS: Under APRNs may provide or furnish drugs to sexual partners, you're limited to two, is that right?
MEMBER ZAMUDIO: Correct.
CHAIRWOMAN KEELS: Do you want to put that in there? But you have a link to the rule.
MS. EMRICH: That's in statute.
MEMBER ZAMUDIO: Where are you right now?
MEMBER DI PIAZZZA: The last bullet point.
MS. EMRICH: We can add up to two, up to the number two.
CHAIRWOMAN KEELS: Up to two sexual partners.

MEMBER MINIARD: I think it's good.

Those little things that you can put in there to avoid people having to go back and read the legal jargon that they don't understand half the time, you know.

CHAIRWOMAN KEELS: That they should be aware.

MEMBER MINIARD: I know, but you know what I'm saying? Like they read it and they get confused.

CHAIRWOMAN KEELS: Any more comments on the prescribing piece? Standard care arrangements. Any comments?

MEMBER ZAMUDIO: I'm sorry, I have one quick question. So on the prescribing part, do we need to address -- because I think it was somewhere in Holly's 9-10 this morning about prescribing of abortion medications?

CHAIRWOMAN KEELS: That's in the Inclusionary Formulary.

MEMBER ZAMUDIO: Well, my only thought was -- in the formulary does it link to -- I went back to look at the Ohio Revised Code's definition of abortion, and actually I think it would be helpful to write that in there because it definitely is not that you can't prescribe the -- you can't effect an abortion, but there's some medications that we use for other reasons, but that can cause an abortion if given at a different time.

MS. EMRICH: Talking about Cytotec?

MEMBER ZAMUDIO: Cytotec, misoprostol, there's other ones. I don't know if we could reference the Ohio Revised Code's definition of abortion, because I thought it would be helpful.

CHAIRWOMAN KEELS: Abortion or abort a patient?

MEMBER ZAMUDIO: Abort a patient. So it's on 2119-11. It says it's the purposeful termination of a human pregnancy with an intent other than to produce a live birth, or to remove a dead fetus or embryo, and that's Ohio rule.

So if we put that in there, I just think it would be helpful for the prescribing part of it, because it might not be a nurse midwife, it could be anybody here. You could be in the ER, you could be covering, and we don't know.

MS. EMRICH: We have an AG opinion regarding abortion, administering -- even administering meds for that, and it's an explicit prohibition for APRNs and RNs. I'm trying to --

MEMBER ZAMUDIO: I think it would effect more than just women's health.

CHAIRWOMAN KEELS: Standard care arrangements?

MEMBER MINIARD: No.

MEMBER ZAMUDIO: I have another question. On that first paragraph where it said the collaborating physician must be authorized to practice, it's under the standard care arrangement, the first paragraph, they must be practicing in a specialty that is the same.

Do you think it would be helpful to just write clinical area or clinical arena, because now we're taking about the physician's specialty?

MS. DI PASQUALE: I think that's straight out of a statute, but I'm going to look.

MEMBER BOLTON: I kind of feel it has to be specialty, because their certification is different than ours.

I get this with the medical staff all the time, in that they are certified in ortho or critical care or internal medicine, where we are more generically certified with a specialty, so I think --

MEMBER ZAMUDIO: But what if they are not a specialist? Many physicians will tell you they are not a specialist, they are primary care.

MEMBER BOLTON: Or internal medicine.

MEMBER ZAMUDIO: And so they are not technically considered specialties. I was just thinking should we write -- because the -- the idea says clinical are.

MS. EMRICH: So it was just to clarify, when we're looking at the collaborating physician, we have never interpreted the physician's practice in a particular specialized area as being their board certification, we have looked at what is their practice and what does it look like, does that make --

MEMBER ZAMUDIO: That's why I was thinking the word specialty. It just said must be practicing in a specialty. So it sounds a little like they have to be in a specialty.

CHAIRWOMAN KEELS: I think we definitely want to stay away from location setting.

MEMBER ZAMUDIO: No, I was thinking clinical arena.

MS. EMRICH: It's in our statute.

MEMBER ZAMUDIO: It is in statute.
CHAIRWOMAN KEELS: Is there language that you can say to clarify that a little bit more, that -- I mean, it has to remain, must be practicing in a specialty, or like in parentheses or --

MS. EMRICH: Patient population.

MEMBER ZAMUDIO: There you go.

MS. DI PASQUALE: In our statute -- it makes it very clear that in our statute primary care or family practice is considered a specialty for the purposes of this statute.

I know it's not necessarily in the way that you might use it in everyday practice, but if you look at 4723.431(2)(B), it says that except as defined below for psyche, mental health, parents, the physician must be practicing in a specialty that is the same or similar to the nurse's nursing specialty.

And then it goes on to say that if the CNP or CNS is practicing psyche, mental health, pursuant to their certification, they may -- they have more choices.

They may enter into a standard care arrangement with a person who is practicing as a physician, who is practicing in one of the following specialties, and they list psychiatry, pediatrics, or primary care or family practice. So clearly in this context, specialty doesn't mean --

MEMBER MINIARD: Population.

MEMBER ZAMUDIO: That might be good to clarify there because -- or we could include all what you just said like a little blurb about that in this paragraph so they are not --

MEMBER MINIARD: That is in here somewhere, isn't it?

MEMBER ZAMUDIO: That's just for psyche, mental health.

CHAIRWOMAN KEELS: Specialty or population, that is same or similar.

MEMBER ZAMUDIO: What she said. Like family medicine is considered a specialty, so whatever, people who are in family medicine are included in them.


MEMBER MINIARD: I just have one question. So the broadest limit of the APRNs' practice is set forth in this the specific designations, statutory scope. Is that the same role?

MS. EMRICH: Yes.

MEMBER MINIARD: Can we put "slash role" like we were for specialty, and we're putting population, aka role?

MS. EMRICH: Got it.

CHAIRWOMAN KEELS: And then it refers back to the stuff -- the section we just reviewed. I think we -- we're going to have to be --

MEMBER ZAMUDIO: So the top of page 6 will be the exclusionary language I was talking about with the midwife.

So it does say that although our states say we can't do newborn care, our rule says what we can and cannot do, and it doesn't address circumcision per say.

There's an exclusionary comment underneath the first paragraph that says, "Although a nurse midwife's education and national certification may address a CNM's provision of newborn care for up to 28 days, and the performance of circumcision, this is not included in the CNM's statutory scope of practicing."

That's where I was asking that a statement be put in there recognizing that we do provide, because that's nowhere in -- that exclusionary which doesn't exist right now in our statute.

So to say it here is a big leap. So just to recognize that we would provide immediate or whatever, that's where I'd like Holly and Tom to come in and address this exclusionary language.

CHAIRWOMAN KEELS: Sure.

MEMBER SIEVERS: I think that would be good, because how do you take care of a newborn baby, a neonate that just came out, if you can't take care of a newborn? You know what I mean? You can't give newborn care, so it doesn't say anything about that.

MS. EMRICH: And I think the --

MEMBER SIEVERS: Like what case would somebody have if they say well, how do I take care of a newborn? Where does it say I can't do a circumcision? That's part of the care of the -- you know what I'm saying?

MS. EMRICH: Circumcision the Board addressed several years ago with a group, and the -- it's not immediate newborn care, and it's providing care to a male patient, and CNM scope of practice is specific to females.

MEMBER SIEVERS: But how --

MS. EMRICH: Now immediate newborn care and all that, I think we need to discuss that, and
how that is.
MEMBER SIEVERS: I think at some point the statute sounds like it needs to be more specific in this area.
MS. EMRICH: And that was the discussion.
MEMBER SIEVERS: So that would mirror the current circumstance.
CHAIRWOMAN KEELS: Which is what the CRNAs are trying to do with their legislation.
MEMBER ZAMUDIO: And it would make it consistent with OB/GYNs, they do the circumcisions.
I just -- like if we're going to write the exclusionary part of that, could we address it, because I don't want to give fodder to the malpractice attorneys, no offense to anybody listening or watching. I don't want to give information that says we can't provide that, and then there's a situation where a midwife would be resuscitating an infant, and then that --
CHAIRWOMAN KEELS: I don't think in emergency care --
MEMBER ZAMUDIO: Definitely a hundred percent. That written record is brought up, put on a screen in front of His Honor, and we go through it line by line. And were you even authorized to stop and provide that emergent care? Why didn't someone else who's in the law who could have done that. I mean, it would be a quagmire if we put prohibitory language here without just a one liner, we recognize this, or, you know.
MEMBER SIEVERS: Lead the way in, I was just going to ask if we felt like it's common knowledge that people know they can't do circumcision.
MEMBER ZAMUDIO: It's not.
MEMBER SIEVERS: Because newborn in the neonate is defined as up to 28 days, and this is newborn, which technically, when you look at definitions in the pediatric literature, like when I teach my pediatric students, it's up to a year. Newborn is the 28 day -- I'm sorry, neonate is the 28-day period. So I think being really careful, even newborn care up to 28 days is probably not --
CHAIRWOMAN KEELS: I don't think this document is going to be able to take everything you can and cannot do, but going back to get some more clarity around that would be helpful. Did you have more?
MS. EMRICH: No, that's fine.
MEMBER ZAMUDIO: Thank you.
CHAIRWOMAN KEELS: Next bullet, are we on CNS?
MS. EMRICH: Yes. That should be --
MEMBER DI PIAZZA: Second bullet.
MS. EMRICH: Got it.
CHAIRWOMAN KEELS: Everybody okay with that, CNPs scope of practice?
MEMBER MINIARD: I would just make a comment where it says within the nurse's specialty again that --
MS. EMRICH: National certification.
MEMBER MINIARD: Or population. I do like in the second -- the second bullet down under that, the sentence, "Similarly, a ACNP whose national certification is Pediatric Acute Care would practice 'consistent with' the population focus or nursing specialty..." So there it was very well defined that those were the same thing.
MS. EMRICH: So I'll use this as an example.
MEMBER MINIARD: I thought that was really -- it was very clear to me that those were the same thing, or maybe instead of saying -- or you might want to say just a slash or something, because or can mean either or, or both.
CHAIRWOMAN KEELS: Any other comments?
Next bullet, delegation. That's from rule.
MS. EMRICH: Yes.
CHAIRWOMAN KEELS: It's pretty clear to me.
MEMBER DI PIAZZA: Bottom of 6, second-to-last.
MEMBER MINIARD: Okay.
CHAIRWOMAN KEELS: Then the next bullet requires to utilize and incorporate into their practice knowledge of the Medical Practice Act and rules adopted thereunder, in the Dental Practice Act for CRNAs, and it looks like you have links to those.
MEMBER SIEVERS: Can I --
CHAIRWOMAN KEELS: Yes, Sherri.
MEMBER SIEVERS: I guess, is there a better word than govern? Because we're not governed by the Medical Board, we're governed by the Nursing Board. But maybe like instead of governed, the laws that relate to us, you know what I mean?
CHAIRWOMAN KEELS: Well, govern is used under the CRNA who is supervised by --
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<td>1 MS. EMRICH: Govern is referring to the</td>
<td>1 MEMBER BOLTON: Either one of those is</td>
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<td>2 supervising physician's practice.</td>
<td>fine.</td>
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<td>3 CHAIRWOMAN KEELS: It could be maybe --</td>
<td>4 MEMBER MINIARD: I think it would be</td>
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<td>4 MEMBER SIEVERS: You're in the last</td>
<td>good to have --</td>
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<td>5 bullet on page 6.</td>
<td>5 MEMBER BOLTON: You know what? Not a</td>
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<td>6 MEMBER ZAMUDIO: Keep reading.</td>
<td>FAQ, I want them to see it before.</td>
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<td>7 MEMBER DI PIAZZA: It refers to the</td>
<td>7 MS. EMRICH: What is a subspecialty,</td>
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<td>8 CRNA's supervising physician.</td>
<td>what does that mean?</td>
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<td>9 MEMBER SIEVERS: But it's in the</td>
<td>9 MEMBER ZAMUDIO: Did we address the</td>
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<td>10 sentence with the --</td>
<td>decisionmaking model anywhere in there?</td>
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<td>11 CHAIRWOMAN KEELS: It's a different</td>
<td>11 CHAIRWOMAN KEELS: We haven't.</td>
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<td>12 sentence, but it is in the same paragraph. We could</td>
<td>12 MEMBER ZAMUDIO: I know it's later in</td>
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<td>13 potentially just move that down and make it its own</td>
<td>the FAQ, but I wonder -- I know it doesn't have to be</td>
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<td>14 bullet if you wanted to.</td>
<td>all inclusive, but I'm just excited to have all this</td>
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<td>15 MEMBER SIEVERS: So the govern would be</td>
<td>15 in one place, so maybe referencing that because some</td>
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<td>16 part of the similar?</td>
<td>people still don't know about it or use it.</td>
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<td>17 CHAIRWOMAN KEELS: The governance would</td>
<td>17 It might be good to say something, you</td>
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<td>18 be part of the supervising language.</td>
<td>know, because a Consensus Model recommends a</td>
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<td>19 MEMBER BOLTON: I agree. I think that's</td>
<td>decisionmaking tool.</td>
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<td>20 good.</td>
<td>20 CHAIRWOMAN KEELS: So maybe after the</td>
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<td>21 MEMBER DI PIAZZA: New bullet.</td>
<td>last -- because it says -- this last bullet is APRNs</td>
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<td>22 CHAIRWOMAN KEELS: Next bullet there's a</td>
<td>must comply with the standards related, perhaps</td>
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<td>23 link there to the standards related to competent</td>
<td>another bullet would be the decisionmaking model</td>
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<td>24 practice. And that is where we come to the end of</td>
<td>available that the Board can help guide, because that</td>
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<tr>
<td>25 the general information.</td>
<td>sentence is in there later.</td>
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<td>1 MEMBER BOLTON: I struggle with that. I</td>
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<tr>
<td>2 think of that should be in the general information?</td>
<td>struggle with that being in this document because it</td>
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<td>3 We covered licensure, role, population, prescribing.</td>
<td>is so subjective.</td>
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<td>4 MEMBER BOLTON: Do we need to say</td>
<td>4 And I think in the last meeting I asked</td>
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<td>5 anything about some specialty exams?</td>
<td>the OAAPN rep to utilize the decisionmaking model to</td>
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<td>6 MEMBER MINIARD: That is something that</td>
<td>drive the question about scope of practice, and it</td>
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<td>7 is in the Consensus Model that is not addressed in</td>
<td>could not be done.</td>
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<td>8 here at all.</td>
<td>8 So I do not believe that that is going</td>
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<tr>
<td>9 CHAIRWOMAN KEELS: Maybe yes, we do the</td>
<td>9 to add clarity to this. I think it's going to add</td>
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<td>10 definitions.</td>
<td>10 more confusion.</td>
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<td>11 MEMBER BOLTON: I think there's a lot</td>
<td>11 CHAIRWOMAN KEELS: I think perhaps --</td>
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<td>12 of -- there are questions at times about if a</td>
<td>12 MEMBER SIEVERS: Go ahead.</td>
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<td>13 subspecialty exam can expand your skills.</td>
<td>13 CHAIRWOMAN KEELS: Perhaps there is an</td>
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<td>14 MEMBER MINIARD: There are a lot of</td>
<td>opportunity to explain that the decisionmaking model</td>
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<td>15 questions about that.</td>
<td>helps you determine tasks, activities, and procedures</td>
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<td>16 MEMBER BOLTON: I think that's important</td>
<td>within your scope of practice.</td>
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<td>17 to address.</td>
<td>17 MEMBER BOLTON: I'm okay with that. I</td>
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<td>18 CHAIRWOMAN KEELS: If a subspecialty</td>
<td>would like for there to be an example of how that can</td>
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<td>19 exam can expand your scope outside of your</td>
<td>be utilized, because I still think the subjective --</td>
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<td>20 original --</td>
<td>subjectivity in that model in answering those</td>
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<td>21 MEMBER MINIARD: Right, I've had that</td>
<td>questions can still get someone who does not have the</td>
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<td>22 conversation with people. That's a very good point.</td>
<td>skill -- or the education appropriate to that skill,</td>
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<td>23 MS. EMRICH: We can add that actually</td>
<td>23 they can answer. I mean, they can answer it</td>
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<td>24 somewhere -- as a direct informational paragraph or</td>
<td>subjectively and still get them down the --</td>
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<tr>
<td>25 we can add it as more of a detailed FAQ.</td>
<td>CHAIRWOMAN KEELS: You have to know what</td>
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would be okay with that being referenced in here.

MEMBER ZAMUDIO: My proposition was just awareness. So the APRNs don’t come in and use that, or haven’t gone to the Board’s website would be able to use that.

CHAIRWOMAN KEELS: I think it’s a good point, a valid point, because on the Board website under the practice resources, there are certain things that are available, and to have something that says oh, well, that’s why that is there, or this is how you use that --

MEMBER MINIARD: Maybe just to what you said, that this is a -- the skill. It’s addressed to do you have the skill to perform this activity, not does this activity fall within your scope of practice.

Just a statement that clarifies this, because this is not interpretive guidelines, so that should be something that could be written in a nonprovisionary way that says you don’t use this tool to determine scope of practice.

MEMBER BOLTON: And --

MEMBER MINIARD: That might be a great way.

MEMBER BOLTON: I think it’s excellent.

---

what I’m saying?

CHAIRWOMAN KEELS: I think I remember that.

MEMBER MINIARD: It’s in the Consensus Model. Like it gives fairly clearly defined -- doesn’t exactly give a no, but it says here is where the ACNP and the adult primary care people -- this is where you stop and you have to hand off care.

So I think -- I’m not trying to get in that gray zone, or get there, but I think it would be good to have at least an example of how to use that tool correctly, because just when we were looking at the pharmacy one earlier, there’s sometimes you can draw the arrow in the wrong place and end up on the wrong thing.

MEMBER BOLTON: And I think the other piece to that is that maybe one of the examples, trying to use it for scope of practice, because it doesn’t work for that. You know what I mean? It works for skills, and I think if you have an example of a skill and you take it down through, and you show how you avoid the subjectivity, and that would be a good thing.

The no is scope, no, you can’t use this for scope. We clearly identified that. And then I to have it in this. If we could have the clarifying example and the context that would be awesome, because then it clearly says that what some feel out there is a document to describe scope is really not that.

CHAIRWOMAN KEELS: Okay.

MEMBER BOLTON: I like that.

CHAIRWOMAN KEELS: Thank you. Anything else that you think should be included in the general information, without making it so, so long that nobody looks at it?

MEMBER MINIARD: I think this is awesome.

CHAIRWOMAN KEELS: I think it’s very helpful for not only new to practice, but even those who are practicing. I’m sure I learned at least one or two things.

MEMBER ZAMUDIO: Ditto.

MEMBER MINIARD: I do like the questions and answers, because it gives you some examples of questions, and it’s a problem based way to learn the material without --

CHAIRWOMAN KEELS: So let’s go under senior care arrangement FAQs. Anybody have any questions about those Q and As?
MEMBER ZAMUDIO: I'm so sorry. On page 8? Did I skip to the next section? I thought we were done. We're still on 7, okay.
MEMBER BOLTON: Wishful thinking.
CHAIRWOMAN KEELS: We're getting there.
MEMBER SIEVERS: So my prescribing thing is there.
CHAIRWOMAN KEELS: Nothing under SCA?
MEMBER SIEVERS: No, it's under SCA.
It's that third one down. I don't think we can do anything to help it, but I've had people say to me what does that mean? Like how would you operationalize that if we were both in the clinic together, and you're in a room prescribing?
So I guess I mean, does it mean you can't have more than five people in one clinic with one doctor? I mean, what if I'm not prescribing today, you know what I mean?
MEMBER DI PIAZZZA: Do we really want anyone to clarify that?
MEMBER SIEVERS: No, we don't.
CHAIRWOMAN KEELS: But you typically have more than one collaborating physician, typically.
MEMBER SIEVERS: True. Right.
CHAIRWOMAN KEELS: Who may not be in that room or even on-site, but is available for phone consultation.
MEMBER ZAMUDIO: Right. So to that end, I agree with Sherri about the maybe we don't need to clarify that.
But it does go on to add information that is not in the statute where it says this is a matter of scheduling. That might have been the intend, but that's not what it says, right?
So if we address scheduling, we have just now prescribed to them, to not schedule more than five at one time who could be prescribed at one time. I think we should leave that sentence off there.
MEMBER BOLTON: I agree.
CHAIRWOMAN KEELS: Angela, did you have a comment?
MEMBER GAGER: No, it was already said.
CHAIRWOMAN KEELS: You think we should leave that last --
MEMBER SIEVERS: The last sentence.
MEMBER GAGER: Or just get rid of the sentence that says this is a matter of scheduling,
but leave the rest of it.
MEMBER SIEVERS: Yeah, it's fine. It doesn't really make sense.
CHAIRWOMAN KEELS: But when you explain it to people, you can call your -- one of your collaborating physicians --
MEMBER SIEVERS: I guess if you only had one collaborator and you had five NPs and they were all working the exact same day, you'd be okay, but if you had six, it could get sketchy. If you have like one practice, yeah.
And maybe that was the intent of it.
They didn't want one doctor to have ten people working in their office at the same time.
Who is to say they are all prescribing and it's at the same time, the exact minute, or is it you prescribe now, I'll prescribe in the next hour.
MS. EMRICH: This kind of limits for a physician and how many prescribing APRNs they may collaborate with at the same time is a longstanding like ratio, and with 216 it got increased from three to five. So how --
MEMBER SIEVERS: I know.
MS. EMRICH: There's not --
MEMBER SIEVERS: We're not going to fix it. It's just when I try to explain it, it's really, really hard.
MEMBER BOLTON: I think you need to go back to the definition of collaboration, and you can call anyone. Just because this doctor is here, if I'm number six, I can call the other one, or you know what I'm saying?
MEMBER SIEVERS: Yes.
MS. EMRICH: This is a requirement for that physician, and so the physician may make it a scheduling thing.
And that's just to be -- that's how we have explained it over the years is -- to physicians who call us, is that when you can collaborate with however many aids, say APRNs, but only five should be actively working with prescriptive authority, and having the ability --
MEMBER SIEVERS: At one time.
MS. EMRICH: -- during the same period of time, yes.
MEMBER BOLTON: It doesn't mean prescribing at that time. You have one physician for five NPs, it's just so the potential for him to be engaged with one NP or more than one NP at any time to alleviate that confusion or potential problem.
MS. EMRICH: Or more than the number of phone calls that --
MEMBER BOLTON: That's how I describe it to them. I don't go down to the you're prescribing the --
CHAIRWOMAN KEELS: Okay. Moving onwards, prescribing, inclusionary formulary that is written out there. We're at the bottom of 7, and the next paragraph.
MEMBER ZAMUDIO: Maybe at the bottom of 7 is a good place to reference the 2919.11 on the abortion per the exclusionary. Is that a place to squeeze it in instead of a FAQ?
MS. EMRICH: It would be related to the exclusionary formulary that it's prohibited by law. So you're really restating something that's already in the exclusionary.
MEMBER ZAMUDIO: I just kind of like to keep it all in one place, so that might be a good place to put that.
MEMBER SIEVERS: But you don't want people to think that's the only exclusionary, you'd have to put everything.
MEMBER ZAMUDIO: It just says it's restricted by this, but it also has that other

restriction. And then we could reference the -- and it does state -- in our chapter it states it does reference 2919, so it says the definition of abortion.
I mean, that's in there. I just thought if we're trying to keep it all together, if it's exclusionary language, it's part of the exclusionary formulary, we could list it right there with the exclusionary formulary. Just a thought.
CHAIRWOMAN KEELS: There were other things that were prohibited by law prescribing to, too, so we list those out.
MEMBER MINIARD: Just reference the exclusionary formulary, and they can find it themselves. That's my opinion.
MEMBER ZAMUDIO: Right.
CHAIRWOMAN KEELS: Are you ready for page 8, DATA waiver training?
MEMBER ZAMUDIO: I'm good. Everyone good with DATA waiver?
CHAIRWOMAN KEELS: Information on how to obtain specific drugs.
MEMBER BOLTON: Sounds good.
CHAIRWOMAN KEELS: Put you back to pharmacy. Right. Group medical practice asking for

cross coverage.
MEMBER MINIARD: I like that. I thought that was really good. It's vague enough that it doesn't -- could be these. It's not limited to, pertinent considerations may include, because this happens a lot.
CHAIRWOMAN KEELS: Well, we do --
MEMBER MINIARD: So-and-so is not here, can you sign for it?
MEMBER SIEVERS: I like it, too.
MEMBER ZAMUDIO: So the only thing I had a little struggle with -- I mean, I had a struggle with a lot of it, actually, but where it says the criteria for establishing the valid prescriber, the answer mostly addresses prescribing to someone, because that's what their question asks, prescribing to cross coverage, but it doesn't recognize that you might not be actually prescribing it, but you might be prescribing, you might be advising, you might be caring for them, doing something beside prescribing.
You might just be answering a patient's phone call. Is that allowed? Does that just need to be in your SCA?
And then when it talks about the subparts of the rule on the third dot down towards the number 8, it says the APRN has access to the patient's medical records during the encounter. But that's not in the definition after prescriber relationship.
It doesn't mean you have to have the medical record during the encounter, because you may not be -- if you're cross covering, you're answering a phone call, that's saying if you're not in the office looking at the chart in that encounter you may not prescribe anything.
MEMBER MINIARD: Just a few clarifications. So when you say you're answering, I just wasn't sure exactly how to take what you said.
So if you say you're answering a patient's question, are you saying that you're asking -- you're answering a question about what is Gabapentin, or are you asking a question like this isn't working for me, so I want to increase the dose; or what would be your recommendations on this? Should I increase -- you know, is there ability to take more of this?
Because in that case, if you are telling the patient to increase the medication, then you are prescribing.
MEMBER ZAMUDIO: Absolutely.
MEMBER MINIARD: So I didn't understand what the --
MEMBER ZAMUDIO: Well, people cross cover a lot of things, especially in OB. You cross cover telling somebody -- and somebody else's patient call in saying they are having a miscarriage or whatever.
I'm saying the answer primarily prescribing during cross coverage, without saying -- so should we put something in there saying you can provide care during cross coverage if that's something that's addressed in your SCA?
But most importantly, is the access to the medical records of the patient during the encounter. So some people don't have Epic. And what I'm trying to think about is that rural NP who is answering a phone call, she doesn't have a chart in front of her, she's met all the by law required the top -- what is that, six or five components. It doesn't say it has to be medical records, it has to be present during the encounter.
It says you have to obtain a relevant history.
MEMBER MINIARD: So I think it goes back -- I am by no means an expert in this. It goes back to the statute and the rule that says you have to have developed a patient and provider relationship, and if you don't know this patient from Adam, and you're on call and don't have access to the EMR, then you don't have a patient/provider relationship.
MEMBER ZAMUDIO: That's not true. It has the five criteria for establishing the relationship.
MEMBER MINIARD: You don't.
MEMBER ZAMUDIO: But the Board of Pharmacy -- and in here lists the five things that establish a valid relationship, and one of them is not that you have your hands on their medical record.
MEMBER GAGER: But I think what it's saying though are these are the things that define a patient/provider relationship, but it says --
MEMBER MINIARD: Prescriber.
MEMBER GAGER: I'm sorry. But then it goes on to say it's not necessary that every subpart be present. So if maybe you haven't seen the patient before you have access to their medical record, you can initiate prescribing.
MEMBER ZAMUDIO: That's how I interpreted it.
CHAIRWOMAN KEELS: It's not -- one at a time.
MEMBER ZAMUDIO: I just thought that sounds -- it's a little bit easier for somebody who looks down through there and says I don't have their medical record.
CHAIRWOMAN KEELS: But regardless, whether you give advice, prescribed or whatever, you still need to document that somewhere.
MEMBER ZAMUDIO: Absolutely.
CHAIRWOMAN KEELS: So you may not have it at the beginning of the encounter, but soon after the encounter you should have had that.
MEMBER ZAMUDIO: Yes, many practices just have a tear off pad. They give advice, they write a prescription, the next day all of those are placed in the medical records.
MR. DILLING: This is a terribly complex legal issue as well.
MEMBER ZAMUDIO: I didn't mean for it to be.
MR. DILLING: Good questions. You know, good questions that you bring up. I threw out there that the APRN prescriber cannot exceed the scope of their collaborating physician.
They are also, by rule, to be attentive and follow Medical Board rules in those relevant areas, and there is a Medical Board rule on prescribing to patients not seen. And so now you have the intricacies of that governance as well.
There are parts of that rule, though, that do address cross coverage situations. I'm probably not the best person to speak to it, I'm rather critical of the rule, my abilities to understand it totally and to explain it well.
I will say that the Medical Board, in addition to that rule, has like eight pages of FAQs related to the rule which further --
MEMBER ZAMUDIO: She has the rule.
MR. DILLING: -- simple complexity, and, you know, difficulty in reading certain aspects of it.
So this is something I think we have got to go back and, and you know, really hone in on and take a look at. I'd be hesitant to give you hard and fast answers to different scenarios.
MEMBER MINIARD: That's what I was saying.
MEMBER ZAMUDIO: I have a question. So my question is for Lisa, then. So you listed it out, so this is -- the second one, the second four, is
Do the first one. "As an APRN I've been asked how I am authorized to make my medical diagnoses and to prescribe. Where can I find this? Just gives the statute.

MEMBER MINIARD: Good.

CHAIRWOMAN KEELS: Next, what is the scope of practice for a CNP who is certified in Women's Health Care?

MEMBER ZAMUDIO: From a perspective of nurse midwife, women's health, sexual health practices, I think this is going to open up a bunch of stuff.

I mean, I really do. For one thing, it talks about the male partners of a female patient. And if you're considering just this general -- or female or male patients, that's one thing.

But the statute, or the rule, I think actually states individuals, which might be better. I think this whole example is going to open up gender fluidity issues.

MEMBER MINIARD: I was just going to say that.

MEMBER ZAMUDIO: There's going to be -- I can guarantee a lot of push back and questions about gender fluid issues.

So I don't know -- I mean, we go into the treating STDs, et cetera, but the actual question was about a woman's health person treating a male in oncology.

I hope that's never actually an absolute question from somebody, but it's just that's an odd question.

And then the answer to be addressing, male, female issues, there's transgender practices in our city where there are women's health practitioners who are treating someone who was biologically a female and has a vagina, but they have vaginal dryness from their testosterone therapy at their transgender clinic. So I think this is going to be an issue to address in this.

CHAIRWOMAN KEELS: So my question is, is it practice or scope because of the gender fluid, and do we need to be very clear on what the statute is right now?

MS. EMRICH: And -- and what's NCC standards? I guess that's another thing. NCC is women's health.

CHAIRWOMAN KEELS: Because you always need to go back to those standards as they evolve. I would wonder, are they addressing gender fluidity at
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1. this time?
2. MEMBER ZAMUDIO: So more recently some
3. are. Most are not. Although down here at our level,
4. practice level, it's huge.
5. So there's a gap there, so I think maybe
6. we could take out the example of a woman's health
7. practitioner wanting to do male oncology.
8. Like is that a realistic question?
9. Could we address it some other way for scope of
10. practice for women's health not making it about STDs
11. and vaginas and gender parts? I think maybe the
12. whole question --
13. CHAIRWOMAN KEELS: Lisa can look at it.
14. These come from real live questions.
15. MEMBER ZAMUDIO: That's just scary.
16. MEMBER SIEVERS: He's got breast cancer.
17. It's a male with breast cancer.
18. CHAIRWOMAN KEELS: Right. Hence the
19. question.
20. MEMBER SIEVERS: That is a good
21. question.
22. MEMBER MINIARD: I mean, a nonwomen's
23. health provider, if one of my students asked me this
24. question, I'd have to think about it for a minute.
25. CHAIRWOMAN KEELS: Let me call Lisa.

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1. MEMBER ZAMUDIO: Sorry, Lisa. It's just
2. such an area, I wanted to point it out.
3. CHAIRWOMAN KEELS: I think it's a good
4. area for more discussion and language as the practice
5. evolves.
6. MEMBER ZAMUDIO: But where it's
7. documented in here earlier, it says the
8. individuals -- the individuals who are sex partners
9. of your patient. Here it says male, female.
10. So I'm just saying either be consistent
11. and take out the word male, because can I treat a
12. female partner of my patient for an STD?
13. Well, according to this it says a male
14. partner of female patients. I just know earlier when
15. we addressed it, it says individual.
16. CHAIRWOMAN KEELS: Just say sexual
17. partners.
18. MEMBER MINIARD: Yeah, was -- it could
19. be male or female or both.
20. MEMBER SIEVERS: Can I make a general
21. recommendation with the question, that you answer yes
22. or no at the beginning, because I might read that
23. answer and not really sure -- at the end I'd say
24. okay, so is it okay or not, they never really said
25. yes or no, because you said, for example, partners.

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1. So I might say does that mean for
2. example a man who has breast cancer is included, or
3. are they saying it's not included.
4. MS. EMRICH: Okay.
5. MEMBER ZAMUDIO: That's good.
6. MEMBER SIEVERS: So for each question a
7. yes or no to start, yes.
8. MEMBER MINIARD: I think it kind of
9. leaves it open that it seems no to me, but --
10. MEMBER SIEVERS: It's not clear.
11. CHAIRWOMAN KEELS: Okay. And there may
12. be some questions, the answer that says it depends on
13. the below.
14. MEMBER SIEVERS: Yes.
15. CHAIRWOMAN KEELS: All right. Next
16. question. Adult gero primary care, would I be able
17. to see patients under the age of 12. This starts
18. talking about what are those age ranges in
19. developmentally focussed --
20. MS. EMRICH: We get those.
21. MEMBER MINIARD: Good.
22. CHAIRWOMAN KEELS: No discussion?
23. MEMBER SIEVERS: The bottom one, is that
24. one?
25. MEMBER MINIARD: The bottom one on

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1. page 9.
2. MS. DI PASQUALE: So based on the
3. discussion earlier, you're looking at the one that's
4. on the decision. So you delete -- I assume your
5. recommendation would be to delete the six sentence of
6. that answer?
7. MEMBER MINIARD: I'm sorry?
8. MS. DI PASQUALE: Are we looking at the
9. decisionmaking model? I'm sorry. I'm sorry.
10. MEMBER MINIARD: I was like wait a
11. minute, what are we talking about.
12. MS. DI PASQUALE: My apologies.
13. CHAIRWOMAN KEELS: So in this example,
14. the answer would be yes or no, and then go on to
15. explain why, right?
16. MEMBER MINIARD: And refer to your
17. certification, the Board doesn't regulate.
18. CHAIRWOMAN KEELS: At least at some
19. point in time somebody feels like -- some
20. organization believes that a 12 year old is now an
21. adult -- developmentally an adult.
22. CHAIRWOMAN KEELS: Page 10. Top of
23. page 10, is a CRNA authorized to administer drugs,
24. such as low dose ketamine infusion for the purpose of
25. pain relief.
I really like this example because it said well, no, not as a CRNA, but as a nurse, here is what you can do. Because don’t forget, you are an RN.

MS. EMRICH: And it asks questions about administering.

CHAIRWOMAN KEELS: So that answer would be it depends.

MS. EMRICH: Are you doing it as a CRNA or an RN? Either way, you have to have an order for that purpose.

MEMBER MINIARD: We can’t order it, can give it.

MS. EMRICH: The CRNA, their current scope does not include the treatment of -- the treatment of treatment resistant depression.

MEMBER MINIARD: So they can’t write the order for it, and then administer it. But if someone else writes the order for it, like the anesthesiologist, then they could administer it in the RN.

CHAIRWOMAN KEELS: In their capacity as an RN.

MEMBER MINIARD: That’s what I’m asking.

MEMBER BOLTON: I hate to go back, but that question just needs to say 12 and under, rather than under the age of 12.

MS. EMRICH: Good question, because the national certification -- just --

MEMBER MINIARD: I tried to get her to drop it.

CHAIRWOMAN KEELS: The only bad question is the one that’s not asked.

MS. EMRICH: They are really going with growth and development stages now, so that’s why I think under the age of 12, because that’s a pediatric pubescent kind of thing.

MEMBER BOLTON: I’m going to call you and say is it 12?

MEMBER MINIARD: Is it 12 or 11?

MS. EMRICH: I’ll look at that.

MEMBER BOLTON: I’m sorry, I don’t mean to be a pain.

MS. EMRICH: Okay. Got it. We can move on.

CHAIRWOMAN KEELS: We’re good to move on?

MEMBER MINIARD: Yes. Are you sure,

Pam?

CHAIRWOMAN KEELS: Okay. The middle of...
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| MEMBER MINIARD: No. I didn't read the answer before I reacted to the question. |
| MEMBER GAGER: But I agree with you, I think it should be out of the question. But I think sometimes scope is defined by setting, and that's not correct. |
| CHAIRWOMAN KEELS: That has to be explained. |
| MEMBER ZAMUDIO: Yes. |
| MEMBER MINIARD: So I jumped the gun, I apologize. Scratch that from the record, please. |
| MEMBER ZAMUDIO: And so then do we -- |
| CHAIRWOMAN KEELS: Hold on. |
| MEMBER ZAMUDIO: Do we go with the two lines down where it says that determine the CNP's nursing specialty, or should we make it consistent and write the word -- |
| CHAIRWOMAN KEELS: We'll have the language consistent throughout the whole -- |
| MS. EMRICH: So we leave the whole question as is, or do we leave the last phrase in the question? |
| MEMBER MINIARD: No, because I think -- I'm sorry, go ahead. |
| MEMBER GAGER: No, go ahead, Jody. |

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| MEMBER MINIARD: This is the hot button question right here, right? Why wasn't that the first one? This is the hot button question, so in my personal opinion, I think it should stay there. |
| CHAIRWOMAN KEELS: As is? |
| MS. EMRICH: As is. |
| MEMBER MINIARD: And then we need to explain that there's no limit in the settings in which they practice, so on and so on. But then the CNP must first look if their defined scope of practice as a section. Does it say scope of practice in this block? |
| MS. EMRICH: That is our section toward definition. |
| MEMBER MINIARD: Because then that takes us back to then questioning what -- I'm targeting all kinds of questions. |
| MEMBER SIEVERS: Not about what you're saying. |
| MEMBER MINIARD: That was my question, is that term scope of practice or specialty/population focus should be put in there, too, so that they know that when you're using that term scope of practice, you're talking about specialty from the statute, and population focus from |

| certified in family, which is primary care. How may I determine the limits of my individual scope if employed in a hospital? |
| MEMBER MINIARD: See what I mean? Because scope of practice has nothing to do with credentialing and -- not credentialing, delineation of privileges. |
| CHAIRWOMAN KEELS: So how can I determine the limits of my individual scope, and leave setting out of it? |
| MEMBER ZAMUDIO: Wait, what? |
| CHAIRWOMAN KEELS: So Jody was concerned that we brought in setting because it said if employed in a hospital, because we want to make this about population in your practice, not where you are. |
| MEMBER MINIARD: Right. We have got to be very careful about that. |
| MS. EMRICH: Then we should get rid of the first sentence in the answer then. There's no -- there's no mention of setting in the question, so there would be no mention of setting in the lead off. |
| MEMBER GAGER: I like that. |
| MEMBER MINIARD: I like that. |
| CHAIRWOMAN KEELS: You want it both ways? |
going to manage DKA, so I think it's a fine line.

CHAIRWOMAN KEELS: So there is the severity of illness or severity of acuity -- we don't want to use acuity.

MEMBER GAGER: Complexity.

CHAIRWOMAN KEELS: Not complexity.

CHAIRWOMAN KEELS: It's really the level of --

MEMBER BOLTON: I mean, you have acute in primary care and you have acute in the acute care.

MEMBER MINIARD: Critical.

MEMBER BOLTON: I mean, that's the problem. No one is really defined in the two. Acute in one does not mean acute in the other, because you wouldn't want me to take care of acute in the primary care stuff, but I'll take care of it in the other setting.

CHAIRWOMAN KEELS: Maybe talk about acute in the very beginning of the document where we do definitions. I think that is within all --

MEMBER BOLTON: Otitis media versus epiglottitis, you know what I mean?

CHAIRWOMAN KEELS: Levels of acuity.

Michelle then Sheri.

MEMBER ZAMUDIO: Along that same lines

though, when you're reading that answer to that, it says there's no limit as to the settings, and then it says there are limits on the patient conditions the CNP with this may be managed. With what?

MS. EMRICH: There was a word left out.

MEMBER BOLTON: They are referring back to the CNP. But it --

MEMBER BOLTON: The CNP --

MS. EMRICH: No, with this certification. With this certification.

MEMBER ZAMUDIO: I think just for clarity, we can put what's in there.

MS. EMRICH: I think it's a typo.

MEMBER ZAMUDIO: Because I thought it meant condition.

MEMBER SIEVERS: So where did we land on the -- are we leaving it on patient condition, or we deciding to put acuity in there?

CHAIRWOMAN KEELS: I think we're going to wordsmith it.

MEMBER SIEVERS: Because defining acuity might get us back to where be started.

CHAIRWOMAN KEELS: But what about that next sentence, national certification of family does not include the family of patients with high acuity,
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<td>unstable conditions.</td>
<td>practicing in bariatric medicine and surgery, asking about prescribing drugs for weight loss.</td>
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<td>MEMBER MINIARD: So why can't you say patient condition/acuity? And then you're going to further define acuity later in the answer, high acuity, unstable critical conditions, because it could be condition dependent or --</td>
<td>I thought this was really good, and reminds you that you have to know what the Medical Board says as well.</td>
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<td>MEMBER SIEVERS: You can have a DKA patient that is very stable that could probably be managed by an adult geri or primary care, but I might have a completely unstable patient that can't be.</td>
<td>MEMBER BOLTON: Yes, I like that, because I just looked this up recently.</td>
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<td>MEMBER GAGER: I think you can get rid of that second sentence all together.</td>
<td>CHAIRWOMAN KEELS: Something that I don't think many, especially our hospital based practitioners, think about.</td>
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<td>MEMBER SIEVERS: And --</td>
<td>MEMBER BOLTON: It was excellent.</td>
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<td>MEMBER GAGER: First sentence talks about settings, and then it goes on further down in the paragraph to talk about acuity and unstable conditions. So I don't think you need to say there's limits on the patient conditions, I think that's confusing.</td>
<td>CHAIRWOMAN KEELS: APRN delegation to unlicensed persons. There's a yes.</td>
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<td>MS. EMRICH: I agree. I just flagged through it.</td>
<td>MEMBER BOLTON: I like that.</td>
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<td>MEMBER MINIARD: There's no reason.</td>
<td>CHAIRWOMAN KEELS: But -- no. The by contrast --</td>
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<td>MEMBER SIEVERS: Then we don't have to do anything else.</td>
<td>MEMBER ZAMUDIO: I have a question. I'm not familiar with this section. I have not read the code until I got this right here, so this is a question and clarification request.</td>
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<td>MS. EMRICH: And everything else is good.</td>
<td>On the by contrast answer, the third dot down, it says including specific requirements as to the unlicensed person's documented education, demonstrated knowledge, skills, ability to administer the drug, and the requirement that the APRN is on-site during the delegated medication administration.</td>
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<td>So would this prohibit, like for example, a standard order for flu shots if you're not standing there when it's given and you're off that day and your patient's there and they are coming in to see somebody?</td>
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<td>MEMBER MINIARD: Just add that word.</td>
<td>Because by protocol, sometimes you might prescribe the MA's, unlicensed people tend to give those medications.</td>
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<td>CHAIRWOMAN KEELS: Add what word.</td>
<td>MEMBER ZAMUDIO: But they are not working independently, so they are still a prescriber on-site.</td>
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<td>MS. EMRICH: Certification.</td>
<td>MEMBER ZAMUDIO: Not at private offices. There's many offices who -- ooh, gosh, yeah, the physician is not there that day, especially in specialties, they are only there a few days a week, but their staff is there every day. It's by a protocol, I mean, but is that considered a delegation?</td>
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<td>CHAIRWOMAN KEELS: Got you. Ready to leave that one?</td>
<td>MS. EMRICH: If an unlicensed person is administering an immunization by protocol, that -- let me back up.</td>
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<td>MEMBER MINIARD: Yes, please.</td>
<td>An LPN or an RN may administer an immunization by protocol. LPNs and RNs have</td>
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<td>CHAIRWOMAN KEELS: CNP certified in primary care, pediatrics. I thought this was good.</td>
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<td>This goes back to where, as I was initially, something that only acute care could do, but now it's become more standard of care, so covered through your primary care certification, because your education has been maintained, right? So the practice, the population evolved over time is included back in your certification guidelines. You should have been maintaining continuing education in this.</td>
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<td>MEMBER BOLTON: I like it.</td>
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<td>MEMBER ZAMUDIO: I like it.</td>
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<td>MEMBER SIEVERS: And it says yes.</td>
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<td>CHAIRWOMAN KEELS: That's from Latecia, right? Years ago. She brought that up. All right. Next, CNS entered into a standard of care arrangement with a physician</td>
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MEMBER SIEVERS: Very nice.
MEMBER MINIARD: This is so much better than the bar graph. I don't know if we ever are going to come to consensus on that.
CHAIRWOMAN KEELS: I feel like this is pretty all encompassing. It's a lot of work. It's going to be fairly long. What do you anticipate this looking like, a document, or on the website with links?
MS. EMRICH: Probably be a document with links.
MEMBER MINIARD: You can pick out the pieces you want.
CHAIRWOMAN KEELS: It will look like this, but the links will be there for more information.
MS. EMRICH: Just to get you to the source of it.
CHAIRWOMAN KEELS: So it's a long document.
MEMBER MINIARD: I just was wondering if there was a way to -- when you set it up -- this is probably even more work -- but by section, you know what I mean? So if you have a question about -- I'm going to stay out of the weeds. You do what you do.

MEMBER BOLTON: You're saying that's not delegation.
MEMBER MINIARD: She's not saying anything. She's not getting in the weeds.
MEMBER ZAMUDIO: It's just a common question. We have not just with immunizations, but when they needed their Rhogam and they came in and did something -- or there's lots of reasons medications that are given for other reasons. So if it's a nonlicensed personnel does the APRN need to be physically standing there?
MS. EMRICH: Has to be on-site.
MEMBER MINIARD: There needs to be a licensed provider in that building on-site.
CHAIRWOMAN KEELS: Whatever on-site means.
MEMBER MINIARD: If an unlicensed provider is giving any kind of treatment or medication, is what I'm understanding, right? But if it's an RN or pharmacist and they are doing it per protocol, then there does not need to be a licensed provider -- I mean prescriber.
MEMBER ZAMUDIO: Just curious.
MEMBER MINIARD: That was a good question.

MS. EMRICH: And I get it. And we want to go there to make it as easy as possible, but on the other hand you have to balance that by every practitioner's responsibility to know what is in the statute.
MEMBER MINIARD: That's why I stopped. It would be easier if you just went to the point you wanted, you want to know about RN, you go here, if you want to know about APRN, you go here. But it is important to read this whole thing.
MS. EMRICH: And it's important to go to the source.
CHAIRWOMAN KEELS: These are the cliff notes, but you still need to read it.
MS. EMRICH: We're giving you at least an inclination on it, just ideas.
CHAIRWOMAN KEELS: Any gaps that you wish were in here? I can't think of a thing.
MEMBER MINIARD: Nicely done.
CHAIRWOMAN KEELS: One thing, from Brian, remember, he wanted us to comment on the use of the title doctor as we have for DMPs graduating, how that should be navigated using your academic title, when and where it's appropriate.
MEMBER ZAMUDIO: I think that was in the
MEMBER MINIARD: It was in here somewhere, I saw it.

MEMBER ZAMUDIO: I saw it in the list of questions.

MEMBER MINIARD: Wasn't it on your questions?

MS. EMRICH: Summary of questions.

CHAIRWOMAN KEELS: It's on the summary questions but --

MS. EMRICH: We can move that to the July --

MEMBER MINIARD: Cool. People probably have a lot of differing opinions about that.

CHAIRWOMAN KEELS: So our next agenda item is public comments. Do we have anybody with a public comment still? Want to make sure nobody changed their mind. We're good.

Well, we did a lot of work today. We can be proud of you all.

MS. DI PASQUALE: Tom needed to leave, but he wanted me to give you the numbers on these House Bills. HB492 is the PA bill, physician assistant bill --

MEMBER MINIARD: What was it?

MS. DI PASQUALE: 492, HB429. And the date here, 2-4-2020. I'm not sure if that's introduced.

And then 1-28-2020, HB448, athletic training bill, that's HB484, athletic training bill. And 12-17-19 was HB455, surgical assisting bill, HB455. So if you Google that --

CHAIRWOMAN KEELS: Thank you.

MEMBER BOLTON: Thank you.

CHAIRWOMAN KEELS: Okay. Wrap up from the meeting. Anything else? Anybody feel the need to discuss? What would you like to see on the next agenda besides the next draft of this?

MEMBER MINIARD: And the doctor thing I guess.

CHAIRWOMAN KEELS: The DMP.

MS. EMRICH: Use of title.

CHAIRWOMAN KEELS: Maybe it's just what is the --

MEMBER MINIARD: Time and place to use that title.

CHAIRWOMAN KEELS: But how about what should my signature look like, because I see a lot of different variations on the -- on how people use their titles.
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, March 2, 2020,
and carefully compared with my original stenographic
notes.

Valerie J. Grubaugh,
Court Reporter and Notary
Public in and for the State
of Ohio.

My commission expires August 11, 2021.
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