

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 Miniard, APRN-CNP, Member
- Angela Gager, APRN-FNP, Member
- Pamela Bolton, APRN-ANCP, APRN-CNS, Member

Also Present:

- Lisa Emrich
- Chantelle Sunderman
- Anita DiPasquale

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

1 Monday Morning Session,  
2 March 2, 2020

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4 CHAIRWOMAN KEELS: By my phone it's  
5 10:00, so we'll go ahead and get started. Good  
6 morning, everyone. Welcome to the Ohio Board of  
7 Nursing APRN Advisory Committee.

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

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

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

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

23 To my left.

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

- 1 am Southeast Region Director for OAAPN.
- 2 MS. DRING: Jennifer Dring, OAAPN.
- 3 MS. GABELE: I'm Christina Gabele,
- 4 Emergency NP and Family NP from Akron. I teach at
- 5 Walsh, and work in the ERA in Akron.
- 6 MS. SULLIVAN: I'm Tori Sullivan. I'm a
- 7 student at Capital University.
- 8 MS. WELLS: Betha Wells. I'm also a
- 9 student at Capital University.
- 10 MS. CLARK: Charlie Clark. I'm also a
- 11 student at Capital University.
- 12 MS. SIEVERS: Dina Sievers, student at
- 13 Ohio State.
- 14 MS. DUBACH: I'm Jessica Dubach, I'm
- 15 staff at ONA.
- 16 MR. DELILLE: Eli Delille, I'm a student
- 17 at Marshall University.
- 18 MS. HUFFMAN: Kate Huffman with the Ohio
- 19 Hospitals.
- 20 CHAIRWOMAN KEELS: Thank you. Welcome.
- 21 Member DI PIAZZA: And I am Pete
- 22 DiPiazza. I apologize for being late. I represent
- 23 the FNP's in primary care.
- 24 CHAIRWOMAN KEELS: Hi, Pete. So if you
- 25 wish to speak during this Committee, we have time for

1 public comments, and you need to complete one of  
2 these yellow forms that's down at the end of the  
3 table.

4 We also have the Public Participation  
5 Guideline there for your information as well.

6 Committee Members, please raise your  
7 hands to speak. And we do have a Court Reporter  
8 joining us today to document the proceedings, so do  
9 please speak one at a time, clearly, and succinctly.  
10 Thank you.

11 So just a brief summary to date for all  
12 of those who are joining us live, or remotely --  
13 hello everybody online -- this Committee has agreed  
14 to continue to follow the Consensus Model in Ohio.

15 We have been working to develop some  
16 online guidance to assist in understanding the scope  
17 of practice, and clarifying terms such as specialty  
18 and acute, and then make this -- or present this to  
19 the Board for review and approval.

20 The Committee, at our last meeting,  
21 agreed that some form of an Interpretive Guideline  
22 and FAQ, or perhaps updating the decisionmaking  
23 model, is needed to help with this.

24 At the last meeting we voted -- or we  
25 agreed to remove the color coded scope of practice

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

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

9 All right. So any comments from the  
10 Committee?

11 (No response.)

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

15 (No response.)

16 CHAIRWOMAN KEELS: Okay. Thank you.  
17 All right. Next is APRN Advisory Committee  
18 application period.

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

23 Pete, I believe yours and Michelle's and  
24 Jody's are up this year, so you'll want to -- we will  
25 email you when those applications are available, and

1 graphs to decrease any confusion that we thought came  
2 along with that, and we also recommended some  
3 editorial changes.

4 We have been stressing, and we continue  
5 to stress, that what we're doing is not new  
6 rulemaking, and is not meant to limit practice in any  
7 way, but that we really do want to have some type of  
8 guidance that's easily accessible for APRNs,  
9 employers, and the public, when there are questions  
10 around scope and so forth.

11 And in the end we think this will help  
12 serve APRNs well as we move to achieve independent  
13 practice in the future at some point.

14 Lisa and her staff have worked  
15 tirelessly to draft a document that we'll review  
16 later.

17 This draft document, along with the  
18 meeting materials, are available online at the Board  
19 of Nursing website under "Contact the Board", and if  
20 you scroll all the way down, at the bottom there's  
21 advisory groups and Committee meeting minutes. So  
22 those materials are found under there.

23 In addition, this Committee has actively  
24 engaged in making recommendations to the Board of  
25 Nursing on law and rules.

1 then they will be -- for anyone else who would like  
2 to apply, those will be available this month; should  
3 be.

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

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

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

14 Can I still reapply since I stepped in  
15 partway through?

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

19 MEMBER ZAMUDIO: Okay. Thank you.

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

23 MS. EMRICH: I sent her a note.

24 CHAIRWOMAN KEELS: Okay. I thought we  
25 would have more public comments.

1 MEMBER DI PIAZZA: We're ahead.  
 2 CHAIRWOMAN KEELS: That is a first in  
 3 the history of this Committee.  
 4 MEMBER SIEVERS: Can I step back just  
 5 real quick? So will her spot be open at the same  
 6 time as these other two even though it's not on the  
 7 same timeline?  
 8 MS. EMRICH: I think the appointment  
 9 date will take effect the day after her current term  
 10 expires.  
 11 MEMBER SIEVERS: But the application  
 12 period will be for all of them?  
 13 MS. EMRICH: Yes, I think we'll do all  
 14 of them at the same time. It just makes sense to do  
 15 it that way.  
 16 MEMBER SIEVERS: Correct.  
 17 MS. EMRICH: It will be the same, yes.  
 18 I can speak to the -- aside from the memorandum  
 19 that's from Holly Fischer, included in your packet  
 20 are just two separate pieces of rules.  
 21 One is 4723-8-08, and this particular  
 22 rule was effective February the 1st of this year, so  
 23 I just wanted to include it in your packet.  
 24 And the most significant thing about  
 25 this rule, it was a technical change that was needed

1 The other changes, as we go, the Board  
 2 has consistently changed any reference to  
 3 "individual" to "patient" when it does refer to the  
 4 patient, so you'll see a change in that word, the  
 5 verbiage.  
 6 And the other significant change is that  
 7 when it comes to treatment of pain in rule -- it's in  
 8 the same rule -- I'm on page 11 -- that we have added  
 9 oncology and hematology certified APRNs as those who  
 10 may potentially exceed 120 MEDs in those certain  
 11 circumstances.  
 12 So we recognize that they would be  
 13 working with pain patients, specifically. And that  
 14 was discussed previously at the Advisory Committee.  
 15 CHAIRWOMAN KEELS: We also -- terminal  
 16 condition.  
 17 MS. EMRICH: In rule -- the definition  
 18 of terminal condition, this is on page 2, was adopted  
 19 to mirror the same definition that the Medical Board  
 20 has adopted. And this comes into play when treating  
 21 pain.  
 22 CHAIRWOMAN KEELS: And then  
 23 consequently, this algorithm was updated to reflect  
 24 that rule back to the definition of terminal.  
 25 MS. EMRICH: Yes, because of the rule

1 because it impacted APRNs who were receiving their  
 2 initial APRN license during a renewal period.  
 3 I don't know if you recall on that last  
 4 renewal period, if you received your initial APRN  
 5 license last July 1st, it was good only through  
 6 October the 31st of that same year, and you had to  
 7 renew with no fee.  
 8 But the rule change -- and that was  
 9 really a holdover from the implementation of House  
 10 Bill 216.  
 11 So we changed it so that any new initial  
 12 license issued within that renewal period that begins  
 13 July 1st will go through that whole two-year cycle,  
 14 so they don't all have to renew again. So that will  
 15 be helpful.  
 16 The next rule that became effective  
 17 February the 1st is 4723-9-10, which is actually the  
 18 prescribing authority rule, and the most -- there's a  
 19 few significant changes within this rule that we  
 20 needed to accomplish this past year.  
 21 One was the exclusionary formulary is  
 22 now in rule. It is no longer just this document that  
 23 is approved or adopted every -- it's in rule, so any  
 24 change in the exclusionary formulary would require a  
 25 rule change, okay? And that was required.

1 change, our prescribing flow chart was updated to --  
 2 at the bottom, the next to the last -- in the last  
 3 open square, white square, it represents the terminal  
 4 condition as defined in rule.  
 5 CHAIRWOMAN KEELS: 4723-9-10(A)(13).  
 6 That's the only change that was made to this.  
 7 MS. EMRICH: Holly is on her way.  
 8 CHAIRWOMAN KEELS: Thank you. Do we  
 9 want to just wait for her? Do you want to talk about  
 10 CPG?  
 11 MS. EMRICH: Yes, we can do that.  
 12 MEMBER ZAMUDIO: I just have a -- is  
 13 this the appropriate time to ask a question about the  
 14 algorithm for prescribing?  
 15 MS. EMRICH: She may want to wait for  
 16 Holly to come for -- Holly may want to hear your  
 17 comments or questions.  
 18 CHAIRWOMAN KEELS: Take it out of my  
 19 done pile list.  
 20 MEMBER ZAMUDIO: I'm sorry.  
 21 MS. EMRICH: In the Sunset Committee for  
 22 CPG and the APRN, we're required to respond to the  
 23 Sunset Review Committee.  
 24 This is the legislative kind of  
 25 committee to look at the continuation or whether it's

1 necessary to continue with certain committees. And  
 2 Tom, on behalf of the Board, provided testimony, and  
 3 we have given you copies of that.  
 4 Consistent with what the CPG had  
 5 recommended, we are suggesting or recommending that  
 6 it be Sunset, the CPG, simply for the reasons stated  
 7 in the testimony and the questionnaire.  
 8 The exclusionary is in rule, the CPG  
 9 members themselves have said that they are not  
 10 inclined to add anything to the exclusionary  
 11 formulary at this point because it's really a matter  
 12 of standard of practice and the individual's  
 13 practice. So we feel there are other safety  
 14 measures.  
 15 MEMBER SIEVERS: What are we looking at  
 16 for timeline? What is the next steps there with Tom?  
 17 MS. EMRICH: Tom would follow up with  
 18 that. It would be a statutory change, and it would  
 19 not be -- I'm waiting to hear back what happens next.  
 20 We can't -- it doesn't automatically  
 21 happen, so --  
 22 MEMBER SIEVERS: Right. About a month,  
 23 six months?  
 24 MS. EMRICH: Time frame, I have no idea.  
 25 CHAIRWOMAN KEELS: Just trying to plan

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

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

1 MEMBER MINIARD: Sorry.  
 2 CHAIRWOMAN KEELS: How are you?  
 3 MEMBER MINIARD: Sorry.  
 4 CHAIRWOMAN KEELS: It's okay, parking  
 5 and drive.  
 6 MEMBER MINIARD: There was an accident  
 7 in Cincinnati. I was stuck for like 40 minutes not  
 8 moving, and I'm like well, this is not good.  
 9 MEMBER ZAMUDIO: I know, I almost went  
 10 down the side of the road. I didn't, but I thought  
 11 about it.  
 12 CHAIRWOMAN KEELS: I'm glad you could  
 13 join us.  
 14 MEMBER MINIARD: Sorry I'm late.  
 15 CHAIRWOMAN KEELS: Right now we're  
 16 waiting for Holly to join us so she can review the  
 17 five-year review highlights. We are down to No. 6.  
 18 MS. EMRICH: Okay. I can speak to 6,  
 19 too.  
 20 CHAIRWOMAN KEELS: Okay.  
 21 MS. EMRICH: So having gone through, as  
 22 Program Manager involved directly with licensure this  
 23 last APRN renewal period, we looked at some things  
 24 that are maybe helpful through the next cycle of  
 25 renewals.

1 And one was, believe it or not,  
 2 something so simple as a fee schedule, a document on  
 3 the website that lists all of the fees for every type  
 4 of licensure.  
 5 So that is now published on the website,  
 6 and it gives licensure fees for initial renewal, for  
 7 example, APRNs, your initial APRN, your renewal, late  
 8 fees, and when they are added, the dates when late  
 9 fees go into effect, licensure periods, et cetera.  
 10 So we hope and believe that everyone will find that  
 11 helpful as well.  
 12 We have received suggestions,  
 13 recommendations, regarding reminders. Is it possible  
 14 to do any other kind of reminder for R.N. and then  
 15 APRN renewal?  
 16 Apparently there's some who renewed  
 17 their R.N. license, but forgot they also have to  
 18 renew their APRN license, and one does not  
 19 automatically make the other happen.  
 20 So we did initially reach out to the  
 21 Department of Administrative Services. The process  
 22 we asked for, they don't have, which is to connect  
 23 one directly with the other, meaning when you finish  
 24 it, to move you directly. That particular technology  
 25 is not available.

1 MEMBER ZAMUDIO: Okay. Got it.  
 2 CHAIRWOMAN KEELS: So those are already  
 3 in effect.  
 4 MEMBER ZAMUDIO: Right.  
 5 CHAIRWOMAN KEELS: But then we do have a  
 6 rule review, five-year rule review of 8 and 9.  
 7 MEMBER ZAMUDIO: Got it.  
 8 CHAIRWOMAN KEELS: Which Holly has  
 9 joined us to talk about.  
 10 MS. FISCHER: Good morning. How is  
 11 everybody this morning? Nice to see you.  
 12 CHAIRWOMAN KEELS: Good. Thank you.  
 13 MS. Fischer: Yes, so this year the rule  
 14 Chapters that are scheduled for five-year review,  
 15 which is the minimum time period that we're required  
 16 to look at them, include Chapter 4723-8, 9,  
 17 and 23; 23 relates to dialysis, 8 relates to the  
 18 standards of practice for the Advanced Practice  
 19 Registered Nurses, and 9 is prescriptive authority.  
 20 Chapters 8 and 9 were substantially  
 21 revised after House Bill 216. And then there have  
 22 been more changes especially to Rule 9-10 in the  
 23 prescribing role because under the legislation it  
 24 changes.  
 25 So even though we have a five-year rule

1 But we are continuing to work with them  
 2 and on messaging as well to get information out. So  
 3 we have got until July of 2021, so we're hoping to  
 4 ramp up to that and get a lot more information out  
 5 and to help with that messaging and all.  
 6 So we want to make it -- we have the  
 7 information on the website, and information out there  
 8 as much as possible. And to even add information to  
 9 the R.N. licensure piece, even if it's just an  
 10 informative message that we can do that.  
 11 MEMBER ZAMUDIO: I have a question. So  
 12 when we were kind of going through things really  
 13 quickly, I thought we were just waiting for someone.  
 14 Will we come back to the sunset Committee with Tom?  
 15 CHAIRWOMAN KEELS: The time line of it.  
 16 MEMBER ZAMUDIO: Okay. Great. And then  
 17 the application period and the fee, the fees that  
 18 we're talking about now, I just had a question.  
 19 Are we addressing the 4723-8-08? Is  
 20 that what we're talking about right now, or is that  
 21 what Holly is going to discuss?  
 22 MS. EMRICH: Holly is going to discuss  
 23 the upcoming review of that Chapter. We talked about  
 24 the rule change that went into effect February  
 25 the 1st of this year.

1 review, it's definitely not been five years since we  
 2 went into these chapters to look at changes.  
 3 The time frame for this process this  
 4 year is based on your meeting schedule and our  
 5 Board's meeting schedule, would be that at the April  
 6 Board retreat, the Board would take a first look to  
 7 see if it has -- the members of the Board have any  
 8 changes to these chapters.  
 9 I have a memo that identifies changes  
 10 coming from staff, things that look like they need to  
 11 be cleaned up a little bit. So I will cover those  
 12 with the Board at the April retreat.  
 13 Then at the May meeting, typically we  
 14 would have a first draft of language. Then your  
 15 group will meet again July 6. So by that time, this  
 16 Committee's recommendation should be finalized to get  
 17 to the Board members so that they can look at those  
 18 changes at the July meeting if there are any.  
 19 We also have an intervening interested  
 20 party meeting which is open to the public, and  
 21 certainly all members of the Committee are welcome to  
 22 attend. That's tentatively scheduled for June 22nd,  
 23 so it will be before the July meeting.  
 24 So it would be best if we could get a  
 25 recommendation from this group by the July 6th

1 meeting so the Board can consider the  
2 recommendations.

3 The next step would be that I would file  
4 the proposed changes with the Office of Common Sense  
5 Initiative which is a branch of the Lieutenant  
6 Governor's office, or it's also known as CSI.

7 Then they take a look at this. They  
8 look at the adverse effect of any changes in the  
9 rules as a whole. And then they need to send a memo  
10 to us, and then we need to respond to that memo.

11 At that point in time we can file the  
12 rules with the Secretary of State and JCARR, and we  
13 do that usually in mid October.

14 There's a very limited window for  
15 filing, and it's all based on when we want to  
16 schedule the rule hearing, and there's a filing date  
17 deadline for each rule that exists. So it's usually  
18 around mid October.

19 Then we would have the public rule  
20 hearing in conjunction with our November Board  
21 meeting, usually the first day of the Board meeting,  
22 which would be November 18th.

23 Then the rules would be subject to JCARR  
24 final review, a JCARR hearing, and then a final  
25 filing in late December, and then they would be

1 recommended that one hour be this, or we can say one  
2 hour qualifies if it's in this area, or it could be  
3 more than one hour.

4 So we're throwing it out there. We have  
5 a lot of options. We could also add it -- instead of  
6 adding it to 8, we could add it to our continuing  
7 education rule, as I mentioned, for the RN.

8 So it's something I wanted you to think  
9 about, if you have any opinions on that.

10 MEMBER ZAMUDIO: So Holly, is it sexual  
11 assault or sex trafficking? Because they are  
12 different.

13 MS. FISCHER: They are different, and  
14 this would be geared toward sexual assault victims,  
15 the victimology, how to identify, assess, and treat  
16 those kind of people that have been through those  
17 traumatic experiences.

18 MEMBER ZAMUDIO: I would hope that we  
19 would include trafficking since Ohio is pretty high  
20 on that list. And it's a national initiative to  
21 identify those individuals. It's a form of assault,  
22 but it's a different issue, and I think all  
23 healthcare providers, not just APRNs, so I think RNs  
24 licensure would be a good time to add it.

25 MS. FISCHER: We have added that for

1 effective February 1st, 2021. So that's the whole  
2 process in a nutshell.

3 So Chapter 8 -- this is on page 2 of the  
4 memo that you should have received. You can see we  
5 don't have a lot of identified changes at this time.

6 If legislation is passed, particularly,  
7 you know, the CRNA, pending House Bill 224, or other  
8 pieces of legislation, then we would for sure need to  
9 go in and change Chapter 8, and probably Chapter 9.  
10 So what we have now is just what exists at this point  
11 in time.

12 One of the considerations would be to  
13 consider adding additional continuing education for  
14 Advanced Practice Registered Nurses and identifying  
15 and dealing with treating victims of sexual assault.

16 Some of this is emanating from a  
17 study -- a work group, I should say, that involves  
18 multiple state agencies, and is an outcome really of  
19 Dr. Strauss' investigation, so what can agencies do  
20 to better prepare their practitioners to identify and  
21 treat victims of sexual assault.

22 So the CE could be added as part of the  
23 RN 24 hours. It could be an additional hour. It  
24 could be part of the APRN hours. It can be something  
25 that is recommended. So out of the 24 hours it's

1 trafficking, and it's in Chapter 14. So it  
2 references it up to one hour of CE in trafficking  
3 counts towards your CE.

4 It's not mandated that you get the one  
5 hour, though, it's that one hour will qualify for it.  
6 So it's a distinction. If you have 24 hours, you  
7 have to decide, okay, are you going to mandate that  
8 one be in that area, and that change has not been  
9 made.

10 So this would be -- we could do a  
11 similar pattern, one hour or more could qualify, but  
12 when you're only talking about 24 hours and there's  
13 so many topics to consider, mandating it is, you  
14 know, something that I guess -- then it takes away  
15 from another hour and another subject.

16 MEMBER ZAMUDIO: So it would be  
17 inclusionary like it would count towards your 24, but  
18 not mandated.

19 MS. FISCHER: That's what we're here to  
20 talk about, and whether or not that would be an RN,  
21 or APRN, or both. But currently we don't have  
22 anything except for -- either the trafficking, which  
23 as you mentioned, is different.

24 CHAIRWOMAN KEELS: I feel like at the  
25 very least it should be a recommendation that it

1 would be counted, somebody like that.  
 2 But I could see -- so I'm in neonatal  
 3 pediatrics, women's health. Even -- it seems like  
 4 sexual abuse goes across all populations. It would  
 5 be valuable to have that education. I don't know  
 6 whether it should be recommended or required or not.  
 7 MEMBER ZAMUDIO: So the other thing we  
 8 could do is link in our responsibility. I get a lot  
 9 of questions about what our responsibility is as  
 10 mandatory reporters.  
 11 And so I mean, maybe we should address  
 12 that. If you're going to have -- part of the CE  
 13 could be what is our role when we suspect that, who  
 14 is a mandatory reporter, how do you do it. I get a  
 15 lot of questions about that from resident physicians,  
 16 physicians, and faculty as well.  
 17 CHAIRWOMAN KEELS: Other comments?  
 18 MS. FISCHER: Is there any feeling at  
 19 this early point as to whether or not this is  
 20 something that would be better added to the RN 24  
 21 hours, or the APRN, or both.  
 22 MEMBER ZAMUDIO: I think RN.  
 23 MEMBER BOLTON: I think RN.  
 24 MEMBER GAGER: I agree as well.  
 25 MS. FISCHER: Is it the feeling it would

1 relicensure, and this recommendation would then go to  
 2 the Board.  
 3 MS. FISCHER: Okay.  
 4 CHAIRWOMAN KEELS: Is there another  
 5 comment.  
 6 MEMBER SIEVERS: Just that I agree with  
 7 Michelle. The RNs are the ones that are doing the  
 8 safety screening -- are you guys doing that? So when  
 9 they are with a patient they say do you feel safe in  
 10 your home, and they are the ones documenting in Epic,  
 11 those screenings, so I think training would be good.  
 12 CHAIRWOMAN KEELS: And of course, then  
 13 we'll be required to complete it as well.  
 14 MEMBER SIEVERS: Right. They are  
 15 probably doing a lot more frontline screening than we  
 16 even are.  
 17 CHAIRWOMAN KEELS: But then as a  
 18 provider you're doing face-to-face, and if you get  
 19 that information --  
 20 MEMBER SIEVERS: But it would be good to  
 21 have education on how they handle that, and recognize  
 22 that, and throw questions to the patient.  
 23 CHAIRWOMAN KEELS: Okay.  
 24 MS. FISCHER: Okay. The other  
 25 legislative activity included the temporary licenses

1 be best in the form of a recommendation, it will  
 2 qualify for, but not mandatory?  
 3 MEMBER SIEVERS: If you don't mandate it  
 4 people won't do it.  
 5 MEMBER BOLTON: I think it should be  
 6 mandated.  
 7 MS. FISCHER: So it should be one of  
 8 the 24 shall be in this area, but not for the APRN 24  
 9 hours, just the RN 24 hours?  
 10 MEMBER ZAMUDIO: We would have to --  
 11 MS. FISCHER: Of course you would have  
 12 to do it.  
 13 MEMBER ZAMUDIO: I think it's important,  
 14 the RNs are at the bedside. A lot of times they are  
 15 directly with the patient, checking in at the  
 16 clinics, et cetera, so I think it's appropriate.  
 17 MS. EMRICH: Just a question. We can  
 18 have this -- maybe this discussion later. There's no  
 19 differentiation currently between mandatory CE for RN  
 20 and LPN, so would we require them both maybe, if it  
 21 was to go that route?  
 22 MS. FISCHER: I mean, that would be  
 23 something to consider as well.  
 24 CHAIRWOMAN KEELS: So this Committee is  
 25 recommending to require this as an RN CE for

1 for military members and their spouses.  
 2 Ohio's a little unique in that for  
 3 nurses we have always had temporary license permits,  
 4 and we don't condition that on being a member of the  
 5 military, so it can be open to anyone.  
 6 So these permits are issued to people  
 7 getting licensed by reciprocity, or we used to -- I  
 8 guess we call it endorsement, too, but this is not  
 9 something that we have implemented in the past for  
 10 the APRNs coming from other states.  
 11 So we would probably cross reference the  
 12 temporary permit possibly in Chapter 8, but we could  
 13 also do this in Chapter 2, which is the Chapter that  
 14 deals with military licensees and applicants.  
 15 So I wanted to bring that to your  
 16 attention, if anybody has questions about it.  
 17 MEMBER ZAMUDIO: So when they are  
 18 addressing the military licensure, does the rule  
 19 specify the military member, veteran or active, and  
 20 their spouse? Does it address the word dependent at  
 21 all?  
 22 Because I know there are dependents of  
 23 military who have tried to get licenses, and it's  
 24 been a very difficult process for them.  
 25 MS. FISCHER: I don't think so, I think

1 it's just spouses. I think --  
 2 MEMBER ZAMUDIO: I wish they had used  
 3 the word dependent.  
 4 MS. FISCHER: If you look -- has Tom  
 5 done his legislative report?  
 6 MEMBER ZAMUDIO: No.  
 7 MS. FISCHER: So on page 2 it kind of  
 8 gives you a little outline on the status of that, but  
 9 I've never seen dependent in conjunction with that.  
 10 MEMBER ZAMUDIO: To their children who  
 11 were maybe like couldn't get that -- but in Ohio, I  
 12 guess they could still do the expedited.  
 13 MS. FISCHER: Anybody can get a temp in  
 14 Ohio, and again, not conditioned on military status.  
 15 MS. EMRICH: It's in Tom's summary from  
 16 the last Board meeting.  
 17 MS. FISCHER: Does anyone right now,  
 18 before I move on to Chapter 9, have anything that  
 19 they have identified thus far they want to talk about  
 20 as a change in Chapter 8?  
 21 CHAIRWOMAN KEELS: Michelle, did you say  
 22 something about 8-08?  
 23 MEMBER ZAMUDIO: I thought it was 9.  
 24 Right now are we talking about like the -- you mean  
 25 the graph?

1 And the administrative burden that's  
 2 going to be put on our institution to redo 450  
 3 standard care arrangements is unreasonable.  
 4 I mean, it is -- and we did get the idea  
 5 that we could do like an out of station, but it still  
 6 is a resigning of something by all these people and  
 7 trying to get those signatures.  
 8 So I don't know how you all do that, but  
 9 other similar states like Kentucky, they have a  
 10 one-time -- it's in place until either party cancels  
 11 or revokes it.  
 12 And of course you would redo it if there  
 13 was a change, either an addition or deletion, because  
 14 we're notifying the Board, but if there are no  
 15 changes to it, that it could remain in existence  
 16 without a renewal two years.  
 17 The other thing I get tons of questions  
 18 on, and I'm not really sure how to explain it, is the  
 19 collaboration with no more than five people who are  
 20 prescribing.  
 21 So I'm picturing the clinic where, you  
 22 know, you have a physician -- there's no number to --  
 23 and then I saw that was one of the FAQ questions --  
 24 about how many people can you be in a collaborative  
 25 agreement with, and there was no number.

1 CHAIRWOMAN KEELS: No, Chapter 8.  
 2 MEMBER SIEVERS: It's everything.  
 3 CHAIRWOMAN KEELS: Advanced Practice  
 4 Registered Nursing, nurse certification of practice,  
 5 Chapter 2723-8.  
 6 MEMBER ZAMUDIO: Which handout are we  
 7 on?  
 8 MEMBER SIEVERS: It's not there, it's a  
 9 whole chapter.  
 10 MS. FISCHER: Does everyone have their  
 11 new lavender rule books? So it's really the whole  
 12 chapter that we look at. And if you have this copy,  
 13 it starts on page 99 of this book. This is where the  
 14 chapter starts.  
 15 CHAIRWOMAN KEELS: Sherri.  
 16 MEMBER SIEVERS: So we have House  
 17 Bill 177, but let's just assume -- let's take that  
 18 out and just look at the rules as they are.  
 19 I'm wondering if there's any tweaks that  
 20 could be made with the standard care arrangement that  
 21 is in rule and not in law?  
 22 One thing as an employer -- and I look  
 23 to Pam, maybe, and your other folks that have  
 24 institutional SCAs, is the two-year review -- so  
 25 we're coming up on that right now.

1 But you can't be -- they all can't be  
 2 prescribing at the exact same time. So you have a  
 3 group of people, say you have six on in a day, you  
 4 know, do you say you don't prescribe at this moment  
 5 because I'm going to prescribe? I think it's very  
 6 confusing to people.  
 7 MEMBER ZAMUDIO: Definitely.  
 8 MEMBER SIEVERS: And really, I don't  
 9 understand the rationale behind it. If there's no  
 10 limit to the number of people you can have on your  
 11 SCA, if we could consider removing that limit for  
 12 prescribing.  
 13 MS. EMRICH: That's in statute.  
 14 MEMBER SIEVERS: Okay.  
 15 MEMBER DI PIAZZA: And I believe the  
 16 Board, at one point when this was first introduced,  
 17 when we increased the numbers, talked about it, it  
 18 being really scheduled, you know, how many nurses are  
 19 scheduled at one time.  
 20 MEMBER ZAMUDIO: It doesn't say that.  
 21 MEMBER SIEVERS: That's prescribing.  
 22 MEMBER DI PIAZZA: But they commented  
 23 looking at -- you know, think about how many are  
 24 scheduled at one given time, because if they are  
 25 scheduled and you're an Advanced Practice Nurse,

1 you're likely prescribing at any given time. That's  
2 what I recall.

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

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

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

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

15 MS. EMRICH: It used to be three.

16 MEMBER SIEVERS: Two year --

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

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

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

1 the --

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

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

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

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

17 MS. EMRICH: It might be.

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

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

25 MEMBER SIEVERS: The only issue with

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

4 CHAIRWOMAN KEELS: Right. It's the  
5 statute.

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

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

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

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

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

22 MS. EMRICH: .431.

23 MS. FISCHER: What paragraph?

24 MS. DI PASQUALE: It's in A.

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

1 that is not everybody is on the same cycle.

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

4 MEMBER SIEVERS: And you're constantly  
5 doing that.

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

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

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

16 MEMBER SIEVERS: That's a thought for  
17 sure.

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

20 MS. FISCHER: I think it is, too. I  
21 can't find it in law, so let's say we propose to  
22 discuss changing that every -- minimum of every  
23 two-year review. What would the alternative be, that  
24 it's only reviewed? I don't know, every four years?  
25 Or it does not need to review unless changes are

1 made?  
 2 MEMBER ZAMUDIO: Right.  
 3 MEMBER SIEVERS: I think that.  
 4 MEMBER ZAMUDIO: Yes.  
 5 MEMBER SIEVERS: That's what we're doing  
 6 currently. There may be more things, that just came  
 7 to mind.  
 8 CHAIRWOMAN KEELS: I think now is the  
 9 time to bring up questions so they can cross  
 10 reference to statute.  
 11 My other question is, sort of thinking  
 12 about the political piece of it, because if we work  
 13 on making the standard of care arrangement a little  
 14 easier, does that disrupt our efforts to remove it  
 15 through House Bill 177?  
 16 MEMBER DI PIAZZZA: Right.  
 17 CHAIRWOMAN KEELS: I'm trying to think  
 18 of unintended consequences.  
 19 MEMBER SIEVERS: Good point. And I  
 20 haven't talked to anyone about it, I was just using  
 21 that as sort of an example if there are things like  
 22 that that are not in statute with those people.  
 23 MEMBER DI PIAZZZA: It might be  
 24 worthwhile running by OAAPN and --  
 25 MEMBER SIEVERS: I can do that.

1 from nurses and APRNs learning in other areas, and I  
 2 didn't know if the Board had kind of like a threshold  
 3 before they say you know what, we're going to have to  
 4 go back and increase the required CEs.  
 5 MEMBER ZAMUDIO: I don't think there's  
 6 any evidence that shows a certain number of CEs  
 7 making you safe or not safe. I wouldn't recommend  
 8 adding to the requirement.  
 9 MEMBER DI PIAZZZA: No, I'm just  
 10 concerned about taking away from learning that's  
 11 pertinent -- not that sexual assault is not pertinent  
 12 to their learning, but worried about taking away some  
 13 of maybe the clinical CEs.  
 14 MEMBER ZAMUDIO: You can always do more.  
 15 MEMBER DI PIAZZZA: You could.  
 16 CHAIRWOMAN KEELS: But you don't require  
 17 it. Like we said before, it's not mandatory.  
 18 MEMBER ZAMUDIO: But I have a question  
 19 for Holly.  
 20 MS. EMRICH: APRNs have to maintain  
 21 their national certification. You have to get lot of  
 22 CEs for that.  
 23 MEMBER ZAMUDIO: This is probably for  
 24 Lisa or for Holly. So back to the 8-08. And I know  
 25 it's already in -- it's there, we can't change

1 CHAIRWOMAN KEELS: I wouldn't --  
 2 MEMBER SIEVERS: If we have an official  
 3 request, I'll mail it.  
 4 CHAIRWOMAN KEELS: I would not want this  
 5 Committee to sort of undermine the work we're trying  
 6 to do.  
 7 MEMBER SIEVERS: And it was really a --  
 8 more of a hypothetical.  
 9 MEMBER DI PIAZZZA: I do have a question  
 10 about the CEs, and I'm curious, whenever we start to  
 11 require CEs, is there a threshold that says okay, we  
 12 now have required four CEs, we need to up the number  
 13 of CEs that are obtained?  
 14 MS. FISCHER: I think the 24-hour is  
 15 statutory. So, you know, you can modify the content  
 16 within the 24, but you can't require more than  
 17 the 24.  
 18 Now, somebody could voluntarily get as  
 19 many as they want, but they can't be required to  
 20 without a statutory change.  
 21 MEMBER DI PIAZZZA: I guess I'm just  
 22 wondering, you know, if we -- if in the future, you  
 23 know -- because I could see more things coming to  
 24 light where we say you know what, we might need to  
 25 require this, and now we require 4 CEs that take away

1 things, but I had a question just for clarification.  
 2 Where it talks about, on page 1, under  
 3 A-1-A and B, documentations satisfactory to the Board  
 4 of our continuing education, and the fact that we  
 5 have maintained our certification, what documentation  
 6 is that?  
 7 Do we need to actually send you copies,  
 8 or just when we renew that little box that says we  
 9 have completed or CEs?  
 10 MS. FISCHER: Right.  
 11 CHAIRWOMAN KEELS: But you could be  
 12 audited.  
 13 MEMBER ZAMUDIO: It just said  
 14 documentation. I thought are we going to have to  
 15 send that then.  
 16 MEMBER MINIARD: I just have a comment.  
 17 So when you renew your certification, you actually  
 18 have to document and you have to say who --  
 19 MEMBER ZAMUDIO: And check the box.  
 20 MEMBER MINIARD: You actually have to  
 21 put in what it is, who the sponsor is, so you can't  
 22 just go on Joe Schmoe's CE, it has to be a certain --  
 23 ANA or ANCC, or AANP, or some things like that?  
 24 MEMBER DI PIAZZZA: And some are  
 25 required to be able to speak of the objectives of the

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1 CE as well.  
 2 MEMBER MINIARD: I just renewed mine a  
 3 few days ago, so it was very painful.  
 4 MEMBER ZAMUDIO: And that will satisfy  
 5 that requirement?  
 6 MEMBER MINIARD: Yeah, it will for sure.  
 7 CHAIRWOMAN KEELS: From accurate  
 8 recordkeeping, it will be helpful.  
 9 MEMBER MINIARD: Well, I did it.  
 10 CHAIRWOMAN KEELS: Anything else about  
 11 Chapter 8 right now?  
 12 MEMBER ZAMUDIO: That's not open to any  
 13 changes right now, this is just interpretive  
 14 clarification?  
 15 MS. FISCHER: What?  
 16 MEMBER ZAMUDIO: So as part of this  
 17 five-year review on 8-08 on the second page under C,  
 18 I think writing the failure of the licensee to  
 19 receive an application for renewal does not excuse  
 20 them from the requirements, I thought that was pretty  
 21 demeaning to say that's not an excuse.  
 22 I think if we said something to the  
 23 effect of license holders bear sole responsibility  
 24 for meeting these renewals, it's probably just  
 25 semantics, but I thought that really sounded kind of

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1 demeaning to the provider saying well, that's not an  
 2 excuse.  
 3 I understand the thought behind it,  
 4 though, like we want to tell them us not writing to  
 5 you doesn't mean you don't have to respond to it, so  
 6 that was one thing.  
 7 And then in E where it said that they  
 8 may be subject to disciplinary action in accordance  
 9 with that section of the Revised Code, who provides  
 10 the disciplinary action, is it the Board, or their  
 11 national, or both?  
 12 MS. FISCHER: That would be the Board.  
 13 MEMBER MINIARD: The Board.  
 14 MEMBER ZAMUDIO: I just thought if we're  
 15 going to revise this -- because it says does not  
 16 excuse. These are professionals, I thought that  
 17 sounded kind of demeaning.  
 18 MEMBER MINIARD: Just for the national  
 19 certification question, you can let your national  
 20 certification lapse at any point, certifying body --  
 21 MEMBER ZAMUDIO: They don't do anything.  
 22 MEMBER MINIARD: They don't care. Then  
 23 it's just up to you if you want to renew it, and then  
 24 you have to -- depending on the timeline, you either  
 25 have to retest --

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1 MEMBER ZAMUDIO: And then you have to  
 2 send that renewal to the Board.  
 3 MEMBER MINIARD: Right. That's later on  
 4 in, in the same thing, within 30 days of  
 5 recertification then the national certified body says  
 6 you need to contact -- for me it's ANCC. So you have  
 7 to contact your national certified body, and have  
 8 them send something directly to the Board that  
 9 verifies your recertification.  
 10 MEMBER ZAMUDIO: So this makes it our  
 11 responsibility for them to do something?  
 12 MEMBER MINIARD: Yes. So for example,  
 13 like I said, I just renewed, so I'm waiting -- they  
 14 have to go through and look at everything and make  
 15 sure it's good.  
 16 But once they get yes, you're good, then  
 17 I need to tell them to send something to the Board of  
 18 Nursing, so it's a separate thing I'm responsible  
 19 for.  
 20 MEMBER ZAMUDIO: Do people call you to  
 21 see if it got there? How do we follow up on that?  
 22 CHAIRWOMAN KEELS: You check the Board  
 23 website, and then if it's not there, you call them.  
 24 Just clarifying some of this for people.  
 25 MEMBER MINIARD: You have to remember to

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1 go back and have them send it, because they will not  
 2 send it just automatically.  
 3 MEMBER ZAMUDIO: I just thought if we  
 4 were changing like what documents had to be sent to  
 5 the Board, when we would do that, for people reading  
 6 it.  
 7 MEMBER BOLTON: And that depends. Some  
 8 certifiers are a little better.  
 9 MEMBER MINIARD: And --  
 10 MEMBER BOLTON: It depends on the  
 11 certifying organization.  
 12 MEMBER ZAMUDIO: Okay.  
 13 CHAIRWOMAN KEELS: Other comments on 8?  
 14 As you review these and have questions, or comments,  
 15 then please do email them to Lisa and I; not to the  
 16 group, but to Lisa and I. And then we'll pull them  
 17 together and they will be in your meeting packet for  
 18 the next time, because we cannot meet offline. Just  
 19 remember to email the stuff.  
 20 MS. FISCHER: Let's move to Chapter 9.  
 21 It's on page 113 of the new rule book. The first --  
 22 well, the first thing that we have relates to  
 23 Rule 9-10.  
 24 And this is a very technical point, but  
 25 it's something that really just struck me when I was

1 looking in preparation for this meeting. And it  
2 relates to the definition of terminal condition.

3 So I realize that we had changed our  
4 language to mirror that of the Medical Board with  
5 respect to exceeding the MED limits.

6 And I'm not going to go into all the  
7 hows and whys the Medical Board changed their  
8 definition, but we did the same. So we changed the  
9 definitional section.

10 But unlike the Medical Board, we have  
11 this other statute that says that that definition is  
12 in 2133.01, so what I think we need to do, it's a  
13 small change, but we need to change the reference to  
14 terminal condition to define it specifically in the  
15 MED components which are -- I think it's K7 -- I  
16 and K, the terminal condition means this.

17 And then when you're talking about the  
18 Schedule 2 prescribing limits, terminal condition  
19 means as defined in 2133.01, because that's what the  
20 law says. So I don't want to belabor the point, but  
21 it's just sort of a technical correction.

22 MEMBER ZAMUDIO: Right.

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

1 CHAIRWOMAN KEELS: As the final, or  
2 draft?

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

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

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

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

21 I know that's an awful lot to look at,  
22 but if you could take some time, and if you see some  
23 things, send them to Lisa and Erin so they can put  
24 your comments together for a packet for the July  
25 meeting.

1 treatment.

2 The Medical Board's rules -- it got  
3 delayed, delayed, delayed, so they still don't have  
4 their rule yet, and we were waiting on that.

5 So what I have given you today as part  
6 of the package is just a copy of the most current  
7 Medical Board language, and this language is for  
8 physicians. There's also a separate chapter for PAs.  
9 That's attached to the memo.

10 CHAIRWOMAN KEELS: It's attached to the  
11 memo?

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

18 CHAIRWOMAN KEELS: I was surprised how  
19 specific it is.

20 MEMBER ZAMUDIO: Right.

21 CHAIRWOMAN KEELS: But that's what the  
22 Medical Board approved?

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

1 CHAIRWOMAN KEELS: I was just again very  
2 concerned about how specific it is. So as practice  
3 evolves and changes, now it's in rule, that would  
4 then need to go back -- but we are required to have  
5 similar rules.

6 MS. FISCHER: Yes.

7 CHAIRWOMAN KEELS: So it can't be  
8 substantially different, it needs to be very similar.

9 MS. FISCHER: Right.

10 CHAIRWOMAN KEELS: Almost the same.

11 MS. FISCHER: Almost the same.

12 CHAIRWOMAN KEELS: Pretty much the same.

13 MEMBER ZAMUDIO: One thing that struck  
14 me that I thought was interesting was the testing.  
15 Is there a specific on Hep-B, Hep-C, HIV. Consider  
16 STD? First of all, who is paying for it, and then  
17 secondly what time frame?

18 So if you're going to be treating  
19 someone and they were tested last year for Hep-B, I  
20 don't know if -- I mean, we obviously have to adopt  
21 similar ones, but maybe clean that up a little bit.  
22 It's required testing before you can get treated for  
23 addictions to get those lab tests done.

24 CHAIRWOMAN KEELS: That's a good point,  
25 Michelle. I know that many times, even on the

1 neonatal side, we'll see a mom that's been tested at  
 2 the beginning of the pregnancy, but not towards the  
 3 end, and she's converted or she's been infected.  
 4 MS. FISCHER: So what I'm going to do in  
 5 the meantime is follow up and talk to the Medical  
 6 Board and see if they have a sense where this is  
 7 going.  
 8 And timing-wise, if I could draft a rule  
 9 like this for APRN but have it available for the July  
 10 meeting -- but it depends on what the Medical Board  
 11 says.  
 12 I don't want to go through the time.  
 13 It's very laborious to translate it to APRN language,  
 14 and then it's going to be completely regutted and  
 15 start over. But at the same time, we need to draft  
 16 something.  
 17 So I thought this is the best we could  
 18 do for now. Take a look at their language. Let me  
 19 know if you see something that strikes you like the  
 20 time frame, can we clarify that, clean it up a  
 21 little. That's a good point.  
 22 MEMBER ZAMUDIO: Is this an appropriate  
 23 time to address the algorithm in 9, 9-10?  
 24 MS. FISCHER: Yeah, 9-10 is completely  
 25 open for review. There were a couple changes made

1 MEMBER ZAMUDIO: And they lead to that  
 2 point, but then nothing happens to that point.  
 3 MS. FISCHER: Well, you have to look at  
 4 this arrow that shows it goes up. So that's a matter  
 5 if there's a symbol that could be injected there.  
 6 MEMBER ZAMUDIO: I thought it looked  
 7 like a dead end, and I thought wait a minute.  
 8 CHAIRWOMAN KEELS: Unless perhaps the  
 9 points just touch that line.  
 10 MEMBER SIEVERS: Or make a right angle.  
 11 MEMBER ZAMUDIO: Is sounds as -- I tried  
 12 to review this as I didn't know the answer, and that  
 13 looked like a dead end.  
 14 And the other question I had was, under  
 15 the black box at the top about the gabapentin, it  
 16 says may prescribe, but note that gabapentin products  
 17 require days supply.  
 18 This is just a clarification for me.  
 19 Does that include only oral gabapentin? Because in  
 20 sexual health we use a lot of like the gabapentin  
 21 creams, et cetera. Does that apply to that as well?  
 22 Like can you -- you can't drink your gabapentin  
 23 cream.  
 24 MS. FISCHER: I don't think it  
 25 distinguishes the route of administration.

1 last year.  
 2 We have the new updated flow chart that  
 3 reflects some of that, mostly just because it's in  
 4 cross-references, the subparagraph numbers changed  
 5 and that kind of thing.  
 6 MEMBER ZAMUDIO: I didn't know if this  
 7 was something that was maybe cut off at the bottom.  
 8 If you get to the very bottom of the algorithm it  
 9 says is the patient -- prescription for inpatient  
 10 use, there's an arrow to the side, but it leads to  
 11 nothing, it's like out in the open. Was that cut  
 12 off?  
 13 CHAIRWOMAN KEELS: No, I think it means  
 14 to go up and then up -- it's over and then up. I  
 15 thought that, too.  
 16 MEMBER ZAMUDIO: I thought that is kind  
 17 of a little blank area, it leads to a blank.  
 18 MS. FISCHER: It's -- yes, and then it  
 19 goes up.  
 20 MEMBER ZAMUDIO: I think we need to just  
 21 fix that little intersection on the algorithm there  
 22 so there's something at the bottom of the arrow or  
 23 something.  
 24 MS. FISCHER: Actually, there's two  
 25 little arrows there.

1 MEMBER ZAMUDIO: Okay.  
 2 CHAIRWOMAN KEELS: So a tube is what,  
 3 a 30-day?  
 4 MEMBER ZAMUDIO: Yes.  
 5 CHAIRWOMAN KEELS: So it would be  
 6 a 30-day supply for your topical. Good point.  
 7 MEMBER ZAMUDIO: There's so many other  
 8 pain creams, I just thought we need to address it.  
 9 CHAIRWOMAN KEELS: I didn't know that  
 10 was available. Interesting.  
 11 Any other comments or questions on  
 12 Chapter 9 that you can think of? Again, send them to  
 13 Lisa and I as you look through those. And we'll  
 14 again have to cross reference those against the  
 15 statute, see what we're able to change.  
 16 MEMBER ZAMUDIO: Thanks for all of that  
 17 ahead of time, Holly, that's great.  
 18 CHAIRWOMAN KEELS: Any other questions  
 19 for Holly before she exits?  
 20 MS. FISCHER: Okay. Well --  
 21 CHAIRWOMAN KEELS: Thank you, Holly.  
 22 MS. FISCHER: I'll talk to you again  
 23 soon.  
 24 MEMBER BOLTON: Thanks, Holly.  
 25 CHAIRWOMAN KEELS: We're clipping along.

1 Is Tom coming?  
 2 MS. EMRICH: I just emailed him. We  
 3 could move ahead or we can --  
 4 CHAIRWOMAN KEELS: So we'll try to get  
 5 Tom Dilling down here so he can give us a legislative  
 6 update. I did want to ask if everybody has visited  
 7 the new website?  
 8 MEMBER DI PIAZZA: Yes.  
 9 CHAIRWOMAN KEELS: I think it looks  
 10 great.  
 11 MEMBER MINIARD: It does.  
 12 CHAIRWOMAN KEELS: And Lisa and I were  
 13 talking about that earlier today, and made a  
 14 recommendation to see if there's something under APRN  
 15 practice resources that we could say -- we could  
 16 cross link, or at least reference you back to the  
 17 APRN Advisory Committee and the material so you don't  
 18 have to go hunt for those, because the Committee --  
 19 the materials did say they are available, but they  
 20 are under Contact Support.  
 21 But if we can just do CE, whatever, it's  
 22 not even a hyperlink -- or if it's a hyperlink, that  
 23 would be even better. But I think it looks  
 24 fantastic.  
 25 Lisa, do you want to talk about LPN

1 understanding about what APRNs in the community  
 2 are -- have questions about that we can work to help  
 3 make that a little bit easier for them.  
 4 MS. EMRICH: Some of these you'll find  
 5 in the draft document as well. I think there's some  
 6 similar ones. I think we --  
 7 CHAIRWOMAN KEELS: Yeah, it seems like  
 8 each time we meet there are some general themes that  
 9 come up again, that we can then move into the draft  
 10 documents to help proactively steer people. Any  
 11 questions or comments about that?  
 12 And not to be -- this is in no way  
 13 punitive because we always want people to email  
 14 questions to the Board, because the worst question is  
 15 the one that is not asked, right?  
 16 So I would -- I was still struck by the  
 17 fact that someone who is certified in women's health  
 18 was helping to manage a pediatric patient, not a  
 19 nonfemale pediatric patient.  
 20 And there was also -- there was another  
 21 adult gero certified person, I think, that was  
 22 wondering if they could treat pediatric patients,  
 23 which then goes to the developmental age parameters.  
 24 So at what point does the pediatric  
 25 patient become the adult patient, which is what we're

1 renewal?  
 2 MS. EMRICH: Sure. Just a reminder, LPN  
 3 renewal will begin on July the 1st of 2020. We have  
 4 about 630,000 LPNs that will be up for renewal. And  
 5 we anticipate that to go as smooth, if not smoother,  
 6 than the RN did last year.  
 7 But again, we think the fee schedule  
 8 that's published, and then the additional messaging  
 9 that we're going to be sending, will be helpful.  
 10 CHAIRWOMAN KEELS: And that just  
 11 reminded me. As I was on the Board website looking  
 12 at the upcoming Board meeting materials, the APRN  
 13 work force statistics are posted from the last year's  
 14 renewal period where we answered those surveys. So  
 15 I'll call your attention to that if you're  
 16 interested.  
 17 MS. EMRICH: And then those will be  
 18 provided to the Committee the next meeting, too. Of  
 19 course, they are going to be --  
 20 CHAIRWOMAN KEELS: They are available  
 21 now, too. Summary of APRN practice questions is  
 22 included in your packet and online for your review.  
 23 Lisa and her staff provided us with the  
 24 most recent questions that they received from APRNs  
 25 as an FYI for us to sort of have a general

1 trying to do to help. Right? Okay.  
 2 MEMBER ZAMUDIO: Erin, were these  
 3 questions already answered on the website, or are  
 4 these just the questions?  
 5 MS. EMRICH: They are not on the  
 6 website. These are email questions that we received.  
 7 MEMBER ZAMUDIO: Do we get the answers  
 8 that they got, or no? I was curious about the answer  
 9 to No. 1, what the Board wrote.  
 10 CHAIRWOMAN KEELS: Oh, about injury  
 11 during insemination?  
 12 MS. ZAMUDIO: Yeah, about the common  
 13 studies that they do.  
 14 CHAIRWOMAN KEELS: Do we have the answer  
 15 available?  
 16 MS. EMRICH: We can provide that.  
 17 MEMBER ZAMUDIO: I think --  
 18 CHAIRWOMAN KEELS: It would be helpful  
 19 for us to see the answer.  
 20 MEMBER ZAMUDIO: That's a great  
 21 question.  
 22 MS. EMRICH: I don't know if there was  
 23 more context provided to the question.  
 24 CHAIRWOMAN KEELS: We'll definitely want  
 25 to keep it anonymous.

1 MEMBER ZAMUDIO: Absolutely. I thought  
2 that was a good question more so than even addressing  
3 a different population.

4 Like the other one in the draft document  
5 was can you do something for a newborn or a male. I  
6 thought this is really good for scope of practice,  
7 because it's a common thing done by a nurse midwife  
8 and --

9 MS. EMRICH: This is more of a  
10 procedural.

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

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

16 MS. EMRICH: Unless there's more  
17 discussion.

18 CHAIRWOMAN KEELS: Okay.

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

23 MEMBER SIEVERS: We had sent  
24 recommendations, not me, but my institution, a while  
25 back to ODH, because what our concussion people tell

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

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

6 MS. EMRICH: Certifying bodies.

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

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

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

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

1 us is that sometimes there's an intermediate -- it's  
2 a gradual return, they are restricted to some  
3 activities.

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

11 CHAIRWOMAN KEELS: And of course --

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

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

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

23 CHAIRWOMAN KEELS: All right. Thanks  
24 for that comment.

25 NCSBN APRN roundtable.

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

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

6 MEMBER ZAMUDIO: Reporting what?

7 MS. EMRICH: The clinical site issues.

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

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

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

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

23 MEMBER ZAMUDIO: Maybe they could  
24 collaborate.

25 CHAIRWOMAN KEELS: But the accrediting

1 body --  
 2 MEMBER SIEVERS: The accrediting body  
 3 says they have to, but the schools don't interpret  
 4 it, and there's no policing.  
 5 What one person told me is that we  
 6 interpret it as we try to help, and if we can't -- we  
 7 do help, but there's nothing that says that the  
 8 student can't also go on their own, where the PA  
 9 programs, they do not allow the students to look for  
 10 their own at all, and they have to -- and that's why  
 11 their programs are so limited in numbers. So it is  
 12 just -- it's the interpretation, but that would be a  
 13 great --  
 14 MEMBER ZAMUDIO: It's a fatigue factor  
 15 for those who get five or ten times a week emails,  
 16 calls, I know so-and-so and you know them at church  
 17 or whatever, and it is nonstop. And it's not just  
 18 myself, it's a common conversation we have with the  
 19 nurse practitioners.  
 20 CHAIRWOMAN KEELS: And sometimes the  
 21 requests are not appropriate for that population that  
 22 the student is dealing with.  
 23 MEMBER MINIARD: I would just like to  
 24 speak to that directly as APRN faculty.  
 25 MEMBER ZAMUDIO: Thank you, Jody.

1 I mean, you can't make people precept  
 2 students, and there are a lot of not well accredited  
 3 institutions that actually pay preceptors, you know,  
 4 but that's very difficult to do from a budgeting  
 5 perspective at a state university.  
 6 MEMBER ZAMUDIO: I think if the  
 7 preceptors are actually doing their job, it is a huge  
 8 undertaking. I mean, I think they should be  
 9 compensated just saying that.  
 10 But it is a significant amount. I  
 11 invest in them. I mean, I'm all in; you're coming to  
 12 every meeting with me, I'm talking to you, you're  
 13 going to the CEs with me, so it is a big undertaking.  
 14 So I think it should be done with compensation.  
 15 But that said, them finding a preceptor  
 16 doesn't mean they have found an educator. So I like  
 17 that you're vetting them.  
 18 CHAIRWOMAN KEELS: Yeah, because the  
 19 Board does not regulate graduate programs. I don't  
 20 know what can be done through this Committee other  
 21 than just bringing awareness.  
 22 MEMBER ZAMUDIO: We need good ideas.  
 23 MEMBER MINIARD: It is something we talk  
 24 about on the national level --  
 25 CHAIRWOMAN KEELS: Challenging.

1 MEMBER MINIARD: So the accrediting body  
 2 does state that it is the school's responsibility to  
 3 assist the student in finding adequate placement.  
 4 So at my institution what we do is we do  
 5 have a clinical preceptor liaison who -- and we have  
 6 a very large distance learning program, so we have  
 7 students all over the United States, and we are  
 8 required to assist them in finding preceptor  
 9 placement.  
 10 We have a vetted system. Students are  
 11 allowed to find their own preceptors, but we have a  
 12 vetted system that goes through and checks all these  
 13 preceptors, you know, to make sure that they have  
 14 adequate licensing, they have no board sanctions on  
 15 their license, or anything like that.  
 16 So -- but the thing about this is, it's  
 17 a national crisis. So we talk about this at NONPF,  
 18 the National Organization of Nurse Practitioner  
 19 Faculty. It's a national crisis to get preceptors in  
 20 every APRN specialty.  
 21 So what we do is we have to assist the  
 22 student, but if they live in Texas and the only  
 23 preceptor we can find is in Minnesota, then they have  
 24 to go to Minnesota, because that's just the way it  
 25 is.

1 MEMBER MINIARD: -- every meeting. So  
 2 it's a known problem.  
 3 CHAIRWOMAN KEELS: All right. So the  
 4 remaining item is legislative report, and I think --  
 5 MS. EMRICH: I haven't heard from him.  
 6 CHAIRWOMAN KEELS: He's probably in a  
 7 meeting.  
 8 CHAIRWOMAN KEELS: And let's see what  
 9 else. We can skip down to No. 10. And just as a  
 10 reminder, our remaining meetings for 2020 are  
 11 July 6th and November 16th. We'll clarify with  
 12 everybody, validate that everybody has that on their  
 13 calendar.  
 14 Are there other topics that were not on  
 15 the agenda that folks would like to discuss?  
 16 MEMBER ZAMUDIO: Are we waiting for Tom  
 17 for the Sunset thing?  
 18 MS. EMRICH: Legislative report.  
 19 MEMBER ZAMUDIO: Okay.  
 20 CHAIRWOMAN KEELS: Then you can ask him  
 21 about the Sunset CPG.  
 22 Do we need to take a five-minute break?  
 23 MS. EMRICH: Sure. Let's take a  
 24 five-minute break for those of you who need to.  
 25 (Recess taken.)

1 CHAIRWOMAN KEELS: We'll get started.  
 2 So thank you, Tom, for joining us. And we're going  
 3 to turn it over to you for the legislative report.  
 4 MR. DILLING: Okay. I think maybe I'll  
 5 start with the -- since we last met, I appeared at  
 6 the Sunset Review Committee on behalf of the Board,  
 7 and the APRN Advisory Committee and the CPG.  
 8 They don't give you a schedule at the  
 9 end of the year, you get a phone call and say can you  
 10 come, we need somebody on such and such date, right?  
 11 However, I had prepared the CPG stuff.  
 12 We had had -- for like six months we thought we were  
 13 going to get called in, and then didn't or whatever.  
 14 So whatever.  
 15 The -- we were not concerned as far as  
 16 the Sunset Review Committee reviews all types of  
 17 agencies and committees of agencies and so forth,  
 18 looking for is there something that's redundant or  
 19 out of date, so forth.  
 20 But again, we didn't fear like somebody  
 21 was gunning for the APRN Advisory Committee,  
 22 especially since it's just been a couple years old.  
 23 On the other hand, for the CPG, we had  
 24 talked about the CPG previously and said we got this  
 25 call and, you know, what do you think about it?

1 be fine with that.  
 2 There really wasn't, you know, questions  
 3 asked in terms of, you know, the continued existence  
 4 of the Committee, continued work. So that's about as  
 5 exciting as it was, if you catch that.  
 6 CHAIRWOMAN KEELS: So Sherri was  
 7 wondering about the timeline. Now that we have made  
 8 the recommendations to Sunset and CPG, what will  
 9 happen.  
 10 MR. DILLING: So they make a report at  
 11 the end of the year.  
 12 CHAIRWOMAN KEELS: End of 2020?  
 13 MR. DILLING: Yeah, and that's the  
 14 official report. That doesn't stop them from going  
 15 in and doing something, you know, ahead of time.  
 16 It's a good question, because we hadn't been going  
 17 through it for anything else.  
 18 So that is something I can go and visit  
 19 and share and ask, you know, hey, is it okay if we  
 20 speed up that process, and then you can report it was  
 21 done, you know, at the end of the year, or do they  
 22 like to play credit at the end. I haven't explored  
 23 that as of yet.  
 24 CHAIRWOMAN KEELS: To Sherri's point, I  
 25 think the people's schedules and travel would be good

1 And I talked to people behind the  
 2 scenes, too, you know, in terms of it, and so we went  
 3 in there with an -- answering their questions, but  
 4 saying nobody sees the need for the CPG anymore in  
 5 the sense that it's an exclusionary formulary, and  
 6 reviewing new drugs, but none of these are ever going  
 7 to be deleted or added to the exclusionary  
 8 formularies as far as anyone sees.  
 9 If they really needed to, we still have  
 10 the APRN Advisory Committee we can go through, you  
 11 know, the Board can go through rulemaking, statutory  
 12 changes. There's all these different routes, you  
 13 know, available.  
 14 And then added to that, it was that the  
 15 Medical Board had a PA equivalent of the CPG, and  
 16 that was recently eliminated in the statute as well.  
 17 So basically went in there and fell on our sword, and  
 18 they were more than happy to -- this is really --  
 19 that makes my day when somebody comes in and says,  
 20 you know, their time has come.  
 21 Then I also presented for the APRN  
 22 Advisory Committee, which you have the written  
 23 materials and that, was positive about what the  
 24 Committee was doing and its helpfulness to both the  
 25 Board and the State. And they seemed to have the --

1 to know when that would take place.  
 2 MR. DILLING: Absolutely. I think the  
 3 CPG would love it to be gone, right, the next day.  
 4 Of course, you also have these other bills that we'll  
 5 report on as well, the House Bill 177 and so forth.  
 6 I don't see that being a political issue  
 7 or problem. I think this is, again as we have  
 8 discussed previously, CPG, the cleanest way is to do  
 9 it through this process, then nobody has to get too  
 10 concerned about it from a political perspective. But  
 11 I'll check on that and see and report back.  
 12 CHAIRWOMAN KEELS: Thank you.  
 13 MR. DILLING: In terms of other  
 14 legislation on, the mover is House Bill 224. So, you  
 15 know, that's a good thing. And the Bill moved out of  
 16 the House.  
 17 There was, I think -- I believe that the  
 18 CRNAs were supportive of the bill. Certainly wasn't  
 19 as introduced, but supportive of the process in that  
 20 there were changes made.  
 21 The OSMA and the anesthesiologists took  
 22 a neutral position, and that's usually the best that  
 23 you can hope for in these type of bills. And so that  
 24 helped move things along.  
 25 And now it's being heard over in the

1 Senate Health Committee, and Senator Burke, who had a  
2 bill on the Senate side which was a bit different in  
3 terms of its introduction, and probably introduced in  
4 a more conservative level.

5 He is the Chair of the Senate Health  
6 Committee, but has been supportive, gave testimony on  
7 his own Bill, and changed and amended his own Bill to  
8 reflect that of the House Bill 224 changes. So  
9 everybody seems to be on board.

10 They had proponent testimony last week,  
11 and I believe it's up for opponent interested party  
12 this week, and I believe you'll see it move this  
13 spring.

14 I don't know if -- sometimes when a bill  
15 moves of that type, people add amendments to it, not  
16 necessarily as it relates to the CRNAs, but other  
17 similar health issues. I don't know if that is going  
18 on, because they do go on spring break, too.

19 So sometimes they maneuver bills in such  
20 a way that they can be used as vehicles if needed for  
21 other pieces of legislation. But it's -- as far as I  
22 know, the train is moving forward, it's not stopping,  
23 the destination is the last stop.

24 CHAIRWOMAN KEELS: Does that mean  
25 Senator Burke's bill and this 224 have been

1 That's the way I basically read it. And  
2 the expansion of the authority has been to clarify  
3 their CRNA's ability to write these orders and have  
4 other people fill them out.

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

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

21 In terms of House Bill 177 and standard  
22 of care arrangements, I don't know, we're like on  
23 draft 8, 10, you know, something like that, version.  
24 Now some more changes were made.

25 The 2,000 hour requirement for people

1 consolidated, or are they still two separate bills?

2 MR. DILLING: They are two separate  
3 bills, yes. I think it's more of the floor show,  
4 because that was assigned to another one of the  
5 committees just to say basically I'm on board with  
6 the changes that were made, so I don't want anything  
7 to slow it down and pretend like that there's a  
8 Senate version and a House version.

9 They are not going to play any -- they  
10 are basically saying we're not playing any games or  
11 anything.

12 CHAIRWOMAN KEELS: So then will Senator  
13 Burke's bill just sort of --

14 MR. DILLING: Just disappears.

15 CHAIRWOMAN KEELS: Very good.

16 MR. DILLING: And so the changes that  
17 were made I think are reflective in, you know, the  
18 bill itself.

19 And it's really the hospitals, instead  
20 of having -- I think they used the word protocol  
21 before and so forth. It's the same as any type of  
22 practice within a hospital setting, that you're going  
23 to have some privilege committee, some credentialing  
24 committee that reviews who is doing what and what  
25 they are doing.

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

8 We do not want to get into the business  
9 as far as I understand, as far as everybody else's  
10 understanding goes, of trying to go review  
11 documentation that says, you know, have at least  
12 2,000 hours, it's basically, I think, being set up  
13 where somebody says I've been working for such and  
14 such a date over these amount of hours, a couple  
15 people sign it and send it into the Board and we move  
16 on.

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

22 MR. DILLING: It's the new graduate, I  
23 believe, yeah. And anybody who doesn't have, you  
24 know -- again, the year is more of a definitive point  
25 than the 2,000 hours.

1 Don't want to get into a situation where  
2 somebody says yeah, I did my 2,000 hours. But you  
3 graduated four months ago. Yeah, I've been working  
4 really hard.

5 CHAIRWOMAN KEELS: A lot of hours.

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

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

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

25 So I think that that's left to be heard

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

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

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

22 And when that happens -- that's happened  
23 in the past and in other bills, you know, when we  
24 talked about whether or not there should be  
25 certain -- like global licensing and consolidation

1 here when they enter Committee sessions again and  
2 start hearing on that bill.

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

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

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

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

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

25 A lot of my time and energies here

1 and things like that, I didn't think that the  
2 associations would stand by, and kind of just watched  
3 the landscape change so dramatically without weighing  
4 in.

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

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

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

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

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

1 state by state, and it's all very similar.

2 And what you do is you get like this  
3 common -- these common statutes or these common  
4 standards, and it's maybe a little bit easier for  
5 some occupations than it is for some professions.

6 And while maybe in the year 2020 we  
7 should be closer to maybe more common standards and  
8 more common understandings, the way that these  
9 licensing laws have birthed and lived over the years  
10 makes it that there are differences at least between  
11 certain states.

12 And so when the occupational -- or the  
13 professionals come in from the associations they are  
14 saying -- they are pointing out certain states that  
15 are very different, you know, on the scale from  
16 others. And so that's causing people to take pause  
17 and notice.

18 I've been reading some things here  
19 recently about from some of the proponent groups  
20 where, like down in Florida, they are hearing this  
21 type of bill now. There are only two states, I  
22 think, that have it currently -- it's Arizona and  
23 Pennsylvania, that as law.

24 And those are fundamentally the same,  
25 the difference being, I think Arizona you have to

1 are practicing in those areas without licensure, the  
2 idea being that they are performing more rote tasks  
3 and not practicing medicine or nursing or some other  
4 profession in and of itself, they just say hand me  
5 this or do this.

6 Then there are people who will explain  
7 to you that perhaps there are some people that are  
8 doing more than that. And there's certainly a desire  
9 to do more than that on the part of some. But again,  
10 that's a good one to take a look at.

11 It comes every two years, but it seems  
12 like one session it will say let's be licensed by the  
13 Nursing Board, and this one says let's be licensed by  
14 the Medical Board. They try, you know, different  
15 routes and so forth.

16 But I thought the scope of practice that  
17 was being offered up here was quite broad, more so  
18 than I've ever seen before, and it really was about  
19 hey, we as the hospitals and the professionals, we'll  
20 determine how far this stuff goes, and where it ends,  
21 and where it stops, and things and so forth.

22 You know, to me it's a jaw dropper.  
23 I'll be interested to see how that is viewed. But  
24 again, gosh, it seems like that dates back 15 years  
25 on these types of bills have been coming through.

1 move into the State, actually physically be there  
2 before it kicks in.

3 But in Florida, they seem to have  
4 understood this differentiation between certain  
5 professions from others, and are more focused on more  
6 universal licensing standards for occupations like  
7 hair braiding, interior design, you know, things like  
8 that, that might lend itself to lesser number of  
9 hours, lesser testing, more common standards from the  
10 start, and ones that are being heard in individual  
11 bills, you know, maybe even here in Ohio where we  
12 don't have them.

13 So that is what, in part, we are  
14 arguing, too, is that, you know, there should be some  
15 differentiation made, thinking about hey, before you  
16 license somebody or create a licensing board, you  
17 know, what's happening in other states and what  
18 should those standards be, you know, that there are  
19 differences in those questions.

20 There's also -- and again, it's not  
21 reflected here, but since the last Board meeting we  
22 had a search goal assisting bill that was introduced,  
23 and, you know, you have certification boards I  
24 believe in surgical technicians and surgical  
25 assistants, and here in Ohio there are people that

1 I think that's a good overview of what's  
2 happening over in the Statehouse. I'm certainly open  
3 to any of your questions and concerns you might have.

4 CHAIRWOMAN KEELS: Well, I became aware  
5 of the acute -- the Advanced Practice Respiratory  
6 Therapy role because the Ohio State University is now  
7 offering a graduate degree in that, in collaboration  
8 with the College of Nursing, for some shared  
9 education on the PPPs, and faculty approached me to  
10 accept their graduate students for clinicals.

11 It sounds to me like they are patterning  
12 their scope of practice after the physician  
13 assistants, so it's a broad across the lifespan  
14 generalist education with a focus on cardio  
15 respiratory, and so they are doing it as the head of  
16 National Certification and head of a legal scope of  
17 practice in Ohio, and so I asked Tom if he had heard  
18 any information about that.

19 The RTs roll up under the Medical Board  
20 for regulation, and so I guess this would come  
21 through there, and I don't know what you've heard.

22 MR. DILLING: No, you and I have to have  
23 a talk about what your conversations were, you know,  
24 specifically with -- or what you heard back, you  
25 know, from them.

1 The Medical Board told me that they had  
2 gone to and spoken -- "they" the program had talked  
3 with the Medical Board. And yeah, it's almost as if  
4 the Medical Board thought it was kind of like oh,  
5 that's a nursing thing, you know. It was like no,  
6 you license the respiratory care therapist. Oh,  
7 yeah.

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

11 MR. DILLING: Right. So there was --  
12 yeah, it's -- certainly the timing has been  
13 coincidental in terms of you asking about it.

14 Yes, supposedly the only -- the first  
15 advanced practice respiratory care, but please  
16 understand, it is respiratory care, and you need a  
17 license to practice respiratory care. And you have a  
18 defined scope of practice for respiratory care, and  
19 you're licensed as a respiratory care therapist.

20 There is no statutes or anything  
21 creating an advanced practice rule either in  
22 respiratory care or nursing, you know, in that way.

23 Yes, preceding the National Association  
24 for Respiratory Care coming up with model guidelines  
25 and recommendations for scope, regulation, you know,

1 their territory, then it's, you know, quite a  
2 different thing, you know, in terms of scrutiny on  
3 questions and so forth.

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

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

18 25 years ago I was telling Lisa, I told  
19 the Medical Board keep sending me over to the  
20 Statehouse, we ought to all be overdone -- at Ohio  
21 State schools, you know, that's where it's -- all  
22 these changes are happening before they get over  
23 here.

24 CHAIRWOMAN KEELS: So I digress back  
25 to 177. So it's still in the House, still being

1 of this practice and, you know, what are the  
2 differences and so forth. That recently came out  
3 within the last month, and those are published. You  
4 can go online and see what they are doing.

5 There in turn comes the chicken before  
6 the egg, or whatever the conundrum here, of -- you  
7 know, from a regulation standpoint. If you're going  
8 to actually be practicing something, you need to be  
9 licensed.

10 And you see even in our statutes and  
11 others, there are exceptions to the requirements for  
12 licensure for the most part for students and that.  
13 And they have a good group of attorneys and others  
14 over at Ohio State, and I'm sure they are following  
15 all the rules and so forth with respect to that, but  
16 perhaps they want to, you know, move forward.

17 I've also, at the same time asking about  
18 that, heard that respiratory care is facing some  
19 questions about the desire on the part of some to  
20 have respiratory care assistance at the same time,  
21 and that not necessarily being welcomed by the  
22 association on that side of things.

23 So this happens, too, in some scope  
24 issues. People like to move up their scope and  
25 concentrate on that, but when someone comes into

1 debated with the recent change, is that right?

2 MR. DILLING: Yes. I mean, it's had  
3 some hearings and that, and I'm sure it will have  
4 some more, you know.

5 All scope issues are, I would say, kind  
6 of hot. People want to hear about different things.  
7 But now you've moved on to -- with the CRNAs, you  
8 know, apparently.

9 Once that's happened then, you know,  
10 there's good and bad to that. Then you become the  
11 spotlight, you become the focus, and both proponents  
12 and opponents can concentrate, you know, in that area  
13 as well.

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

18 CHAIRWOMAN KEELS: Okay.

19 MEMBER ZAMUDIO: So this kind of came up  
20 when I was reading this Sunset review on this  
21 Committee, as well as I guess it's timely because  
22 we're talking about the applications to be on this  
23 Committee.

24 And I'm curious what your interpretation  
25 is, and Lisa's as well. On 4723.493 under (B), it

1 says as far as the formation of this Committee -- I'm  
 2 just reading it out of your review -- the Board of  
 3 Nursing shall appoint members described in Division  
 4 A, which is all of us, recommendations for the  
 5 initial appointment and the vacancies are submitted  
 6 by organizations for APRNs and by schools for APRNs.  
 7 The Board shall appoint the members and fill the  
 8 vacancies according to the recommendations it  
 9 receives. If it does not receive any recommendations  
 10 or receives an insufficient number, the Board shall  
 11 appoint members and fill vacancies on its own advice.

12 So I'm just curious, because of the  
 13 process as far as us reapplying, et cetera, it seems  
 14 the intent of that would be that obviously the Board  
 15 doesn't want to choose who is advising it, that's not  
 16 a very robust process right to get input from  
 17 everybody because we're supposed to be advising and  
 18 representing these organizations and other peers.

19 So the way I'm reading it, the times  
 20 when the Board will decide who fills that, it very  
 21 clearly states that the Board shall appoint them if  
 22 it does not receive any recommendations. Is that  
 23 correct?

24 MR. DILLING: If I'm following  
 25 correctly, no. I would say that it's an

1 people, then what is that statute telling me to do?  
 2 MEMBER ZAMUDIO: That's the same  
 3 question I had, because how do you decide?

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

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

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

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

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

24 MEMBER ZAMUDIO: Yeah.

25 MR. DILLING: So that keeps people into

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

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

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

9 It's more about here is names, maybe  
 10 you'll have 14 names, maybe you'll have 21, maybe  
 11 you'll have 7, utilize those in selecting that point  
 12 group.

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

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

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

25 MR. DILLING: If they recommend 15

1 a -- keeps people in a certain direction. You know,  
 2 that's consistent with how many other groups are  
 3 appointed, and that's not necessarily at the Medical  
 4 Board level, these are things that are done  
 5 throughout the State.

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

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

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

25 MR. DILLING: Yeah. But again, we

1 haven't drilled down to perceive any necessity to  
2 come up with rules to say if nobody has come forward,  
3 the Board will try again and -- you know, for two  
4 more months and shall go look, we --

5 MEMBER ZAMUDIO: This happened, right?

6 MR. DILLING: Yeah, we have a number of  
7 advisory committees that are from outside the Board  
8 that aren't necessarily created by statute.

9 And so we go out and we say to the  
10 grouping of them, nurse educators, their associations  
11 and so forth, send out notice to the ONA, OAPI, hey,  
12 we're recruiting, it's recruiting time of the year,  
13 send us in some names.

14 MEMBER ZAMUDIO: But not for this  
15 Committee. This Committee is a statute.

16 MR. DILLING: Yeah, I'm just telling you  
17 that on occasion for, like dialysis or somebody, it's  
18 come back and we don't -- here again, nobody is  
19 volunteering to be the physician --

20 MS. EMRICH: APRN?

21 MR. DILLING: Yeah, that supervises a  
22 dialysis tech, they got other things that they want  
23 to do and that, so then we go out and -- I don't call  
24 up my friend and say hey, are you doing anything for  
25 the next year? Would you like to come in?

1 according to the recommendations?

2 MS. EMRICH: The statute is what guides  
3 our appointments to this Committee.

4 MEMBER ZAMUDIO: Thanks.

5 MS. EMRICH: That's it.

6 MR. DILLING: You know, like if it kept  
7 happening and so forth, then we would, I think, have  
8 to probably revisit the situation and find out where  
9 it is.

10 MEMBER ZAMUDIO: But I could see the  
11 situation where there would be a recommended person  
12 with a letter and one without.

13 So that's like I was trying to clarify,  
14 like do you go with the recommendations, or can the  
15 Board select somebody different? This says it would  
16 use its own advice if there were no recommendations.  
17 I just don't want it to happen again.

18 MEMBER DI PIAZZA: You can't apply  
19 without a recommendation, and it would really behoove  
20 the appropriate agency, organizations --

21 MEMBER ZAMUDIO: To limit that, right?

22 MEMBER DI PIAZZA: Well, to make a  
23 recommendation, because that's the person that's  
24 going to represent your profession.

25 MEMBER ZAMUDIO: I agree with that.

1 No, we go back and say we're going to  
2 start it again, and we go and start -- pick up the  
3 phone and start talking to different groups and say  
4 can you find us somebody, and most of the time they  
5 find us --

6 MEMBER ZAMUDIO: I was just curious  
7 about your and Lisa's interpretation, because this  
8 situation actually happened.

9 The midwife spot wasn't filled.  
10 Remember, we started later because there wasn't  
11 someone.

12 So I'm curious, when I read this, so  
13 what it's saying is the Board shall appoint according  
14 to any recommendations, and it says that exact  
15 verbiage, and it says if it doesn't reach a  
16 recommendation, then it can do it on its own advice.

17 And in that situation you would call  
18 ACNM or whatever, and solicit applications, is that  
19 correct.

20 MS. EMRICH: We have an application  
21 process, and the application process includes  
22 providing, with your recommendation, a recommendation  
23 from whichever organization is recommending you. I  
24 think the process works.

25 MEMBER ZAMUDIO: Do you appoint

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

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

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

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

9 MEMBER ZAMUDIO: Thanks. Appreciate it.

10 CHAIRWOMAN KEELS: Anything else for  
11 Tom? Thank you.

12 MR. DILLING: Thank you.

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

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

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

23 So next up is the draft document.

24 That's what we're calling it, the draft document.

25 You know, big kudos to Lisa and her Staff who are

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1 inundated with other work, but this took a lot of  
 2 time and effort to pull in salient points from the  
 3 Interpretive Guidelines.  
 4 Conversations that we have been having,  
 5 questions that we have been receiving, we try to pull  
 6 it all together. It's a draft, and I'll let Lisa  
 7 explain more.  
 8 MS. EMRICH: Thank you. So the  
 9 discussion to date has primarily focused around an  
 10 Interpretive Guideline which was specific to CNP.  
 11 Now, we have heard various concerns and  
 12 questions over the course of several meetings, the  
 13 last one being for the IG as it still exists, we're  
 14 going to get rid of that visual chart, which we can  
 15 do that.  
 16 But especially at the last meeting we  
 17 heard a lot about well, just an informative document  
 18 might be helpful. So we haven't really looked at or  
 19 talked about that, so what we thought we would do in  
 20 an attempt to be helpful, and to give you some  
 21 alternative pieces of information that may either be  
 22 used in conjunction with the IG, or even without an  
 23 IG, we thought we would put together just an overview  
 24 document.  
 25 And it pulls information directly from

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1 statute and rules, pulls in a little bit of the  
 2 Consensus Model, simply because the Consensus Model  
 3 is congruent with existing statute and rules, and  
 4 basically to see if this is somewhere close or an  
 5 aspect of what might be helpful to APRNs and the  
 6 general public.  
 7 It is applicable to all types of APRNs  
 8 as well, so that's the other positive thing about it.  
 9 So with that said -- and it's provided to you as a  
 10 starting point for discussion.  
 11 CHAIRWOMAN KEELS: And I like that you  
 12 titled it in such a way that you could kind of scroll  
 13 down and find the topic that you're sort of  
 14 interested in.  
 15 We talked about adding some live links  
 16 to take you to pertinent pieces of the legislation.  
 17 It would be really time consuming and challenging to  
 18 do links everywhere though, from what I understand.  
 19 MS. EMRICH: And the Word document does  
 20 have a lot of things linked. Did it come through on  
 21 the pdf?  
 22 MEMBER BOLTON: Yeah, I just tried to  
 23 pull it up and it came right in.  
 24 MS. EMRICH: Good.  
 25 CHAIRWOMAN KEELS: So I liked how it

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1 started with role, and then designation. You know,  
 2 we have been struggling really a lot with there are  
 3 four roles, and then the population based  
 4 certification, or population based foci, has been  
 5 used in statute as specialties. So trying to give  
 6 definition to that so people are clear when you see  
 7 that word, what that means.  
 8 I talked to Lisa. One of my suggestions  
 9 would be, in this introduction area, is maybe have a  
 10 little bit more information around how continuing  
 11 education, ongoing experience and training continues  
 12 to expand your scope within your population focus.  
 13 You know, you're different as a novice  
 14 as you are when -- than when you're several years  
 15 down the pike, because you have a lot more experience  
 16 and education and training and expertise, which then,  
 17 in fact, can increase your scope, which you're  
 18 permitted to do within your organization, or what  
 19 your collaborating physician will ask you to do.  
 20 But it's still within your population,  
 21 so it doesn't jump you out of your population, but  
 22 it's within your population. Pam has it -- she's  
 23 thinking. No? What is your thought?  
 24 MEMBER BOLTON: I just want it to be  
 25 extremely clear, because I think that could cause

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1 some interpretation that might go down a different  
 2 track.  
 3 The other thing I'm thinking about is  
 4 what about that provider that goes from one specialty  
 5 to another? I mean, I don't want them to assume that  
 6 if they have, you know, ten years in this specialty,  
 7 and they go to another specialty, that they are  
 8 equivalent.  
 9 CHAIRWOMAN KEELS: Specialty meaning  
 10 population, or you're talking about --  
 11 MEMBER BOLTON: Like if you are in  
 12 pulmonary or -- I mean, that's a different -- it's  
 13 not -- it's good to have that experience, but I see  
 14 that kind of as a novice again; you know, not novice  
 15 in the term of new graduate.  
 16 CHAIRWOMAN KEELS: You're a novice  
 17 within that patient subspecialty, actually, right?  
 18 MEMBER DI PIAZZZA: You're fine. You  
 19 had used the word scope, and I think it's more of the  
 20 clinical skill, right?  
 21 MS. EMRICH: And expertise.  
 22 MEMBER BOLTON: Thank you, Pete, that's  
 23 what --  
 24 CHAIRWOMAN KEELS: It does, but I say  
 25 that only because in statute, scope is defined by

1 your education and experience.  
 2 MEMBER DI PIAZZA: The population is  
 3 your scope, not the skill set. Does that make sense?  
 4 MEMBER BOLTON: Correct. But your skill  
 5 set is based on your education.  
 6 MEMBER DI PIAZZA: Right.  
 7 CHAIRWOMAN KEELS: It all needs to come  
 8 back to that so that you continue to evolve.  
 9 MEMBER BOLTON: I think it's going to be  
 10 a couple sentences, and it's going to need some  
 11 clarity.  
 12 MEMBER SIEVERS: You bring up a really  
 13 good point, and I was hoping maybe this is where we  
 14 could start, because it's the first paragraph.  
 15 It says that it's congruent with the  
 16 Ohio laws and rules of the Consensus Model, but the  
 17 point you just made was it's not.  
 18 These definitions -- and I think it's --  
 19 I was very confused having -- when I read it, to go  
 20 back to think about is this Consensus Model  
 21 definition or is this law/rule definition, as far as  
 22 foci, specialty, designation, all those terms.  
 23 CHAIRWOMAN KEELS: So back in our  
 24 original conversations we talked about that the  
 25 Consensus Model came out after the law, the Ohio law,

1 say -- if you're reading the Consensus Model and you  
 2 see the word specialty, it means foci and it means  
 3 oncology, if you're in the law and you see the word  
 4 specialty it means education and certification, like  
 5 CNS.  
 6 That to me is not congruent, and they  
 7 are going to send them down a track where I don't  
 8 know what they are talking about.  
 9 CHAIRWOMAN KEELS: I'll get to you guys  
 10 in a second. This Committee agreed to follow the  
 11 Consensus Model, and so I think we do need some of --  
 12 literally one paragraph about the Consensus Model.  
 13 I think the language could be made more  
 14 simple, so I'd like to use the words plain language  
 15 or simple language because, you know, sometimes you  
 16 read these and it feels a little bit legalese, and a  
 17 little confusing, so we may need to just -- so maybe  
 18 if we make it a little bit more plain, Sherri, that  
 19 might help you.  
 20 MEMBER SIEVERS: Do you see what I'm  
 21 saying though?  
 22 CHAIRWOMAN KEELS: I do. But that has  
 23 been the crux of these discussions for two years, is  
 24 the mass confusion around what does that mean and,  
 25 you know, so on and so forth.

1 and that it was felt to be congruent, meaning the  
 2 same, but that the words are different.  
 3 So in the Consensus Model they use role,  
 4 population based foci, specialty, to mean what you  
 5 specialize -- really a subspecialty or specializing  
 6 within that population. In Ohio law we use the word  
 7 designation.  
 8 MS. EMRICH: And that word was  
 9 introduced after HB 216, that it became designation  
 10 at that point.  
 11 CHAIRWOMAN KEELS: Instead of role.  
 12 MEMBER SIEVERS: I guess that's my  
 13 point.  
 14 CHAIRWOMAN KEELS: But they have the  
 15 same meaning, which is what we're trying to say in  
 16 here. Designation and role have the same meaning;  
 17 specialty certification or population based  
 18 certification has the same meaning as specialty.  
 19 MEMBER BOLTON: So could we define that  
 20 in here?  
 21 MEMBER SIEVERS: Or do we need the  
 22 Consensus Model stuff if we're -- the language? I  
 23 think that's going to be confusing.  
 24 We can have the underlying concept of  
 25 it, and the idea, but if you already are having to

1 So I think if we can get that defined in  
 2 a way that people kind of understand that that is  
 3 what this means, this is what that means.  
 4 MEMBER SIEVERS: But I guess by defining  
 5 it, you're going to have to -- maybe we have a better  
 6 way, but when you see specialty in the Consensus  
 7 Model it means foci like oncology blah, blah, blah.  
 8 MEMBER MINIARD: No, it doesn't.  
 9 CHAIRWOMAN KEELS: Specialty in the APRN  
 10 Consensus Model mean --  
 11 MEMBER MINIARD: You have a specialty in  
 12 cardiology, a specialty in --  
 13 MS. EMRICH: It's a level beyond what  
 14 your national certification is in.  
 15 MEMBER SIEVERS: Right, a foci.  
 16 MEMBER MINIARD: No, population focus is  
 17 acute care, family.  
 18 MEMBER SIEVERS: See, I'm already  
 19 confused and I'm --  
 20 MEMBER DI PIAZZA: There's advanced  
 21 cardiology certification.  
 22 MEMBER SIEVERS: But they are calling  
 23 that specialty. But specialty in the eyes of the law  
 24 is --  
 25 (Multiple people speaking.)

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1 CHAIRWOMAN KEELS: Bring in your mind's  
 2 eye the Consensus Model, and at the bottom are the  
 3 four roles. That's what the Consensus Model says.  
 4 Ohio law now refers to that as designation.  
 5 So role equals designation; CNP, CNS,  
 6 CNM, CRNA. Then the next layer are your population  
 7 based foci, your national certification in your  
 8 population, which is acute care, primary care, peds,  
 9 and adult, neonatal, those are your certifications,  
 10 and Ohio refers to those as specialties.  
 11 That's where it gets confusing, because  
 12 then the Consensus Model has, at the very top of the  
 13 pyramid, specialty, which is not regulated by the  
 14 Board of Nursing, but it's something that you may  
 15 specialize in your population.  
 16 So as a PNP I could specialize in  
 17 cardiology, and that is not regulated by the Board.  
 18 That is why we have had so many discussions and  
 19 points of confusion. So this document could -- my  
 20 hope would be that it helps to clarify those.  
 21 Michelle had her hand up.  
 22 MEMBER ZAMUDIO: I was trying to follow  
 23 the rule. I was just raising my hand.  
 24 So my first thought when I read this was  
 25 thank you, because this is an enormous amount of

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1 work. I don't know if this was Lisa -- it looks like  
 2 a whole team of people. But I loved it. I thought  
 3 this was a really great -- like you said, a great  
 4 place to start.  
 5 When I look at the beginning -- and I  
 6 heard what Sherri was saying. I know we agreed that  
 7 we were going to follow the Consensus Model.  
 8 Our laws don't necessarily follow the  
 9 Consensus Model, and if you think about it, it's kind  
 10 of a shame that the Consensus Model is 12 years old  
 11 and our laws predated that.  
 12 CHAIRWOMAN KEELS: Michelle, I'll stop  
 13 you there when you say the law doesn't follow the  
 14 Consensus Model, because we agreed it did.  
 15 MEMBER ZAMUDIO: I mean for things like  
 16 compact and --  
 17 CHAIRWOMAN KEELS: We don't follow all  
 18 the recommendations.  
 19 MEMBER ZAMUDIO: That's what I mean.  
 20 CHAIRWOMAN KEELS: But they regulate the  
 21 license.  
 22 MEMBER ZAMUDIO: They are not matched up  
 23 completely.  
 24 CHAIRWOMAN KEELS: We're working towards  
 25 compacts.

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1 MEMBER ZAMUDIO: So my thought was, at  
 2 the beginning, if everyone's interpretation, or their  
 3 definitions between the model and the law, are  
 4 different, why not start with definitions, and put  
 5 definitions at the top?  
 6 And then I strongly recommend and feel  
 7 that we should include the ORC definition of the  
 8 APRN, because it includes that word nursing  
 9 specialty, it says 4723.01, and it says it includes  
 10 formal education, training, and clinical experience.  
 11 So that would solve all that.  
 12 MEMBER BOLTON: Within the population  
 13 foci.  
 14 MEMBER ZAMUDIO: Whatever it says.  
 15 CHAIRWOMAN KEELS: It doesn't say that  
 16 in statute, but that's what we're trying to clarify  
 17 here.  
 18 MEMBER ZAMUDIO: That's 4723.01, so it's  
 19 not in statute, but if we put that in the rules, I  
 20 think all the definitions could you say population  
 21 equals this. But why do we have to mention the  
 22 Consensus Model? We agree to follow it without  
 23 putting it in here, can't we?  
 24 MEMBER BOLTON: Can I ask a question?  
 25 CHAIRWOMAN KEELS: Pam has had her hand

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1 up.  
 2 MEMBER BOLTON: I mean, I feel like the  
 3 Consensus Model was -- I mean, I think we owe homage  
 4 to that group who put this together, who truly tried  
 5 very hard to make this a unified document to guide  
 6 Boards of Nursing, and I feel like we are -- if you  
 7 look at the document, which talks about the degree of  
 8 implementation by the State's Board of Nursing, we  
 9 are one of the highest there.  
 10 And so I think we need to -- we need to  
 11 have mention of the Consensus Model in this document  
 12 because we are following that.  
 13 We aren't doing it all 28 points, I  
 14 think we're in 22, 24, if I remember correctly, but  
 15 we are -- it's definitely a part of who we are and  
 16 how we look at advanced practice nursing. And  
 17 leaving that out of the document I think would be --  
 18 it would be reckless.  
 19 MEMBER ZAMUDIO: But you're beginning  
 20 with a comparison.  
 21 CHAIRWOMAN KEELS: Jody, response?  
 22 MEMBER MINIARD: I would agree with Pam  
 23 because I think, one, we did agree to follow the  
 24 Consensus Model here as a group, and, two, I would  
 25 agree with Pam's comments about, you know, this is

1 not just some -- it is a guideline. It's not rule,  
2 it's not statute, it's something that was created.

3 It is 12 years old, but it has been  
4 followed by many other states of nursing who have  
5 since then obtained independent practice. So it  
6 gives a very -- a consensus across the APRN role  
7 across the United States.

8 So I think it is -- and not to mention  
9 the members of the groups who -- the member -- the  
10 elite people who created this document says a lot  
11 about -- I just think it says a lot about a lot of  
12 things, and I think it's really important to have the  
13 Consensus Model in there, because I think most  
14 people -- I mean, it's something as a faculty, we  
15 teach our students about the Consensus Model, okay?

16 I mean, we don't say this is rule or  
17 this is statute, but we do kind of -- we do give that  
18 to them as a guideline as to what it means to become  
19 a nurse practitioner for example, right?

20 So what does it mean? Because a nurse  
21 and a nurse practitioner are very different roles.  
22 So in one of our classes that we have that is all  
23 about, you know, becoming a nurse practitioner, and  
24 what does that mean legally, what does that mean for  
25 practice for you, we do talk about the Consensus

1 MEMBER ZAMUDIO: We're working on it,  
2 that's the message.

3 CHAIRWOMAN KEELS: We are working on it,  
4 but the rule -- the statute stood before the  
5 Consensus Model, and so I go to Lisa and then Sherri.

6 MS. EMRICH: Just more a point for  
7 clarification. The Consensus Model, regulation which  
8 is the Board, is only one fourth of that whole  
9 appliance there.

10 It's also about congruent, it's about  
11 the model for a national education of APRNs, the  
12 accreditation of APRNs programs, as well as the  
13 Nursing Board that regulate the APRNs. And when I'm  
14 talking about congruent, I'm talking about how the  
15 Board regulates the APRN.

16 CHAIRWOMAN KEELS: We could probably put  
17 a word around that, maybe regulation is congruent,  
18 maybe?

19 MEMBER ZAMUDIO: I think just starting  
20 with the definitions, too.

21 MEMBER SIEVERS: That's what I was going  
22 to suggest. I just Googled congruent. An agreement,  
23 but then the other definition is coinciding exactly  
24 when superimposed.

25 And so for people to think that the law

1 Model. So I think it's more formally known than a  
2 lot of people think it is.

3 CHAIRWOMAN KEELS: Michelle had a point  
4 before.

5 MEMBER ZAMUDIO: What was it? So I  
6 wasn't saying we don't mention it at all, we don't  
7 use it, we don't follow it, I'm just saying the way  
8 it's laid out by reference, it's going back and  
9 forth, back and forth, back and forth, Consensus  
10 Model this, Consensus Model, state law, Consensus  
11 Model, laws and rules.

12 Beginning with definitions may be  
13 helpful. And the definition of the APRN that's in  
14 our current rules -- and then when it says the APRN  
15 Consensus Model is congruent with Ohio laws and  
16 rules, that almost should be flipped around.

17 We're trying to make our Ohio laws --  
18 the rules congruent with the Consensus Model. It's  
19 not there yet, but we could allude to the fact that  
20 that's our aspiration or something. It's not  
21 completely congruent.

22 CHAIRWOMAN KEELS: Remember that the  
23 Board is congruent because the Board is regulating  
24 the independent -- Yes and no, I understand what  
25 you're saying. I'm sorry.

1 and the -- Consensus Model is one in the same, that's  
2 where I get really worried, because somebody sees  
3 Consensus Model is congruent with the law, then they  
4 think I can just look at the Consensus Model.

5 So maybe a different statement there.  
6 And like Jody's, maybe a little bit more explanation  
7 about what we're really trying to say about the  
8 Consensus Model.

9 MEMBER DI PIAZZA: I have a question  
10 actually for Lisa. Is there any concern that  
11 putting -- I like the idea of definitions.

12 Is there any concern about putting  
13 definitions in there that it will appear to be less  
14 of a guideline and more of interpreting?

15 MEMBER MINIARD: That's a good question.

16 MEMBER ZAMUDIO: I don't understand.

17 MEMBER DI PIAZZA: Because the  
18 guidelines aren't meant to interpret the law.

19 MS. EMRICH: This is not considered an  
20 interpretive guideline, this is an informational  
21 sheet. It's not as formal, but that's why I think  
22 the words and information used is taken mostly from  
23 existing law and rules.

24 So, you know, we could actually not have  
25 the APRN and Consensus Model paragraph in here and it

1 will still be a perfectly legitimate document.  
 2 MEMBER SIEVERS: That might be best.  
 3 CHAIRWOMAN KEELS: I think, however, we  
 4 still have the APRN Consensus Model posted on the  
 5 website, so it feels like it just lives there, right?  
 6 So it feels like there needs to be some reference to  
 7 it in some way.  
 8 MEMBER BOLTON: Guideline around that.  
 9 The other thing is, I was wondering if  
 10 the -- one of the links could be -- one of the  
 11 things, the State has 28 different components and  
 12 tells -- at the bottom it has the summary score of  
 13 each state.  
 14 I'm trying to find it and I'm struggling  
 15 to find it. But it tells how many of those various  
 16 indicators are actually being implemented at the --  
 17 each of the state levels at the Board of Nursing.  
 18 That might be something that would then  
 19 show someone how significant or which components the  
 20 Ohio Board of Nursing is --  
 21 CHAIRWOMAN KEELS: Are you talking about  
 22 the APRN consensus map?  
 23 MEMBER BOLTON: No, it's not a map.  
 24 CHAIRWOMAN KEELS: Are you talking about  
 25 the document that Lisa pulled together?

1 specifically look at the 4723.801 for the definition  
 2 of APRN?  
 3 CHAIRWOMAN KEELS: You want to have  
 4 that --  
 5 MEMBER ZAMUDIO: Yeah, where it says --  
 6 because it uses -- I know it uses that word  
 7 specialty, which is obviously controversial, but it  
 8 is what is in there right now in the rule.  
 9 And so it does say formal education,  
 10 training, and clinical experience. To be honest with  
 11 you, when I was kind of word-smithing some of the  
 12 earlier documents looking at other people coming in  
 13 to be licensed in Ohio, it says "or" on there, they  
 14 can be trained, or educated, or experience.  
 15 I'm like no, we want to claim this. It  
 16 should be an "and", and we should leave this in here.  
 17 It's our current one, and it's good and it recognizes  
 18 clinical experience, is what we have right now.  
 19 CHAIRWOMAN KEELS: Okay. Anything else  
 20 on those first two paragraphs? So we'll get another  
 21 draft out on that one.  
 22 Under APRN Licensure, any comments  
 23 around that? I thought that was helpful to have. I  
 24 was thinking of putting myself in the position of  
 25 being a new APRN to Ohio, and this is a great

1 MS. DI PASQUALE: It's the SPBN document  
 2 and it says this stated has adopted -- congruent with  
 3 or has adopted, but not these three things.  
 4 MEMBER BOLTON: It's worth 28 total  
 5 points, and we're like 22 or 24.  
 6 CHAIRWOMAN KEELS: I've seen that.  
 7 MS. DI PASQUALE: But it's --  
 8 MEMBER BOLTON: It is a SPBN document.  
 9 MEMBER SIEVERS: This one?  
 10 MEMBER BOLTON: Yes.  
 11 MEMBER SIEVERS: But this drives the  
 12 map. This is what the map is based on.  
 13 MEMBER BOLTON: But what -- I think what  
 14 is good there is it gives specific information.  
 15 MEMBER ZAMUDIO: I think that would be  
 16 good. Maybe a link to that, so that nurse  
 17 practitioners -- for somebody who is new, they could  
 18 look for that.  
 19 CHAIRWOMAN KEELS: So we agree that we  
 20 need to work on the two paragraphs to make that more  
 21 plain, and to define terms.  
 22 And then I asked for some information to  
 23 add some information around experience and education  
 24 for training and continuing education.  
 25 MEMBER ZAMUDIO: Can I request that we

1 resource to let me know exactly what needs to be  
 2 done.  
 3 I was wondering if -- I think you put it  
 4 in there, but standard care arrangement, do you have  
 5 to have a standard care arrangement in order to  
 6 practice?  
 7 MEMBER DI PIAZZZA: It's in here. It's  
 8 in here under the scopes of each.  
 9 MS. EMRICH: And you don't have to have  
 10 it to be licensed, you have to have it for practice.  
 11 CHAIRWOMAN KEELS: Good point. Strike  
 12 that. Nothing on licensure.  
 13 MEMBER SIEVERS: Wait, one question. Do  
 14 we want to call out out-of-state, because isn't there  
 15 one more course they have to take? I get that  
 16 question all the time.  
 17 MS. EMRICH: The two-hour online rule.  
 18 MEMBER ZAMUDIO: Where is that.  
 19 MEMBER SIEVERS: And a link to maybe --  
 20 well, that would be hard. I know we used to have a  
 21 link to the courses. It means to call out  
 22 out-of-state, they have to have one more additional  
 23 two-hour.  
 24 MEMBER DI PIAZZZA: Is that for their RN  
 25 license?

1 CHAIRWOMAN KEELS: No, APRN. There's a  
 2 module in Ohio.  
 3 MEMBER SIEVERS: If you had the  
 4 pharmacology but not had state specific things, and I  
 5 think there's -- I can't remember who has the course.  
 6 MS. EMRICH: Well, are you talking about  
 7 the online, so that -- we had a person had to go back  
 8 through for 2016 after transition, or are you talking  
 9 about the three-hour course?  
 10 MEMBER SIEVERS: Three-hour.  
 11 CHAIRWOMAN KEELS: If you are moving in  
 12 from, say Indiana, you need to complete that online  
 13 module.  
 14 MEMBER MINIARD: For a new licensee?  
 15 CHAIRWOMAN KEELS: For a new licensee  
 16 coming into Ohio. That's a good point. Okay.  
 17 Moving on. APRN education programs are not regulated  
 18 by the Board.  
 19 MEMBER MINIARD: I think "not" should be  
 20 in all caps.  
 21 CHAIRWOMAN KEELS: I do like questions  
 22 or concerns should be addressed to the accrediting  
 23 agency or the Ohio Department of Higher Education. I  
 24 like that. Approve national certifying  
 25 organizations.

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

1 MEMBER MINIARD: The only thing I could  
 2 say -- I'm sorry, can I backtrack?  
 3 MEMBER SIEVERS: I think I'm going to  
 4 say --  
 5 MEMBER MINIARD: The thing that we  
 6 brought up earlier about how I think there should be  
 7 something in here, because a lot of people don't know  
 8 this, even when you recertify, it says right there,  
 9 but that you need to require that your certification  
 10 sends -- verifies your certification with the Ohio  
 11 Board of Nursing, because -- within 60 days of your  
 12 certification.  
 13 CHAIRWOMAN KEELS: Good point.  
 14 MS. EMRICH: Certifying organization --  
 15 MEMBER MINIARD: It's in the law we just  
 16 read. I don't know the numbers as well as they do,  
 17 but --  
 18 CHAIRWOMAN KEELS: Using Michelle's  
 19 previous language, it is the sole responsibility of  
 20 the APRN to ensure that the certifying body has  
 21 provided primary source verification.  
 22 MEMBER MINIARD: Right.  
 23 CHAIRWOMAN KEELS: Good callout. I  
 24 still have staff that forget that.  
 25 MEMBER MINIARD: It's just another

1 reminder. I think it's a good --  
 2 CHAIRWOMAN KEELS: Okay. Move on.  
 3 Designation's scope of practice. Designation/role,  
 4 scope of practice.  
 5 With the CRN for 244, will anything of  
 6 this change in this paragraph?  
 7 MS. EMRICH: I would have to --  
 8 CHAIRWOMAN KEELS: See what the final --  
 9 MS. EMRICH: I'm not even going to go  
 10 there until we actually have something substantial,  
 11 something, the final product.  
 12 MEMBER MINIARD: A helpful document.  
 13 CHAIRWOMAN KEELS: And then Michelle,  
 14 CNM scope of practice.  
 15 MEMBER ZAMUDIO: I'm not good with it,  
 16 but I agree, you know.  
 17 CHAIRWOMAN KEELS: It's congruent?  
 18 MEMBER ZAMUDIO: It is congruent. I  
 19 don't know if there's a way -- I think I word-smithed  
 20 that on a different page here, but to say -- here it  
 21 is -- that it's recognized that nurse midwives  
 22 provide care for unborn children.  
 23 I'm a little worried about this because  
 24 we have new fetal care centers and other  
 25 opportunities for newborn care, so under the CNM

1 scope of practice where it says that we don't treat  
 2 newborns, and it's mentioned later in one of the  
 3 FAQs.  
 4 So when we are caring for the patient,  
 5 obviously I'm diagnosing problems with the newborn,  
 6 I'm treating those problems with a newborn.  
 7 I'm responsible for every supplement  
 8 that goes in her mouth and whether or not that  
 9 newborn is healthy, and that newborn can individually  
 10 and on its own merit, sue me for 21 years afterwards,  
 11 that newborn is my patient.  
 12 I realize in Ohio statute, for whatever  
 13 reason we reached with all of the other states and  
 14 said we can't provide newborn care, where does  
 15 neonatal resuscitation fall in there, because that  
 16 baby is in my hands and it's not breathing and we're  
 17 all required to be certified.  
 18 So I think just some statement of -- not  
 19 interpretation, but guideline, saying it is  
 20 recognized that CNMs provide care for the unborn, or  
 21 whatever word you want to use, fetus, fetal, it would  
 22 help with those fetal care centers.  
 23 CHAIRWOMAN KEELS: To me you were  
 24 jumping around between fetus and then the newborn.  
 25 MEMBER ZAMUDIO: In our mind we provide

1 intubating.  
 2 MS. EMRICH: I differentiate a  
 3 gestational and delivered fetus from a newborn.  
 4 MEMBER ZAMUDIO: It's true. But  
 5 somebody could say hey, if you're not doing that, why  
 6 are you resuscitating that baby, it's been born?  
 7 So most states allow up to 28 days  
 8 including or surrounding -- all of our -- and I  
 9 realize that's a whole topic for another day, but we  
 10 do provide newborn resuscitation, we do provide  
 11 immediate newborn care.  
 12 And I think in a lot of the hospitals,  
 13 not going back to looking -- have written immediate  
 14 newborn care, so we have to educate them well, we're  
 15 not allowed to do that.  
 16 So just some kind of statement that  
 17 although I'm not allowed to take care of that  
 18 newborn, that newborn can actually sue me for not  
 19 taking care of it.  
 20 MEMBER MINIARD: Can I ask a question?  
 21 So I'm confused at what you are saying. So are you  
 22 or are you not providing immediate care?  
 23 MEMBER ZAMUDIO: So nurse midwives may  
 24 provide that care, and they should provide that care.  
 25 In Ohio that's not addressed at all.

1 care for both of them, obviously, but the newborn,  
 2 the second it's born, under Ohio statute I'm not  
 3 allowed to do anything, but in fact I'm required to  
 4 resuscitate that baby in an emergency.  
 5 I'm responsible for that actual being  
 6 and what condition that newborn is in when it's born,  
 7 the entire pregnancy, right?  
 8 So if I didn't recommend folic acid, if  
 9 I didn't stop a teratogenic medication, if I didn't  
 10 do the right screening test, I diagnose them  
 11 genetically by testing just the fetus during  
 12 pregnancy.  
 13 So something that's not to expand scope,  
 14 it's not to do anything else, but to say it's  
 15 recognized that CNMs provide care for the newborn  
 16 during pregnancy and labor would be a request.  
 17 CHAIRWOMAN KEELS: Is there something  
 18 from your certifying body or your national  
 19 organization?  
 20 MEMBER ZAMUDIO: Oh, yes. A fourth of  
 21 our training, 25 percent, is newborn care.  
 22 CHAIRWOMAN KEELS: Do they have a --  
 23 MS. EMRICH: Immediate newborn care.  
 24 MEMBER ZAMUDIO: Immediate would be  
 25 great. That at least covers those of us who are

1 So it wouldn't be expanding scope to say  
 2 that it's recognized that we may provide  
 3 stabilization of a newborn or immediate care of a  
 4 newborn.  
 5 MEMBER MINIARD: So there's nothing in  
 6 statute that says you can't?  
 7 MEMBER ZAMUDIO: No prohibitory  
 8 language. It just says newborn, and like that part  
 9 has always just bothered me, because are you not  
 10 taking care of a newborn?  
 11 CHAIRWOMAN KEELS: So what you would  
 12 like to add is something around initial care, which  
 13 includes resuscitation and stabilization?  
 14 MEMBER ZAMUDIO: Right.  
 15 CHAIRWOMAN KEELS: Particularly in  
 16 emergencies?  
 17 MEMBER ZAMUDIO: Right.  
 18 CHAIRWOMAN KEELS: Because then there's  
 19 a whole perinatal guideline that comes out what CNMs  
 20 may be doing based on level of care.  
 21 MEMBER MINIARD: This is an ignorance  
 22 question, because I don't work in pediatrics, but  
 23 like you guys were saying, so what does your national  
 24 organization say is the timeline of immediate  
 25 postnatal care?

1 MEMBER ZAMUDIO: So it doesn't define  
2 immediate because it allows us to care for newborns.  
3 And when I was in practice in another state it was up  
4 to one year of life, all the vaccines, physicals,  
5 everything. Now, obviously -- and that's many -- so  
6 our education includes --

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

9 MEMBER ZAMUDIO: Right. Our education  
10 includes newborn care. Out of your four semesters,  
11 25 percent was newborn care.

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

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

20 CHAIRWOMAN KEELS: But what does Ohio  
21 statute say?

22 MEMBER SIEVERS: I can read it.

23 A nurse authorized to practice as a  
24 certified nurse midwife in collaboration with one or  
25 more physicians, may provide the management of

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

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

13 CHAIRWOMAN KEELS: Find out what the  
14 statutory limit is.

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

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

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

1 preventive services, and those primary care services  
2 necessary to provide healthcare to women  
3 antepartally, intrapartally, postpartally, and  
4 gynecologically, consistent with the nurse's  
5 education and certification, and in accordance with  
6 the rules by the Board of Nursing.

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

9 MEMBER SIEVERS: Right, about --

10 CHAIRWOMAN KEELS: Mr. Dilling.

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

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

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

1 MEMBER ZAMUDIO: But with our input.

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

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

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

14 MEMBER ZAMUDIO: Right, be careful,  
15 sure. Absolutely, always.

16 MR. DILLING: Absolutely bring it back  
17 and have further discussions, because it's very  
18 important.

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

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

25 MEMBER ZAMUDIO: I mean, that's my job,

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1 is to give the input to request things like that.  
 2 MEMBER BOLTON: It's a great thought,  
 3 and I think we do need to research it further. But  
 4 rather than continuing a conversation, I think bring  
 5 some language back and we can then approve it.  
 6 CHAIRWOMAN KEELS: Good point. Moving  
 7 down to CNS scope of practice. My question is on the  
 8 second bullet; CNS may provide and manage the care of  
 9 individuals and groups with complex health problems  
 10 and provide healthcare services that promote,  
 11 improve, and manage healthcare within the nurse's  
 12 nursing specialty, consistent with the nurse's  
 13 education and in accordance with rules adopted by the  
 14 Board.  
 15 Should that say education and  
 16 certification.  
 17 MS. EMRICH: No, because the scope of  
 18 practice in .43, for this particular designation of  
 19 APRN, it says education, not certification.  
 20 CHAIRWOMAN KEELS: But do CNSs meet  
 21 that?  
 22 MS. EMRICH: They have to have national  
 23 certification to practice, and their national  
 24 certification is within certain areas, like acute  
 25 care and all.

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1 CHAIRWOMAN KEELS: But there's a  
 2 general, in case they don't have like a population  
 3 focus.  
 4 MS. EMRICH: And not all CNSs have  
 5 national certification.  
 6 CHAIRWOMAN KEELS: Right, they were  
 7 grandfathered at some point.  
 8 MS. EMRICH: Right.  
 9 CHAIRWOMAN KEELS: So does that need to  
 10 be some sort of bullet explanation, or no?  
 11 MEMBER BOLTON: Oh, boy. Yes.  
 12 CHAIRWOMAN KEELS: Pam.  
 13 MEMBER MINIARD: Be careful, he's going  
 14 to stand back up.  
 15 MEMBER BOLTON: You're allowed, Tom.  
 16 MS. EMRICH: And I should say we do  
 17 not -- this is not scope. Certification has never  
 18 been a question raised by CNSs. This is not a  
 19 high -- nothing as compared to what the CNP question  
 20 is.  
 21 MEMBER BOLTON: The other pieces here,  
 22 if you are a noncertified CNS, and correct me if I'm  
 23 wrong, you cannot bill?  
 24 MS. EMRICH: Yeah.  
 25 MEMBER BOLTON: So you are not going to

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1 be able to truly take care of patients from beginning  
 2 to end, you know what I'm saying?  
 3 So what you find is that the CNS who is  
 4 not certified typically will serve more like an  
 5 educator, policy developer, you know.  
 6 It's not that they don't encompass the  
 7 rules of the CNS, but they cannot bill for those  
 8 services. So they are not going to be managing care  
 9 in a situation where they would bill.  
 10 That does not mean -- because we have  
 11 CNSs in CT surgery where the billing is global, and  
 12 they are seeing them. So it crosses both paths.  
 13 Certification, noncertification. And she would not  
 14 be there if she didn't have acute care certification,  
 15 you know what I'm saying?  
 16 CHAIRWOMAN KEELS: My point was that a  
 17 couple pages ahead, we said in order to be licensed  
 18 you had to have the national certification, and it  
 19 just stood out to me that it wasn't included in that  
 20 sentence, but I understand why.  
 21 MEMBER BOLTON: Does it need to be  
 22 clarified that there are CNSs who were grandfathered,  
 23 and those who had certification? I don't know, is  
 24 that too much?  
 25 CHAIRWOMAN KEELS: I felt like it was in

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1 here somewhere.  
 2 MS. EMRICH: We have chosen -- more out  
 3 of as time has gone on, those grandfathered CNSs are  
 4 fewer and fewer, so really we have just stopped  
 5 mentioning it so much unless it comes up on an  
 6 individual basis. We're going at it --  
 7 MEMBER BOLTON: Might be they are --  
 8 MS. EMRICH: I can tell you 99 percent  
 9 are certified, because as time goes on there's just  
 10 going to be fewer and fewer, because we're talking  
 11 about a person that was grandfathered in 2000.  
 12 CHAIRWOMAN KEELS: So no more  
 13 information needed then. Are we ready to move from  
 14 CNS, Pam?  
 15 MEMBER BOLTON: I'm good.  
 16 CHAIRWOMAN KEELS: Then we have CNP.  
 17 Pretty much taken straight from statute. And that is  
 18 just the certification examination, which we may want  
 19 to put in the words specialty/population.  
 20 MEMBER MINIARD: I think that's probably  
 21 a good idea just to use the -- put the slash --  
 22 CHAIRWOMAN KEELS: Put it in the very  
 23 beginning and --  
 24 MEMBER MINIARD: Always put the "slash  
 25 population" so it's always there.

1 MS. EMRICH: Aka this, aka that.  
 2 MEMBER MINIARD: So you don't know what  
 3 that was, and go back to the definition page. Never  
 4 mind.  
 5 MS. EMRICH: Some are past retired and  
 6 are no longer available. But I just put currently.  
 7 MEMBER MINIARD: Can I make one comment  
 8 about that? I can see this causing some confusion  
 9 for ACNPs who are -- it was a former certification  
 10 through ANCC, that if they don't have the adult gero  
 11 acute care certification, that that would create  
 12 issues for them under the law. I can see you getting  
 13 a lot of questions about that.  
 14 MS. EMRICH: The adult?  
 15 MEMBER MINIARD: It's ACNP. It's adult  
 16 acute care nurse practitioner. And you could maybe  
 17 just put former -- I mean, because it's still a  
 18 certification that you can renew, and you're not  
 19 required to go back and get the AG ACNP. For  
 20 example, I'm an ACNP.  
 21 MEMBER SIEVERS: Maybe say no new exams  
 22 or --  
 23 MEMBER MINIARD: Yeah, there's a lot --  
 24 I know a lot of people who are just ACNPs, because  
 25 that was only in just the last five or six years that

1 link to those pertinent pieces?  
 2 MEMBER MINIARD: That's a good point.  
 3 CHAIRWOMAN KEELS: Because I think a lot  
 4 of people don't --  
 5 MS. EMRICH: They should.  
 6 CHAIRWOMAN KEELS: Remember, I need to  
 7 know what the Medical Board and the Pharmacy Board  
 8 and the DEA -- maybe less about the DEA.  
 9 MEMBER MINIARD: Or tell lawyers how to  
 10 register.  
 11 CHAIRWOMAN KEELS: It's linked to the  
 12 rule, which then gives the direction.  
 13 MEMBER DI PIAZZZA: You said it already,  
 14 so we're good.  
 15 CHAIRWOMAN KEELS: The next bullet,  
 16 prescribing must be consistent with the APRNs' scope  
 17 and standard care arrangement and consistent with the  
 18 standards of practice. I thought again we may want  
 19 to -- APRN specialty/certification.  
 20 MEMBER MINIARD: Or "slash population",  
 21 you want to keep it --  
 22 CHAIRWOMAN KEELS: Whichever word we end  
 23 up with that makes it more clear.  
 24 MEMBER MINIARD: I think most of us know  
 25 it as a certification, but I think it would be better

1 the AG ACNP came up.  
 2 MEMBER GAGER: That's primary care, too.  
 3 It's you can recertify, but you can't --  
 4 MEMBER MINIARD: Good point, because  
 5 there's a lot of them, too, so it would be maybe  
 6 former.  
 7 MS. EMRICH: Just a former.  
 8 MEMBER MINIARD: No new certification  
 9 exams for those, because I could see you getting a  
 10 lot of questions, well, my certification isn't listed  
 11 under there.  
 12 CHAIRWOMAN KEELS: So something like  
 13 some certifications have been retired, and then --  
 14 MEMBER MINIARD: For example, adult  
 15 nurse practitioner, and acute care nurse  
 16 practitioner, without the gero are included.  
 17 MEMBER BOLTON: They are global.  
 18 CHAIRWOMAN KEELS: Okay. Prescriptive  
 19 authority. I don't have the link. I'm assuming this  
 20 links to the formulary?  
 21 MS. EMRICH: Or the rule link --  
 22 CHAIRWOMAN KEELS: The rule would be  
 23 linked. Did we want to -- and I know this is a lot  
 24 of work on your part, the rules and law enforced by  
 25 the Board of Pharmacy and DEA, did we want to have a

1 to use the terms used in the Consensus Model.  
 2 CHAIRWOMAN KEELS: Probably because  
 3 there are certifications in that nonregulated  
 4 specialty in that Consensus Model.  
 5 MEMBER MINIARD: Correct.  
 6 CHAIRWOMAN KEELS: Back to my pyramid in  
 7 my mind. Then there's that nasty little prescribing  
 8 with five APRNs at a time.  
 9 MEMBER SIEVERS: Statute.  
 10 MEMBER BOLTON: There's an extra space  
 11 in there.  
 12 MEMBER MINIARD: There is.  
 13 CHAIRWOMAN KEELS: Under APRNs may  
 14 provide or furnish drugs to sexual partners, you're  
 15 limited to two, is that right?  
 16 MEMBER ZAMUDIO: Correct.  
 17 CHAIRWOMAN KEELS: Do you want to put  
 18 that in there? But you have a link to the rule.  
 19 MS. EMRICH: That's in statute.  
 20 MEMBER ZAMUDIO: Where are you right  
 21 now?  
 22 MEMBER DI PIAZZZA: The last bullet  
 23 point.  
 24 MS. EMRICH: We can add up to two, up to  
 25 the number two.

1 CHAIRWOMAN KEELS: Up to two sexual  
 2 partners.  
 3 MEMBER MINIARD: I think it's good.  
 4 Those little things that you can put in there to  
 5 avoid people having to go back and read the legal  
 6 jargon that they don't understand half the time, you  
 7 know.  
 8 CHAIRWOMAN KEELS: That they should be  
 9 aware.  
 10 MEMBER MINIARD: I know, but you know  
 11 what I'm saying? Like they read it and they get  
 12 confused.  
 13 CHAIRWOMAN KEELS: Any more comments on  
 14 the prescribing piece? Standard care arrangements.  
 15 Any comments?  
 16 MEMBER ZAMUDIO: I'm sorry, I have one  
 17 quick question. So on the prescribing part, do we  
 18 need to address -- because I think it was somewhere  
 19 in Holly's 9-10 this morning about prescribing of  
 20 abortion medications?  
 21 CHAIRWOMAN KEELS: That's in the  
 22 Inclusionary Formulary.  
 23 MEMBER ZAMUDIO: Well, my only thought  
 24 was -- in the formulary does it link to -- I went  
 25 back to look at the Ohio Revised Code's definition of

1 administering meds for that, and it's an explicit  
 2 prohibition for APRNs and RNs. I'm trying to --  
 3 MEMBER ZAMUDIO: I think it would effect  
 4 more than just women's health.  
 5 CHAIRWOMAN KEELS: Standard care  
 6 arrangements?  
 7 MEMBER MINIARD: No.  
 8 MEMBER ZAMUDIO: I have another  
 9 question. On that first paragraph where it said the  
 10 collaborating physician must be authorized to  
 11 practice, it's under the standard care arrangement,  
 12 first paragraph, they must be practicing in a  
 13 specialty that is the same.  
 14 Do you think it would be helpful to just  
 15 write clinical area or clinical arena, because now  
 16 we're taking about the physician's specialty?  
 17 MS. DI PASQUALE: I think that's  
 18 straight out of a statute, but I'm going to look.  
 19 MEMBER BOLTON: I kind of feel it has to  
 20 be specialty, because their certification is  
 21 different than ours.  
 22 I get this with the medical staff all  
 23 the time, in that they are certified in ortho or  
 24 critical care or internal medicine, where we are more  
 25 generically certified with a specialty, so I think --

1 abortion, and actually I think it would be helpful to  
 2 write that in there because it definitely is not that  
 3 you can't prescribe the -- you can't effect an  
 4 abortion, but there's some medications that we use  
 5 for other reasons, but that can cause an abortion if  
 6 given at a different time.  
 7 MS. EMRICH: Talking about Cytotec?  
 8 MEMBER ZAMUDIO: Cytotec, misoprostol,  
 9 there's other ones. I don't know if we could  
 10 reference the Ohio Revised Code's definition of  
 11 abortion, because I thought it would be helpful.  
 12 CHAIRWOMAN KEELS: Abortion or abort a  
 13 patient?  
 14 MEMBER ZAMUDIO: Abort a patient. So  
 15 it's on 2119-11. It says it's the purposeful  
 16 termination of a human pregnancy with an intent other  
 17 than to produce a live birth, or to remove a dead  
 18 fetus or embryo, and that's Ohio rule.  
 19 So if we put that in there, I just think  
 20 it would be helpful for the prescribing part of it,  
 21 because it might not be a nurse midwife, it could be  
 22 anybody here. You could be in the ER, you could be  
 23 covering, and we don't know.  
 24 MS. EMRICH: We have an AG opinion  
 25 regarding abortion, administering -- even

1 MEMBER ZAMUDIO: But what if they are  
 2 not a specialist? Many physicians will tell you they  
 3 are not a specialist, they are primary care.  
 4 MEMBER BOLTON: Or internal medicine.  
 5 MEMBER ZAMUDIO: And so they are not  
 6 technically considered specialties. I was just  
 7 thinking should we write -- because the -- the idea  
 8 says clinical are.  
 9 MS. EMRICH: So it was just to clarify,  
 10 when we're looking at the collaborating physician, we  
 11 have never interpreted the physician's practice in a  
 12 particular specialized area as being their board  
 13 certification, we have looked at what is their  
 14 practice and what does it look like, does that  
 15 make --  
 16 MEMBER ZAMUDIO: That's why I was  
 17 thinking the word specialty. It just said must be  
 18 practicing in a specialty. So it sounds a little  
 19 like they have to be in a specialty.  
 20 CHAIRWOMAN KEELS: I think we definitely  
 21 want to stay away from location setting.  
 22 MEMBER ZAMUDIO: No, I was thinking  
 23 clinical arena.  
 24 MS. EMRICH: It's in our statute.  
 25 MEMBER ZAMUDIO: It is in statute.

1 CHAIRWOMAN KEELS: Is there language  
2 that you can say to clarify that a little bit more,  
3 that -- I mean, it has to remain, must be practicing  
4 in a specialty, or like in parentheses or --

5 MS. EMRICH: Patient population.

6 MEMBER ZAMUDIO: There you go.

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

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

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

21 They may enter into a standard care  
22 arrangement with a person who is practicing as a  
23 physician, who is practicing in one of the following  
24 specialties, and they list psychiatry, pediatrics, or  
25 primary care or family practice. So clearly in this

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

4 MS. EMRICH: Got it.

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

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

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

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

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

1 context specialty doesn't mean --

2 MEMBER MINIARD: Population.

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

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

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

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

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

17 CHAIRWOMAN KEELS: Okay. Anything else  
18 on standard care arrangements?

19 Practice and practice parameters.

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

25 MS. EMRICH: Yes.

1 statute.

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

6 CHAIRWOMAN KEELS: Sure.

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

12 MS. EMRICH: And I think the --

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

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

23 MEMBER SIEVERS: But how --

24 MS. EMRICH: Now immediate newborn care  
25 and all that, I think we need to discuss that, and

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1 how that is.  
 2 MEMBER SIEVERS: I think at some point  
 3 the statute sounds like it needs to be more specific  
 4 in this area.  
 5 MS. EMRICH: And that was the  
 6 discussion.  
 7 MEMBER SIEVERS: So that would mirror  
 8 the current circumstance.  
 9 CHAIRWOMAN KEELS: Which is what the  
 10 CRNAs are trying to do with their legislation.  
 11 MEMBER ZAMUDIO: And it would make it  
 12 consistent with OB/GYNs, they do the circumcisions.  
 13 I just -- like if we're going to write  
 14 the exclusionary part of that, could we address it,  
 15 because I don't want to give fodder to the  
 16 malpractice attorneys, no offense to anybody  
 17 listening or watching.  
 18 I don't want to give information that  
 19 says we can't provide that, and then there's a  
 20 situation where a midwife would be resuscitating an  
 21 infant, and then that --  
 22 CHAIRWOMAN KEELS: I don't think in  
 23 emergency care --  
 24 MEMBER ZAMUDIO: Definitely a hundred  
 25 percent. That written record is brought up, put on a

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1 screen in front of His Honor, and we go through it  
 2 line by line. And were you even authorized to stop  
 3 and provide that emergent care? Why didn't someone  
 4 else who's in the law who could have done that.  
 5 I mean, it would be a quagmire if we put  
 6 prohibitory language here without just a one liner,  
 7 we recognize this, or, you know.  
 8 MEMBER SIEVERS: Lead the way in, I was  
 9 just going to ask if we felt like it's common  
 10 knowledge that people know they can't do  
 11 circumcision.  
 12 MEMBER ZAMUDIO: It's not.  
 13 MEMBER SIEVERS: Becausc newborn in the  
 14 neonate is defined as up to 28 days, and this is  
 15 newborn, which technically, when you look at  
 16 definitions in the pediatric literature, like when I  
 17 teach my pediatric students, it's up to a year.  
 18 Newborn is the 28 day -- I'm sorry,  
 19 neonate is the 28-day period. So I think being  
 20 really careful, even newborn care up to 28 days is  
 21 probably not --  
 22 CHAIRWOMAN KEELS: I don't think this  
 23 document is going to be able to take everything you  
 24 can and cannot do, but going back to get some more  
 25 clarity around that would be helpful. Did you have

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1 more?  
 2 MS. EMRICH: No, that's fine.  
 3 MEMBER ZAMUDIO: Thank you.  
 4 CHAIRWOMAN KEELS: Next bullet, are we  
 5 on CNS?  
 6 MS. EMRICH: Yes. That should be --  
 7 MEMBER DI PIAZZZA: Second bullet.  
 8 MS. EMRICH: Got it.  
 9 CHAIRWOMAN KEELS: Everybody okay with  
 10 that, CNPs, scope of practice?  
 11 MEMBER MINIARD: I would just make a  
 12 comment where it says within the nurse's specialty  
 13 again that --  
 14 MS. EMRICH: National certification.  
 15 MEMBER MINIARD: Or population. I do  
 16 like in the second -- the second bullet down under  
 17 that, the sentence, "Similarly, a ACNP whose national  
 18 certification is Pediatric Acute Care would practice  
 19 'consistent with' the population focus or nursing  
 20 specialty..." So there it was very well defined that  
 21 those were the same thing.  
 22 MS. EMRICH: So I'll use this as an  
 23 example.  
 24 MEMBER MINIARD: I thought that was  
 25 really -- it was very clear to me that those were the

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1 same thing, or maybe instead of saying -- or you  
 2 might want to say just a slash or something, because  
 3 or can mean either or, or both.  
 4 CHAIRWOMAN KEELS: Any other comments?  
 5 Next bullet, delegation. That's from rule.  
 6 MS. EMRICH: Yes.  
 7 CHAIRWOMAN KEELS: It's pretty clear to  
 8 me.  
 9 MEMBER DI PIAZZZA: Bottom of 6,  
 10 second-to-last.  
 11 MEMBER MINIARD: Okay.  
 12 CHAIRWOMAN KEELS: Then the next bullet  
 13 requires to utilize and incorporate into their  
 14 practice knowledge of the Medical Practice Act and  
 15 rules adopted thereunder, in the Dental Practice Act  
 16 for CRNAs, and it looks like you have links to those.  
 17 MEMBER SIEVERS: Can I --  
 18 CHAIRWOMAN KEELS: Yes, Sherri.  
 19 MEMBER SIEVERS: I guess, is there a  
 20 better word than govern? Because we're not governed  
 21 by the Medical Board, we're governed by the Nursing  
 22 Board. But maybe like instead of governed, the laws  
 23 that relate to us, you know what I mean?  
 24 CHAIRWOMAN KEELS: Well, govern is used  
 25 under the CRNA who is supervised by --

1 MS. EMRICH: Govern is referring to the  
 2 supervising physician's practice.  
 3 CHAIRWOMAN KEELS: It could be maybe --  
 4 MEMBER SIEVERS: You're in the last  
 5 bullet on page 6.  
 6 MEMBER ZAMUDIO: Keep reading.  
 7 MEMBER DI PIAZZZA: It refers to the  
 8 CRNA's supervising physician.  
 9 MEMBER SIEVERS: But it's in the  
 10 sentence with the --  
 11 CHAIRWOMAN KEELS: It's a different  
 12 sentence, but it is in the same paragraph. We could  
 13 potentially just move that down and make it its own  
 14 bullet if you wanted to.  
 15 MEMBER SIEVERS: So the govern would be  
 16 part of the similar?  
 17 CHAIRWOMAN KEELS: The governance would  
 18 be part of the supervising language.  
 19 MEMBER BOLTON: I agree. I think that's  
 20 good.  
 21 MEMBER DI PIAZZZA: New bullet.  
 22 CHAIRWOMAN KEELS: Next bullet there's a  
 23 link there to the standards related to competent  
 24 practice. And that is where we come to the end of  
 25 the general information.

1 MEMBER BOLTON: Either one of those is  
 2 fine.  
 3 MEMBER MINIARD: I think it would be  
 4 good to have --  
 5 MEMBER BOLTON: You know what? Not a  
 6 FAQ, I want them to see it before.  
 7 MS. EMRICH: What is a subspecialty,  
 8 what does that mean?  
 9 MEMBER ZAMUDIO: Did we address the  
 10 decisionmaking model anywhere in there?  
 11 CHAIRWOMAN KEELS: We haven't.  
 12 MEMBER ZAMUDIO: I know it's later in  
 13 the FAQ, but I wonder -- I know it doesn't have to be  
 14 all inclusive, but I'm just excited to have all this  
 15 in one place, so maybe referencing that because some  
 16 people still don't know about it or use it.  
 17 It might be good to say something, you  
 18 know, because a Consensus Model recommends a  
 19 decisionmaking tool.  
 20 CHAIRWOMAN KEELS: So maybe after the  
 21 last -- because it says -- this last bullet is APRNs  
 22 must comply with the standards related, perhaps  
 23 another bullet would be the decisionmaking model  
 24 available that the Board can help guide, because that  
 25 sentence is in there later.

1 Is there anything missing that you can  
 2 think of that should be in the general information?  
 3 We covered licensure, role, population, prescribing.  
 4 MEMBER BOLTON: Do we need to say  
 5 anything about some specialty exams?  
 6 MEMBER MINIARD: That is something that  
 7 is in the Consensus Model that is not addressed in  
 8 here at all.  
 9 CHAIRWOMAN KEELS: Maybe yes, we do the  
 10 definitions.  
 11 MEMBER BOLTON: I think there's a lot  
 12 of -- there are questions at times about if a  
 13 subspecialty exam can expand your skills.  
 14 MEMBER MINIARD: There are a lot of  
 15 questions about that.  
 16 MEMBER BOLTON: I think that's important  
 17 to address.  
 18 CHAIRWOMAN KEELS: If a subspecialty  
 19 exam can expand your scope outside of your  
 20 original --  
 21 MEMBER MINIARD: Right, I've had that  
 22 conversation with people. That's a very good point.  
 23 MS. EMRICH: We can add that actually  
 24 somewhere -- as a direct informational paragraph or  
 25 we can add it as more of a detailed FAQ.

1 MEMBER BOLTON: I struggle with that. I  
 2 struggle with that being in this document because it  
 3 is so subjective.  
 4 And I think in the last meeting I asked  
 5 the OAAPN rep to utilize the decisionmaking model to  
 6 drive the question about scope of practice, and it  
 7 could not be done.  
 8 So I do not believe that that is going  
 9 to add clarity to this. I think it's going to add  
 10 more confusion.  
 11 CHAIRWOMAN KEELS: I think perhaps --  
 12 MEMBER SIEVERS: Go ahead.  
 13 CHAIRWOMAN KEELS: Perhaps there is an  
 14 opportunity to explain that the decisionmaking model  
 15 helps you determine tasks, activities, and procedures  
 16 within your scope of practice.  
 17 MEMBER BOLTON: I'm okay with that. I  
 18 would like for there to be an example of how that can  
 19 be utilized, because I still think the subjective --  
 20 subjectivity in that model in answering those  
 21 questions can still get someone who does not have the  
 22 skill -- or the education appropriate to that skill,  
 23 they can answer. I mean, they can answer it  
 24 subjectively and still get them down the --  
 25 CHAIRWOMAN KEELS: You have to know what

1 your scope is before you even start on bullet one.  
 2 MEMBER BOLTON: Right.  
 3 MEMBER ZAMUDIO: But it is what we  
 4 currently use. It's what we have, and it's  
 5 recommended by the Consensus Model -- let me just  
 6 finish this part.  
 7 If we're going to be consistent with the  
 8 Consensus Model, if they recommend a decisionmaking  
 9 tool, I'm just saying if we're going to be complete  
 10 here, and the Board already has it on there for us to  
 11 look at whether you want to debate if we should  
 12 change it on the Board's website, but I think it's  
 13 just a good idea to reference it.  
 14 CHAIRWOMAN KEELS: Maybe it becomes its  
 15 own callout.  
 16 MEMBER MINIARD: This is probably just a  
 17 decision for a whole different thing, but we're  
 18 talking about the Consensus Model and then  
 19 decisionmaking.  
 20 In the Consensus Model, towards the end,  
 21 they give examples of yeses and nos, right? So maybe  
 22 there's a document that goes along with a  
 23 decisionmaking tool that this is a yes, you followed  
 24 it correctly, and this is a no, you didn't do it  
 25 right. An example of a good and a bad. Do you see

1 would be okay with that being referenced in here.  
 2 MEMBER ZAMUDIO: My proposition was just  
 3 awareness. So the APRNs don't come in and use that,  
 4 or haven't gone to the Board's website would be able  
 5 to use that.  
 6 CHAIRWOMAN KEELS: I think it's a good  
 7 point, a valid point, because on the Board website  
 8 under the practice resources, there are certain  
 9 things that are available, and to have something that  
 10 says oh, well, that's why that is there, or this is  
 11 how you use that --  
 12 MEMBER MINIARD: Maybe just to what you  
 13 said, that this is a -- the skill. It's addressed to  
 14 do you have the skill to perform this activity, not  
 15 does this activity fall within your scope of  
 16 practice.  
 17 Just a statement that clarifies this,  
 18 because this is not interpretive guidelines, so that  
 19 should be something that could be written in a  
 20 nonprovisionary way that says you don't use this tool  
 21 to determine scope of practice.  
 22 MEMBER BOLTON: And --  
 23 MEMBER MINIARD: That might be a great  
 24 way.  
 25 MEMBER BOLTON: I think it's excellent

1 what I'm saying?  
 2 CHAIRWOMAN KEELS: I think I remember  
 3 that.  
 4 MEMBER MINIARD: It's in the Consensus  
 5 Model. Like it gives fairly clearly defined --  
 6 doesn't exactly give a no, but it says here is where  
 7 the ACNP and the adult primary care people -- this is  
 8 where you stop and you have to hand off care.  
 9 So I think -- I'm not trying to get in  
 10 that gray zone, or get there, but I think it would be  
 11 good to have at least an example of how to use that  
 12 tool correctly, because just when we were looking at  
 13 the pharmacy one earlier, there's sometimes you can  
 14 draw the arrow in the wrong place and end up on the  
 15 wrong thing.  
 16 MEMBER BOLTON: And I think the other  
 17 piece to that is that maybe one of the examples,  
 18 trying to use it for scope of practice, because it  
 19 doesn't work for that. You know what I mean?  
 20 It works for skill, and I think if you  
 21 have an example of a skill and you take it down  
 22 through, and you show how you avoid the subjectivity,  
 23 and that would be a good thing.  
 24 The no is scope, no, you can't use this  
 25 for scope. We clearly identified that. And then I

1 to have it in this. If we could have the clarifying  
 2 example and the context that would be awesome,  
 3 because then it clearly says that what some feel out  
 4 there is a document to describe scope is really not  
 5 that.  
 6 CHAIRWOMAN KEELS: Okay.  
 7 MEMBER BOLTON: I like that.  
 8 CHAIRWOMAN KEELS: Thank you. Anything  
 9 else that you think should be included in the general  
 10 information, without making it so, so long that  
 11 nobody looks at it?  
 12 MEMBER MINIARD: I think this is  
 13 awesome.  
 14 CHAIRWOMAN KEELS: I think it's very  
 15 helpful for not only new to practice, but even those  
 16 who are practicing. I'm sure I learned at least one  
 17 or two things.  
 18 MEMBER ZAMUDIO: Ditto.  
 19 MEMBER MINIARD: I do like the questions  
 20 and answers, because it gives you some examples of  
 21 questions, and it's a problem based way to learn the  
 22 material without --  
 23 CHAIRWOMAN KEELS: So let's go under  
 24 senior care arrangement FAQs. Anybody have any  
 25 questions about those Q and As?

1 MEMBER ZAMUDIO: I'm so sorry. On  
 2 page 8? Did I skip to the next section? I thought  
 3 we were done. We're still on 7, okay.  
 4 MEMBER BOLTON: Wishful thinking.  
 5 CHAIRWOMAN KEELS: We're getting there.  
 6 MEMBER SIEVERS: So my prescribing thing  
 7 is there.  
 8 CHAIRWOMAN KEELS: Nothing under SCA?  
 9 Everybody is good with SCA and prescribe --  
 10 MEMBER SIEVERS: No, it's under SCA.  
 11 It's that third one down. I don't think we can do  
 12 anything to help it, but I've had people say to me  
 13 what does that mean? Like how would you  
 14 operationalize that if we were both in the clinic  
 15 together, and you're in a room prescribing?  
 16 So I guess I mean, does it mean you  
 17 can't have more than five people in one clinic with  
 18 one doctor? I mean, what if I'm not prescribing  
 19 today, you know what I mean?  
 20 MEMBER DI PIAZZA: Do we really want  
 21 anyone to clarify that?  
 22 MEMBER SIEVERS: No, we don't.  
 23 CHAIRWOMAN KEELS: But you typically  
 24 have more than one collaborating physician,  
 25 typically.

1 but leave the rest of it.  
 2 MEMBER SIEVERS: Yeah, it's fine. It  
 3 doesn't really make sense.  
 4 CHAIRWOMAN KEELS: But when you explain  
 5 it to people, you can call your -- one of your  
 6 collaborating physicians --  
 7 MEMBER SIEVERS: I guess if you only had  
 8 one collaborator and you had five NPs and they were  
 9 all working the exact same day, you'd be okay, but if  
 10 you had six, it could get sketchy. If you have like  
 11 one practice, yeah.  
 12 And maybe that was the intent of it.  
 13 They didn't want one doctor to have ten people  
 14 working in their office at the same time.  
 15 Who is to say they are all prescribing  
 16 and it's at the same time, the exact minute, or is it  
 17 you prescribe now, I'll prescribe in the next hour.  
 18 MS. EMRICH: This kind of limits for a  
 19 physician and how many prescribing APRNs they may  
 20 collaborate with at the same time is a longstanding  
 21 like ratio, and with 216 it got increased from three  
 22 to five. So how --  
 23 MEMBER SIEVERS: I know.  
 24 MS. EMRICH: There's not --  
 25 MEMBER SIEVERS: We're not going to fix

1 MEMBER SIEVERS: True. Right.  
 2 CHAIRWOMAN KEELS: Who may not be in  
 3 that room or even on-site, but is available for phone  
 4 consultation.  
 5 MEMBER ZAMUDIO: Right. So to that end,  
 6 I agree with Sherri about the maybe we don't need to  
 7 clarify that.  
 8 But it does go on to add information  
 9 that is not in the statute where it says this is a  
 10 matter of scheduling. That might have been the  
 11 intend, but that's not what it says, right?  
 12 So if we address scheduling, we have  
 13 just now prescribed to them, to not schedule more  
 14 than five at one time who could be prescribed at one  
 15 time. I think we should leave that sentence off  
 16 there.  
 17 MEMBER BOLTON: I agree.  
 18 CHAIRWOMAN KEELS: Angela, did you have  
 19 a comment?  
 20 MEMBER GAGER: No, it was already said.  
 21 CHAIRWOMAN KEELS: You think we should  
 22 leave that last --  
 23 MEMBER SIEVERS: The last sentence.  
 24 MEMBER GAGER: Or just get rid of the  
 25 sentence that says this is a matter of scheduling,

1 it. It's just when I try to explain it, it's really,  
 2 really hard.  
 3 MEMBER BOLTON: I think you need to go  
 4 back to the definition of collaboration, and you can  
 5 call anyone. Just because this doctor is here, if  
 6 I'm number six, I can call the other one, or you know  
 7 what I'm saying?  
 8 MEMBER SIEVERS: Yes.  
 9 MS. EMRICH: This is a requirement for  
 10 that physician, and so the physician may make it a  
 11 scheduling thing.  
 12 And that's just to be -- that's how we  
 13 have explained it over the years is -- to physicians  
 14 who call us, is that when you can collaborate with  
 15 however how many aides, say APRNs, but only five  
 16 should be actively working with prescriptive  
 17 authority, and having the ability --  
 18 MEMBER SIEVERS: At one time.  
 19 MS. EMRICH: -- during the same period  
 20 of time, yes.  
 21 MEMBER BOLTON: It doesn't mean  
 22 prescribing at that time. You have one physician for  
 23 five NPs, it's just so the potential for him to be  
 24 engaged with one NP or more than one NP at any time  
 25 to alleviate that confusion or potential problem.

1 MS. EMRICH: Or more than the number of  
 2 phone calls that --  
 3 MEMBER BOLTON: That's how I describe it  
 4 to them. I don't go down to the you're prescribing  
 5 the --  
 6 CHAIRWOMAN KEELS: Okay. Moving  
 7 onwards, prescribing, inclusionary formulary that is  
 8 written out there. We're at the bottom of 7, and the  
 9 next paragraph.  
 10 MEMBER ZAMUDIO: Maybe at the bottom  
 11 of 7 is a good place to reference the 2919.11 on the  
 12 abortion per the exclusionary. Is that a place to  
 13 squeeze it in instead of a FAQ?  
 14 MS. EMRICH: It would be related to the  
 15 exclusionary formulary in that it's prohibited by  
 16 law. So you're really restating something that's  
 17 already in the exclusionary.  
 18 MEMBER ZAMUDIO: I just kind of like to  
 19 keep it all in one place, so that might be a good  
 20 place to put that.  
 21 MEMBER SIEVERS: But you don't want  
 22 people to think that's the only exclusionary, you'd  
 23 have to put everything.  
 24 MEMBER ZAMUDIO: It just says it's  
 25 restricted by this, but it also has that other

1 cross coverage.  
 2 MEMBER MINIARD: I like that. I thought  
 3 that was really good. It's vague enough that it  
 4 doesn't -- could be these. It's not limited to,  
 5 pertinent considerations may include, because this  
 6 happens a lot.  
 7 CHAIRWOMAN KEELS: Well, we do --  
 8 MEMBER MINIARD: So-and-so is not here,  
 9 can you sign for it?  
 10 MEMBER SIEVERS: I like it, too.  
 11 MEMBER ZAMUDIO: So the only thing I had  
 12 a little struggle with -- I mean, I had a struggle  
 13 with a lot of it, actually, but where it says the  
 14 criteria for establishing the valid prescriber, the  
 15 answer mostly addresses prescribing to someone,  
 16 because that's what their question asks, prescribing  
 17 to cross coverage, but it doesn't recognize that you  
 18 might not be actually prescribing it, but you might  
 19 be prescribing, you might be advising, you might be  
 20 caring for them, doing something beside prescribing.  
 21 You might just be answering a patient's  
 22 phone call. Is that allowed? Does that just need to  
 23 be in your SCA?  
 24 And then when it talks about the  
 25 subparts of the rule on the third dot down towards

1 restriction. And then we could reference the -- and  
 2 it does state -- in our chapter it states it does  
 3 reference 2919, so it says the definition of  
 4 abortion.  
 5 I mean, that's in there. I just thought  
 6 if we're trying to keep it all together, if it's  
 7 exclusionary language, it's part of the exclusionary  
 8 formulary, we could list it right there with the  
 9 exclusionary formulary. Just a thought.  
 10 CHAIRWOMAN KEELS: There were other  
 11 things that were prohibited by law prescribing to,  
 12 too, so do we list those out.  
 13 MEMBER MINIARD: Just reference the  
 14 exclusionary formulary, and they can go find it  
 15 themselves. That's my opinion.  
 16 MEMBER ZAMUDIO: Right.  
 17 CHAIRWOMAN KEELS: Are you ready for  
 18 page 8, DATA waiver training?  
 19 MEMBER ZAMUDIO: I'm good. Everyone  
 20 good with DATA waiver?  
 21 CHAIRWOMAN KEELS: Information on how to  
 22 obtain specific drugs.  
 23 MEMBER BOLTON: Sounds good.  
 24 CHAIRWOMAN KEELS: Put you back to  
 25 pharmacy. Right. Group medical practice asking for

1 the number 8, it says the APRN has access to the  
 2 patient's medical records during the encounter. But  
 3 that's not in the definition after prescriber  
 4 relationship.  
 5 It doesn't mean you have to have the  
 6 medical record during the encounter, because you may  
 7 not be -- if you're cross covering, you're answering  
 8 a phone call, that's saying if you're not in the  
 9 office looking at the chart in that encounter you may  
 10 not prescribe anything.  
 11 MEMBER MINIARD: Just a few  
 12 clarifications. So when you say you're answering, I  
 13 just wasn't sure exactly how to take what you said.  
 14 So if you say you're answering a  
 15 patient's question, are you saying that you're  
 16 asking -- you're answering a question about what is  
 17 Gabapentin, or are you asking a question like this  
 18 isn't working for me, so I want to increase the dose;  
 19 or what would be your recommendations on this?  
 20 Should I increase -- you know, is there ability to  
 21 take more of this?  
 22 Because in that case, if you are telling  
 23 the patient to increase the medication, then you are  
 24 prescribing.  
 25 MEMBER ZAMUDIO: Absolutely.

1 MEMBER MINIARD: So I didn't understand  
 2 what the --  
 3 MEMBER ZAMUDIO: Well, people cross  
 4 cover a lot of things, especially in OB. You cross  
 5 cover telling somebody -- and somebody else's patient  
 6 call in saying they are having a miscarriage or  
 7 whatever.  
 8 I'm saying the answer primarily  
 9 prescribing during cross coverage, without saying --  
 10 so should we put something in there saying you can  
 11 provide care during cross coverage if that's  
 12 something that's addressed in your SCA?  
 13 But most importantly, is the access to  
 14 the medical records of the patient during the  
 15 encounter. So some people don't have Epic. And what  
 16 I'm trying to think about is that rural NP who is  
 17 answering a phone call, she doesn't have a chart in  
 18 front of her, she's met all the by law required the  
 19 top -- what is that, six or five components.  
 20 It doesn't say it has to be medical  
 21 records, it has to be present during the encounter.  
 22 It says you have to obtain a relevant history.  
 23 MEMBER MINIARD: So I think it goes  
 24 back -- I am by no means an expert in this. It goes  
 25 back to the statute and the rule that says you have

1 time.  
 2 MEMBER ZAMUDIO: I just thought that  
 3 sounds -- it's a little bit easier for somebody who  
 4 looks down through there and says I don't have their  
 5 medical record.  
 6 CHAIRWOMAN KEELS: But regardless,  
 7 whether you give advice, prescribed or whatever, you  
 8 still need to document that somewhere.  
 9 MEMBER ZAMUDIO: Absolutely.  
 10 CHAIRWOMAN KEELS: So you may not have  
 11 it at the beginning of the encounter, but soon after  
 12 the encounter you should have had that.  
 13 MEMBER ZAMUDIO: Yes, many practices  
 14 just have a tear off pad. They give advice, they  
 15 write a prescription, the next day all of those are  
 16 placed in the medical records.  
 17 MR. DILLING: This is a terribly complex  
 18 legal issue as well.  
 19 MEMBER ZAMUDIO: I didn't mean for it to  
 20 be.  
 21 MR. DILLING: Good questions. You know,  
 22 good questions that you bring up. I threw out there  
 23 that the APRN prescriber cannot exceed the scope of  
 24 their collaborating physician.  
 25 They are also, by rule, to be attentive

1 to have developed a patient and provider  
 2 relationship, and if you don't know this patient from  
 3 Adam, and you're on call and don't have access to the  
 4 EMR, then you don't have a patient/provider  
 5 relationship.  
 6 MEMBER ZAMUDIO: That's not true. It  
 7 has the five criteria for establishing the  
 8 relationship.  
 9 MEMBER MINIARD: You don't.  
 10 MEMBER ZAMUDIO: But the Board of  
 11 Pharmacy -- and in here lists the five things that  
 12 establish a valid relationship, and one of them is  
 13 not that you have your hands on their medical record.  
 14 MEMBER GAGER: But I think what it's  
 15 saying though are these are the things that define a  
 16 patient/provider relationship, but it says --  
 17 MEMBER MINIARD: Prescriber.  
 18 MEMBER GAGER: I'm sorry. But then it  
 19 goes on to say it's not necessary that every subpart  
 20 be present. So if maybe you haven't seen the patient  
 21 before you have access to their medical record, you  
 22 can initiate prescribing.  
 23 MEMBER ZAMUDIO: That's how I  
 24 interpreted it.  
 25 CHAIRWOMAN KEELS: It's not -- one at a

1 and follow Medical Board rules in those relevant  
 2 areas, and there is a Medical Board rule on  
 3 prescribing to patients not seen. And so now you  
 4 have the intricacies of that governance as well.  
 5 There are parts of that rule, though,  
 6 that do address cross coverage situations. I'm  
 7 probably not the best person to speak to it, I'm  
 8 rather critical of the rule, my abilities to  
 9 understand it totally and to explain it well.  
 10 I will say that the Medical Board, in  
 11 addition to that rule, has like eight pages of FAQs  
 12 related to the rule which further --  
 13 MEMBER ZAMUDIO: She has the rule.  
 14 MR. DILLING: -- simple complexity, and,  
 15 you know, difficulty in reading certain aspects of  
 16 it.  
 17 So this is something I think we have got  
 18 to go back and, you know, really hone in on and take  
 19 a look at. I'd be hesitant to give you hard and fast  
 20 answers to different scenarios.  
 21 MEMBER MINIARD: That's what I was  
 22 saying.  
 23 MEMBER ZAMUDIO: I have a question. So  
 24 my question is for Lisa, then. So you listed it out,  
 25 so this is -- the second one, the second four, is

1 that from where it says the subparts of the rule, you  
 2 have given us the rule, right?  
 3 MS. EMRICH: But this is -- the bullet  
 4 points are taken from our prescriber rule, our own  
 5 prescriber rule.  
 6 We also reference the rule that Tom was  
 7 referencing at the end of this as well, the  
 8 4731-11-09, prescribing to persons not seen by the  
 9 physician.  
 10 So that's also -- so we're giving you a  
 11 lot of information here, and it's all information  
 12 that the APRN has to consider when they are seeing --  
 13 prescribing for a patient.  
 14 MEMBER ZAMUDIO: I appreciate that. I  
 15 didn't notice the may include, I thought it was  
 16 saying we had to. And this is right out of the rule.  
 17 MEMBER MINIARD: I just want to make one  
 18 comment about that. So both of these say at the end  
 19 of A paragraph before the first four bullets, but is  
 20 not limited to. And then after the second paragraph,  
 21 may include.  
 22 So those are -- that's what I said in  
 23 the very beginning, that that is the part I love  
 24 about this, because it doesn't get into the  
 25 complexities of the law, it leaves a lot open. And I

1 Do the first one. "As an APRN I've been asked how I  
 2 am authorized to make my medical diagnoses and to  
 3 prescribe. Where can I find this? Just gives the  
 4 statute.  
 5 MEMBER MINIARD: Good.  
 6 CHAIRWOMAN KEELS: Next, what is the  
 7 scope of practice for a CNP who is certified in  
 8 Women's Health Care?  
 9 MEMBER ZAMUDIO: From a perspective of  
 10 nurse midwife, women's health, sexual health  
 11 practices, I think this is going to open up a bunch  
 12 of stuff.  
 13 I mean, I really do. For one thing, it  
 14 talks about the male partners of a female patient.  
 15 And if you're considering just this general -- or  
 16 female or male patients, that's one thing.  
 17 But the statute, or the rule, I think  
 18 actually states individuals, which might be better.  
 19 I think this whole example is going to open up gender  
 20 fluidity issues.  
 21 MEMBER MINIARD: I was just going to say  
 22 that.  
 23 MEMBER ZAMUDIO: There's going to be --  
 24 I can guarantee a lot of push back and questions  
 25 about gender fluid issues.

1 didn't see this, but I like that it does reference  
 2 the physician.  
 3 MS. EMRICH: And it's very much  
 4 incumbent upon the APRN who may be providing cross  
 5 coverage or looking at patients within their own  
 6 practice for another practice partner, to know what  
 7 aspects of this are applicable to them. It just  
 8 gives you lots to look at.  
 9 MEMBER BOLTON: Is it possible to make  
 10 that Medical Board rule a link?  
 11 MEMBER MINIARD: That would be nice.  
 12 MS. EMRICH: We can, as long as they  
 13 don't change their link. Sometimes -- and I don't --  
 14 from the word process, it's trying to -- it's the  
 15 amount of person power to make sure our links --  
 16 that's not our primary --  
 17 MEMBER BOLTON: Totally understand that.  
 18 CHAIRWOMAN KEELS: Ready to move on?  
 19 FAQs, scope of practice.  
 20 MEMBER ZAMUDIO: I'm sorry, my hand is  
 21 up again.  
 22 CHAIRWOMAN KEELS: Michelle.  
 23 MEMBER ZAMUDIO: So this is just a  
 24 recommendation, on the women's health CNP question --  
 25 CHAIRWOMAN KEELS: Wait, the first one.

1 So I don't know -- I mean, we go into  
 2 the treating STDs, et cetera, but the actual question  
 3 was about a woman's health person treating a male in  
 4 oncology.  
 5 I hope that's never actually an absolute  
 6 question from somebody, but it's just that's an odd  
 7 question.  
 8 And then the answer to be addressing  
 9 male, female issues, there's transgender practices in  
 10 our city where there are women's health practitioners  
 11 who are treating someone who was biologically a  
 12 female and has a vagina, but they have vaginal  
 13 dryness from their testosterone therapy at their  
 14 transgender clinic. So I think this is going to be  
 15 an issue to address in this.  
 16 CHAIRWOMAN KEELS: So my question is, is  
 17 it practice or scope because of the gender fluid, and  
 18 do we need to be very clear on what the statute is  
 19 right now?  
 20 MS. EMRICH: And -- and what's NCC  
 21 standards? I guess that's another thing. NCC is  
 22 women's health.  
 23 CHAIRWOMAN KEELS: Because you always  
 24 need to go back to those standards as they evolve. I  
 25 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.

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1 I really like this example because it  
 2 said well, no, not as a CRNA, but as a nurse, here is  
 3 what you can do. Because don't forget, you are an  
 4 RN.  
 5 MS. EMRICH: And it asks questions about  
 6 administering.  
 7 CHAIRWOMAN KEELS: So that answer would  
 8 be it depends.  
 9 MS. EMRICH: Are you doing it as a CRNA  
 10 or an RN? Either way, you have to have an order for  
 11 that purpose.  
 12 MEMBER MINIARD: We can't order it, can  
 13 give it.  
 14 MS. EMRICH: The CRNA, their current  
 15 scope does not include the treatment of -- the  
 16 treatment of treatment resistant depression.  
 17 MEMBER MINIARD: So they can't write the  
 18 order for it, and then administer it. But if someone  
 19 else writes the order for it, like the  
 20 anesthesiologist, then they could administer it in  
 21 the RN.  
 22 CHAIRWOMAN KEELS: In their capacity as  
 23 an RN.  
 24 MEMBER MINIARD: That's what I'm asking.  
 25 MEMBER BOLTON: I hate to go back, but

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1 that question just needs to say 12 and under, rather  
 2 than under the age of 12.  
 3 MS. EMRICH: Good question, because the  
 4 national certification -- just --  
 5 MEMBER MINIARD: I tried to get her to  
 6 drop it.  
 7 CHAIRWOMAN KEELS: The only bad question  
 8 is the one that's not asked.  
 9 MS. EMRICH: They are really going with  
 10 growth and development stages now, so that's why I  
 11 think under the age of 12, because that's a pediatric  
 12 pubescent kind of thing.  
 13 MEMBER BOLTON: I'm going to call you  
 14 and say is it 12?  
 15 MEMBER MINIARD: Is it 12 or 11?  
 16 MS. EMRICH: I'll look at that.  
 17 MEMBER BOLTON: I'm sorry, I don't mean  
 18 to be a pain.  
 19 MS. EMRICH: Okay. Got it. We can move  
 20 on.  
 21 CHAIRWOMAN KEELS: We're good to move  
 22 on?  
 23 MEMBER MINIARD: Yes. Are you sure,  
 24 Pam?  
 25 CHAIRWOMAN KEELS: Okay. The middle of

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1 page 10, my CNM education and national certification  
 2 included performing circumcisions of newborns. Back  
 3 to CNM.  
 4 MEMBER ZAMUDIO: Do we need to say it  
 5 again. The answer is no.  
 6 CHAIRWOMAN KEELS: The answer is no.  
 7 Contact your Board so we can get some legislation  
 8 together to--  
 9 CHAIRWOMAN KEELS: Okay. Next, how can  
 10 an APRN determine whether they may include a specific  
 11 procedure, task or activity in their practice?  
 12 This is where the decisionmaking model  
 13 comes up, where we could put some clarifying language  
 14 around, it is not --  
 15 MEMBER MINIARD: It's skill, it's not  
 16 scope.  
 17 CHAIRWOMAN KEELS: You must understand  
 18 your scope of practice within your population first.  
 19 MEMBER BOLTON: That needs to be first.  
 20 CHAIRWOMAN KEELS: And from there, to  
 21 determine a task, activity, or procedure.  
 22 MEMBER ZAMUDIO: Right. But the  
 23 question is, if you read it -- I mean, the question  
 24 says it's about specific tasks.  
 25 I mean, so this has -- this is not a

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1 scope of practice question, it's talking about -- it  
 2 does not maintain a list of procedures that an APRN  
 3 may do.  
 4 And then I really liked this question  
 5 and answer that says a decisionmaking model is  
 6 available, and it does say that you should use it and  
 7 the regulations pertaining to SCAs, and it keeps  
 8 saying specific procedure, tasks, or activity. I  
 9 don't know how much more clarification that can get.  
 10 MEMBER BOLTON: I just think we need to  
 11 add a sentence or two about scope, because there is  
 12 confusion. I mean, our own OAAPN suggested that we  
 13 use it for scope. So I think there needs to be  
 14 clarifying language in here to say it's not.  
 15 MEMBER MINIARD: I'm going to  
 16 respectfully disagree with you, and agree with you,  
 17 because this is what we argued about pretty much for  
 18 the last two years plus, is about people are  
 19 confusing the term scope and population focus with  
 20 skills, right, or -- so I think it's very important  
 21 to have one statement at the top that says the first  
 22 thing you have to do is decide is this skill, task,  
 23 or procedure, within your specialty/population focus.  
 24 Because that's the word that's been used  
 25 consistently, not scope of practice, right? You use

1 specialty from the statute. So specialty/population  
 2 focus.  
 3 Second, then you use the decisionmaking  
 4 tool to further guide you into whether or not you can  
 5 perform this skill, procedure, or task.  
 6 MEMBER ZAMUDIO: I would clarify even  
 7 further. I like the answer constructed with or  
 8 without adding -- you can add a sentence to it, but I  
 9 liked it just referenced to it, and it was very clear  
 10 saying this was only about a procedure.  
 11 MEMBER MINIARD: I would just make sure  
 12 you use the word specialty/population focus, so you  
 13 keep the wordage in the document consistent so that  
 14 it doesn't flip flop around, because that's going to  
 15 create even more confusion.  
 16 CHAIRWOMAN KEELS: Okay. Do a CNP's  
 17 documentation, assessments, orders, or progress notes  
 18 need to be reviewed and co-signed.  
 19 MEMBER SIEVERS: That's a good one.  
 20 MEMBER MINIARD: That is a good one.  
 21 CHAIRWOMAN KEELS: I like the answer.  
 22 No. It does say, however, an employer may require  
 23 that. Sometimes it's for billing, sometimes it's  
 24 just in their bylaws.  
 25 CHAIRWOMAN KEELS: Next, I am a CNP

1 MEMBER MINIARD: No. I didn't read the  
 2 answer before I reacted to the question.  
 3 MEMBER GAGER: But I agree with you, I  
 4 think it should be out of the question. But I think  
 5 sometimes scope is defined by setting, and that's not  
 6 correct.  
 7 CHAIRWOMAN KEELS: That has to be  
 8 explained.  
 9 MEMBER ZAMUDIO: Yes.  
 10 MEMBER MINIARD: So I jumped the gun, I  
 11 apologize. Scratch that from the record, please.  
 12 MEMBER ZAMUDIO: And so then do we --  
 13 CHAIRWOMAN KEELS: Hold on.  
 14 MEMBER ZAMUDIO: Do we go with the two  
 15 lines down where it says that determine the CNP's  
 16 nursing specialty, or should we make it consistent  
 17 and write the word --  
 18 CHAIRWOMAN KEELS: We'll have the  
 19 language consistent throughout the whole --  
 20 MS. EMRICH: So we leave the whole  
 21 question as is, or do we leave the last phrase in the  
 22 question?  
 23 MEMBER MINIARD: No, because I think --  
 24 I'm sorry, go ahead.  
 25 MEMBER GAGER: No, go ahead, Jody.

1 certified in family, which is primary care. How may  
 2 I determine the limits of my individual scope if  
 3 employed in a hospital?  
 4 MEMBER MINIARD: See what I mean?  
 5 Because scope of practice has nothing to do with  
 6 credentialing and -- not credentialing, delineation  
 7 of privileges.  
 8 CHAIRWOMAN KEELS: So how can I  
 9 determine the limits of my individual scope, and  
 10 leave setting out of it?  
 11 MEMBER ZAMUDIO: Wait, what?  
 12 CHAIRWOMAN KEELS: So Jody was concerned  
 13 that we brought in setting because it said if  
 14 employed in a hospital, because we want to make this  
 15 about population in your practice, not where you are.  
 16 MEMBER MINIARD: Right. We have got to  
 17 be very careful about that.  
 18 MS. EMRICH: Then we should get rid of  
 19 the first sentence in the answer then. There's no --  
 20 there's no mention of setting in the question, so  
 21 there would be no mention of setting in the lead off.  
 22 MEMBER GAGER: I like that.  
 23 MEMBER MINIARD: I like that.  
 24 CHAIRWOMAN KEELS: You want it both  
 25 ways?

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

1 the consensus.  
 2 CHAIRWOMAN KEELS: I think Pam's hand  
 3 was up next.  
 4 MEMBER BOLTON: So on the question, I'm  
 5 confused at the beginning. I am a CNP certified in  
 6 family across the lifespan, which is primary care.  
 7 When you say family, I think FNP. When you say  
 8 primary care, I think of the adult.  
 9 MEMBER SIEVERS: No, FNP is primary.  
 10 MEMBER MINIARD: FNP is primary care.  
 11 MEMBER BOLTON: But we have FNP and then  
 12 adult gerop primary care.  
 13 MEMBER SIEVERS: That's just adults, one  
 14 is lifespan.  
 15 MEMBER BOLTON: Okay. Okay. Thank you  
 16 for the clarification.  
 17 Then my second piece is, the piece that  
 18 bothers me, is the end of the sentence, and then the  
 19 standard of care arrangement that is entered with a  
 20 qualified collaborating physician. I'm not sure --  
 21 can someone describe the purpose of that part of  
 22 that?  
 23 CHAIRWOMAN KEELS: Well, because right  
 24 now as it stands, the standard of care arrangement  
 25 can further limit your scope. This person is asking

1 going to manage DKA, so I think it's a fine line.  
 2 CHAIRWOMAN KEELS: So there is the  
 3 severity of illness or severity of acuity -- we don't  
 4 want to use acuity.  
 5 MEMBER GAGER: Complexity.  
 6 CHAIRWOMAN KEELS: Not complexity.  
 7 CHAIRWOMAN KEELS: It's really the level  
 8 of --  
 9 MEMBER BOLTON: I mean, you have acute  
 10 in primary care and you have acute in the acute care.  
 11 MEMBER MINIARD: Critical.  
 12 MEMBER BOLTON: I mean, that's the  
 13 problem. No one is really defined in the two. Acute  
 14 in one does not mean acute in the other, because you  
 15 wouldn't want me to take care of acute in the primary  
 16 care stuff, but I'll take care of it in the other  
 17 setting.  
 18 CHAIRWOMAN KEELS: Maybe talk about  
 19 acute in the very beginning of the document where we  
 20 do definitions. I think that is within all --  
 21 MEMBER BOLTON: Otitis media versus  
 22 epiglottitis, you know what I mean?  
 23 CHAIRWOMAN KEELS: Levels of acuity.  
 24 Michelle then Sherri.  
 25 MEMBER ZAMUDIO: Along that same lines

1 how -- what are the limits of my individual scope.  
 2 MEMBER BOLTON: I didn't get --  
 3 MEMBER MINIARD: Well, maybe it should  
 4 say limit, because the way I read it was that if you  
 5 wrote something into your standard care agreement  
 6 because your physician said you could do it, then you  
 7 can do it. That's the way I read it.  
 8 MEMBER BOLTON: Standard of scope, and  
 9 appropriately.  
 10 CHAIRWOMAN KEELS: Which may further  
 11 limit -- may further limit within your population.  
 12 MEMBER GAGER: I am a little concerned  
 13 about the second sentence that says that there are  
 14 limits on the patient conditions the CNP may manage.  
 15 I don't think it's a limit on the  
 16 conditions, I think it's a limit on the acuity level  
 17 on the patient. So you're not limiting the  
 18 conditions, it's more the acuity level.  
 19 MEMBER ZAMUDIO: So along that same  
 20 sentence it says "with this", but what is this?  
 21 CHAIRWOMAN KEELS: I'm sorry?  
 22 MEMBER MINIARD: A stable sepsis  
 23 patient --  
 24 MEMBER GAGER: But diabetes, I can  
 25 manage diabetes in an outpatient setting, but I'm not

1 though, when you're reading that answer to that, it  
 2 says there's no limit as to the settings, and then it  
 3 says there are limits on the patient conditions the  
 4 CNP with this may be managed. With what?  
 5 MS. EMRICH: There was a word left out.  
 6 MEMBER BOLTON: They are referring back  
 7 to the CNP. But it --  
 8 MEMBER BOLTON: The CNP --  
 9 MS. EMRICH: No, with this  
 10 certification. With this certification.  
 11 MEMBER ZAMUDIO: I think just for  
 12 clarity, we can put what's in there.  
 13 MS. EMRICH: I think it's a typo.  
 14 MEMBER ZAMUDIO: Because I thought it  
 15 meant condition.  
 16 MEMBER SIEVERS: So where did we land on  
 17 the -- are we leaving it on patient condition, or we  
 18 deciding to put acuity in there?  
 19 CHAIRWOMAN KEELS: I think we're going  
 20 to wordsmith it.  
 21 MEMBER SIEVERS: Because defining acuity  
 22 might get us back to where be started.  
 23 CHAIRWOMAN KEELS: But what about that  
 24 next sentence, national certification of family does  
 25 not include the family of patients with high acuity,

1 unstable conditions.  
 2 MEMBER MINIARD: So why can't you say  
 3 patient condition/acuity? And then you're going to  
 4 further define acuity later in the answer, high  
 5 acuity, unstable critical conditions, because it  
 6 could be condition dependent or --  
 7 MEMBER SIEVERS: You can have a DKA  
 8 patient that is very stable that could probably be  
 9 managed by an adult gero or primary care, but I might  
 10 have a completely unstable patient that can't be.  
 11 MEMBER GAGER: I think you can get rid  
 12 of that second sentence all together.  
 13 MEMBER SIEVERS: And --  
 14 MEMBER GAGER: First sentence talks  
 15 about settings, and then it goes on further down in  
 16 the paragraph to talk about acuity and unstable  
 17 conditions. So I don't think you need to say there's  
 18 limits on the patient conditions, I think that's  
 19 confusing.  
 20 MS. EMRICH: I agree. I just flagged  
 21 through it.  
 22 MEMBER MINIARD: There's no reason.  
 23 MEMBER SIEVERS: Then we don't have to  
 24 do anything else.  
 25 MS. EMRICH: And everything else is

1 practicing in bariatric medicine and surgery, asking  
 2 about prescribing drugs for weight loss.  
 3 I thought this was really good, and  
 4 reminds you that you have to know what the Medical  
 5 Board says as well.  
 6 MEMBER BOLTON: Yes, I like that,  
 7 because I just looked this up recently.  
 8 CHAIRWOMAN KEELS: Something that I  
 9 don't think many, especially our hospital based  
 10 practitioners, think about.  
 11 MEMBER BOLTON: It was excellent.  
 12 CHAIRWOMAN KEELS: APRN delegation to  
 13 unlicensed persons. There's a yes.  
 14 MEMBER BOLTON: I like that.  
 15 CHAIRWOMAN KEELS: But -- no. The by  
 16 contrast --  
 17 MEMBER ZAMUDIO: I have a question. I'm  
 18 not familiar with this section. I have not read the  
 19 code until I got this right here, so this is a  
 20 question and clarification request.  
 21 On the by contrast answer, the third dot  
 22 down, it says including specific requirements as to  
 23 the unlicensed person's documented education,  
 24 demonstrated knowledge, skills, ability to administer  
 25 the drug, and the requirement that the APRN is

1 good.  
 2 MEMBER MINIARD: Just add that word.  
 3 CHAIRWOMAN KEELS: Add what word.  
 4 MS. EMRICH: Certification.  
 5 CHAIRWOMAN KEELS: Got you. Ready to  
 6 leave that one?  
 7 MEMBER MINIARD: Yes, please.  
 8 CHAIRWOMAN KEELS: CNP certified in  
 9 primary care, pediatrics. I thought this was good.  
 10 This goes back to where, as I was  
 11 initially, something that only acute care could do,  
 12 but now it's become more standard of care, so covered  
 13 through your primary care certification, because your  
 14 education has been maintained, right?  
 15 So the practice, the population evolved  
 16 over time is included back in your certification  
 17 guidelines. You should have been maintaining  
 18 continuing education in this.  
 19 MEMBER BOLTON: I like it.  
 20 MEMBER ZAMUDIO: I like it.  
 21 MEMBER SIEVERS: And it says yes.  
 22 CHAIRWOMAN KEELS: That's from Latecia,  
 23 right? Years ago. She brought that up.  
 24 All right. Next, CNS entered into a  
 25 standard of care arrangement with a physician

1 on-site during the delegated medication  
 2 administration.  
 3 So would this prohibit, like for  
 4 example, a standard order for flu shots if you're not  
 5 standing there when it's given and you're off that  
 6 day and your patient's there and they are coming in  
 7 to see somebody?  
 8 Because by protocol, sometimes you might  
 9 prescribe the MAs, unlicensed people tend to give  
 10 those medications.  
 11 CHAIRWOMAN KEELS: But they are not  
 12 working independently, so they are still a prescriber  
 13 on-site.  
 14 MEMBER ZAMUDIO: Not at private offices.  
 15 There's many offices who -- oh, gosh, yeah, the  
 16 physician is not there that day, especially in  
 17 specialties, they are only there a few days a week,  
 18 but their staff is there every day. It's by a  
 19 protocol, I mean, but is that considered a  
 20 delegation?  
 21 MS. EMRICH: If an unlicensed person is  
 22 administering an immunization by protocol, that --  
 23 let me back up.  
 24 An LPN or an RN may administer an  
 25 immunization by protocol. LPNs and RNs have

1 authority to administer medications, so the protocol  
2 in this case is authorized by Pharmacy Board law and  
3 rules that says an immunization can be provided  
4 pursuant to a protocol.

5 And so that protocol replaces or is the  
6 order for the RN or LPN to administer that. And  
7 there's no requirement that a prescriber be on-site  
8 at the time that an RN or LPN administers that.

9 I cannot tell you that's the same for an  
10 unlicensed individual, because the medical assistant  
11 has no licensed authority to engage in any kind of  
12 practice, and the only way they administer  
13 medications is through the delegation of a physician,  
14 or now in accordance with .489, an APRN.

15 An APRN has to be on-site when they are  
16 delegating a medication administration to an  
17 unlicensed person.

18 MEMBER ZAMUDIO: I was clarifying on the  
19 on-site. I didn't know. Like do they physically  
20 have to be in the office? Could they be in the ER?  
21 Because -- how does that work? Because a lot of  
22 these small offices work with --

23 MEMBER SIEVERS: The APRN is on-site  
24 during the delegation.

25 MEMBER ZAMUDIO: But is that like --

1 MEMBER SIEVERS: Very nice.

2 MEMBER MINIARD: This is so much better  
3 than the bar graph. I don't know if we ever are  
4 going to come to consensus on that.

5 CHAIRWOMAN KEELS: I feel like this is  
6 pretty all encompassing. It's a lot of work. It's  
7 going to be fairly long. What do you anticipate this  
8 looking like, a document, or on the website with  
9 links?

10 MS. EMRICH: Probably be a document with  
11 links.

12 MEMBER MINIARD: You can pick out the  
13 pieces you want.

14 CHAIRWOMAN KEELS: It will look like  
15 this, but the links will be there for more  
16 information.

17 MS. EMRICH: Just to get you to the  
18 source of it.

19 CHAIRWOMAN KEELS: So it's a long  
20 document.

21 MEMBER MINIARD: I just was wondering if  
22 there was a way to -- when you set it up -- this is  
23 probably even more work -- but by section, you know  
24 what I mean? So if you have a question about -- I'm  
25 going to stay out of the weeds. You do what you do.

1 MEMBER BOLTON: You're saying that's not  
2 delegation.

3 MEMBER MINIARD: She's not saying  
4 anything. She's not getting in the weeds.

5 MEMBER ZAMUDIO: It's just a common  
6 question. We have not just with immunizations, but  
7 when they needed their Rhogam and they came in and  
8 did something -- or there's lots of reasons  
9 medications that are given for other reasons. So if  
10 it's a nonlicensed personnel does the APRN need to be  
11 physically standing there? -

12 MS. EMRICH: Has to be on-site.

13 MEMBER MINIARD: There needs to be a  
14 licensed provider in that building on-site.

15 CHAIRWOMAN KEELS: Whatever on-site  
16 means.

17 MEMBER MINIARD: If an unlicensed  
18 provider is giving any kind of treatment or  
19 medication, is what I'm understanding, right? But if  
20 it's an RN or pharmacist and they are doing it per  
21 protocol, then there does not need to be a licensed  
22 provider -- I mean prescriber.

23 MEMBER ZAMUDIO: Just curious.

24 MEMBER MINIARD: That was a good  
25 question.

1 MS. EMRICH: And I get it. And we want  
2 to go there to make it as easy as possible, but on  
3 the other hand you have to balance that by every  
4 practitioner's responsibility to know what is in the  
5 statute.

6 MEMBER MINIARD: That's why I stopped.  
7 It would be easier if you just went to the point you  
8 wanted, you want to know about RN, you go here, if  
9 you want to know about APRN, you go here. But it is  
10 important to read this whole thing.

11 MS. EMRICH: And it's important to go to  
12 the source.

13 CHAIRWOMAN KEELS: These are the cliff  
14 notes, but you still need to read it.

15 MS. EMRICH: We're giving you at least  
16 an inclination on it, just ideas.

17 CHAIRWOMAN KEELS: Any gaps that you  
18 wish were in here? I can't think of a thing.

19 MEMBER MINIARD: Nicely done.

20 CHAIRWOMAN KEELS: One thing, from  
21 Brian, remember, he wanted us to comment on the use  
22 of the title doctor as we have for DMPs graduating,  
23 how that should be navigated using your academic  
24 title, when and where it's appropriate.

25 MEMBER ZAMUDIO: I think that was in the

1 questions, right?  
 2 MEMBER MINIARD: It was in here  
 3 somewhere, I saw it.  
 4 MEMBER ZAMUDIO: I saw it in the list of  
 5 questions.  
 6 MEMBER MINIARD: Wasn't it on your  
 7 questions?  
 8 MS. EMRICH: Summary of questions.  
 9 CHAIRWOMAN KEELS: It's on the summary  
 10 questions but --  
 11 MS. EMRICH: We can move that to the  
 12 July --  
 13 MEMBER MINIARD: Cool. People probably  
 14 have a lot of differing opinions about that.  
 15 CHAIRWOMAN KEELS: So our next agenda  
 16 item is public comments. Do we have anybody with a  
 17 public comment still? Want to make sure nobody  
 18 changed their mind. We're good.  
 19 Well, we did a lot of work today. We  
 20 can be proud of you all.  
 21 MS. DI PASQUALE: Tom needed to leave,  
 22 but he wanted me to give you the numbers on these  
 23 House Bills. HB492 is the PA bill, physician  
 24 assistant bill --  
 25 MEMBER MINIARD: What was it?

1 MEMBER ZAMUDIO: That's a question on  
 2 there, too.  
 3 MEMBER MINIARD: Well, the National  
 4 organization gives a very specific way of how your  
 5 credential should be supplied, and it's academic  
 6 first, followed by APRN, followed by your population  
 7 focus or your certification.  
 8 CHAIRWOMAN KEELS: And we can put that  
 9 there, and then the use of the title doctor.  
 10 MEMBER MINIARD: Be good to put on the  
 11 website, whatever, because people always ask me.  
 12 CHAIRWOMAN KEELS: Before they get their  
 13 lab coat embroidered.  
 14 MS. EMRICH: And, you know, current  
 15 statute rules specifically say that an APRN has to  
 16 identify themselves as an APRN, so forth. But  
 17 there's no current prohibition.  
 18 CHAIRWOMAN KEELS: Anything else for the  
 19 next meeting? We'll have a legislative update, I'm  
 20 sure. We'll have the draft document, titling.  
 21 We'll have the rules, so don't forget to  
 22 review the rules, the five-year rule review. And  
 23 send your questions, comments, suggestions, because  
 24 we'll need to spend time on that and come up with  
 25 recommendations to the Board for that. Thank you so

1 MS. DI PASQUALE: 492, HB429. And the  
 2 date here, 2-4-2020. I'm not sure if that's --  
 3 introduced.  
 4 And then 1-28-2020, HB448, athletic  
 5 training bill, that's HB484, athletic training bill.  
 6 And 12-17-19 was HB455, surgical assisting bill,  
 7 HB455. So if you Google that --  
 8 CHAIRWOMAN KEELS: Thank you.  
 9 MEMBER BOLTON: Thank you.  
 10 CHAIRWOMAN KEELS: Okay. Wrap up from  
 11 the meeting. Anything else? Anybody feel the need  
 12 to discuss? What would you like to see on the next  
 13 agenda besides the next draft of this?  
 14 MEMBER MINIARD: And the doctor thing I  
 15 guess.  
 16 CHAIRWOMAN KEELS: The DMP.  
 17 MS. EMRICH: Use of title.  
 18 CHAIRWOMAN KEELS: Maybe it's just what  
 19 is the --  
 20 MEMBER MINIARD: Time and place to use  
 21 that title.  
 22 CHAIRWOMAN KEELS: But how about what  
 23 should my signature look like, because I see a lot of  
 24 different variations on the -- on how people use  
 25 their titles.

1 much.  
 2 (Thereupon, the meeting was  
 3 adjourned at 2:45.)  
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**CERTIFICATE**

I do hereby certify that the foregoing is a true and correct transcript of the proceedings taken by me in this matter on Monday, 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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