BEFORE THE OHIO BOARD OF NURSING

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Meeting of the Advisory Committee on Advanced Practice Registered Nursing

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PROCEEDINGS

conducted via Microsoft Teams videoconference, called at 10:00 a.m. on Monday, July 6, 2020.

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ADVISORY COMMITTEE MEMBERS PRESENT:

Erin Keels, APRN-CNP, Chairwoman
Pamela Bolton, APRN-ACNP, APRN-CNS, Member
Peter DiPiazza, APRN-CNP, Member
Margaret Graham, APRN-CNP, Member
Sherri Sievers, APRN-CNP, Member
Michelle Zamudio, APRN-CNM, Member

BOARD STAFF PRESENT:

Holly Fischer, Chief Legal Counsel

Lisa Emrich, RN, Program Manager: Practice, Education, and Licensure

Anita DiPasquale, Staff Attorney

Chantelle Sunderman, Administrative Professional

Tom Dilling, Public and Governmental Affairs Officer/ Liaison

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Monday Morning Session,
July 6, 2020.

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CHAIRWOMAN KEELS: Good morning, everyone. I hope everyone is doing well. Last time we met was March 2nd, just ahead of the massive shutdown, so I hope everyone has been well and doing okay.

This is the Advisory Committee on Advanced Practice Registered Nursing through the Board of Nursing at the State of Ohio. Our charge is as reads: The Committee shall advise the Board regarding the practice and regulation of advanced practice registered nurses and then may -- and may make recommendations -- excuse me, oh, I just lost my place -- and may make recommendations to the Committee on Prescriptive Governance.

So it's 10:00. We'll get started.

So I want to congratulate both Pete DiPiazza and Michelle Zamudio on their reappointments to this Committee, and welcome Dr. Margaret Graham for her appointment to this committee and welcome back.

And next we'll do introductions. As I call your name, introduce yourself, your area of

practice and your role on this Committee.

My name is Erin Keels. I am a Board member of the Ohio Board of Nursing, and Chair of this Committee.

Pete DiPiazza.

MEMBER DIPIAZZA: Hi. Good morning. This is Pete DiPiazza. I am an advanced practice nurse in Ohio. I represent primary care.

CHAIRWOMAN KEELS: Thank you.

Sherri Sievers.

Are you on mute? You must be on mute.

MEMBER SIEVERS: Sorry. Sherri Sievers, family nurse practitioner, also representing practice.

CHAIRWOMAN KEELS: Thank you.

Michelle Zamudio.

MEMBER ZAMUDIO: Hi. I'm Michelle. I'm an assistant professor at the University of Cincinnati College of Medicine. I also work with our residency at the Christ Hospital in Cincinnati, Ohio, and I'm here to represent APRN-CNMs on this committee.

CHAIRWOMAN KEELS: Thank you.

Brian Garrett. I don't believe he's on; is that right, Lisa?

MS. EMRICH: Correct, he's not on.

CHAIRWOMAN KEELS: Margaret Graham.

MEMBER GRAHAM: Hello. I'm Margaret Graham. I'm a family nurse practitioner, I'm Vice Dean of Faculty from the College of Nursing, and I'm representing education.

CHAIRWOMAN KEELS: Thank you.

Angela Gager.

MS. EMRICH: She is absent today.

CHAIRWOMAN KEELS: Oh, that's right. Thank you.

Lisa Emrich.

MS. EMRICH: Yes. I'm Board staff. I'm Program Manager for Licensure, Practice, and Education.

CHAIRWOMAN KEELS: Okay. Holly Fischer.

MS. FISCHER: Hi. I'm here this morning. Thank you.

CHAIRWOMAN KEELS: Anita DiPasquale.

MS. DIPASQUALE: Hi. I'm Board staff as well. Thank you.

CHAIRWOMAN KEELS: Pam Bolton.

MEMBER BOLTON: (Inaudible.)

THE COURT REPORTER: I'm sorry. This is the court reporter. Pam, I need you to come closer

to your microphone, you were much softer than everybody else, and if you could repeat --

MEMBER BOLTON: Okay.

THE COURT REPORTER: -- what you said, please. Thank you.

MEMBER BOLTON: No problem. I'm Pam Bolton from Cincinnati, Ohio. I'm an acute care nurse practitioner, representing the employer.

CHAIRWOMAN KEELS: Thanks, Pam.

Did I get Anita? I did.

And Tom. Did I get you, Tom?

MR. DILLING: Sorry about that. Yeah, Tom Dilling. I'm Board staff. Thank you.

CHAIRWOMAN KEELS: Thank you.

And I see Chantelle.

MS. SUNDERMAN: Hi. I'm Chantelle Sunderman, Board staff.

CHAIRWOMAN KEELS: All right. Thank you. Do I have everybody on the Committee? Okay, great. All right. Thanks for that.

All right. So I have a few announcements. For -- a reminder that this meeting is being live streamed on YouTube, so welcome to everyone who has tuned in.

For the purposes of the proceedings of

today's meeting, we have a court reporter joining us.

Committee members, please state your name prior to making a statement or a question and be sure to speak clearly and slowly so that you may be recorded accurately. And due to the virtual nature of this meeting, there will not be an opportunity for the public to comment or engage in virtual interaction in realtime with Committee members.

The Committee accepted written comments until this morning at 8:00 a.m., and other than comments related to the rules that were submitted by OAAPN, none were received.

Committee members received the transcript of the March 2nd meeting, the agenda, and other documents for today's meeting.

So our first agenda item is draft rule review of the detox rule, so I'm going to turn that over to Holly. A reminder that these draft rules were presented and reviewed by this Committee at the March 2nd meeting and we also received and reviewed input from OAAPN.

So, Holly, you're up.

MS. FISCHER: Okay. Good morning, everybody. We have for your consideration a draft rule which would be a new rule. It's 4723-9-14.

We had legislation, a couple of years ago, that required the Medical Board and the Nursing Board to adopt rules to deal with medication-assisted treatment and then the managed withdrawal from addiction, acute intoxication.

So the first part of the rules were completed, and that is Rule 9-13, but we were delayed in implementing some language for detoxification because the law that implemented this rulemaking requirement which is 4723.15 -- .51(C) mandates that the Nursing Board adopt rules that are consistent with the Medical Board rules.

So the process has been that the Medical Board goes through its various practice committees and adopts a rule and then we follow suit with language that mirrors the Medical Board rules.

So the Medical Board had some delay in getting some rules to the Governor's office of CSI. It did file those rules last year and I think it was around May 21st CSI finally approved of the Medical Board's rules. So those rules are the ones that you reviewed at your last meeting. There's a set of definitions and there's rules for physicians and rules for physician assistants.

And at this meeting what you have before

you is the Nursing Board's version of that rule for APRNs and it's basically line-by-line identical to the rules for physicians and PAs. I mean obviously with PAs where you see that they are in a supervised relationship with the physician, the language that we would have is a Collaborating Agreement relationship. Other than that, there really are no substantive changes between our rule and the rule that will be filed by the Medical Board now that it's approved by CSI.

So, first, does anybody on the Committee have comments or questions about our language; and then, second, I can address the comments received Thursday afternoon from OAAPN.

CHAIRWOMAN KEELS: I don't have any specific questions, Holly, other than to summarize that essentially our language has to mirror almost exactly that of the Medical Board; is that correct?

MS. FISCHER: Substantively they have to be consistent so we can't depart from that language that CSI has now approved for the Medical Board.

CHAIRWOMAN KEELS: Okay. So we're sort of locked in for the most part.

MS. FISCHER: I think that's legally accurate, yes.

CHAIRWOMAN KEELS: My only comment was 4723-9-14, page 7, there's just simply a typo. On No. 9, sentence No. 9, "The advanced practice registered," blank, "instructs...." That's the only thing I can find.

MS. FISCHER: So I have "The advanced practice registered nurse instructs," so we need to add the word "nurse" right there?

CHAIRWOMAN KEELS: Yeah, yeah. I don't have it on my copy.

MS. FISCHER: Yeah. Thank you.

CHAIRWOMAN KEELS: I had some of the same questions that OAAPN raised but understanding that now CSI has approved the Medical Board's -- oh, there's my husband -- rules, that we can't really make much of a change.

MS. FISCHER: Yeah. And I did write back to the attorney for OAAPN and I said we appreciate the comments, here's where we are with the statute.

It's not -- the statute is not worded so that the Medical Board rules need to be consistent with our rules; it's the other way around, so. We've been through this before with the chronic and acute pain rules and the rules for MAT.

So finally I am pleased, though, that the

Medical Board rules are finally through CSI, that took a very long time, and then we would file our rules with CSI probably in late August, early September, and hopefully they would be approved in time for us to adopt the rules at a November rules hearing.

Does any -- does any other member have questions about the rule or the framework?

Any staff comments?

MEMBER GRAHAM: Just to -- just to clarify, Holly. This is Margaret Graham. So we don't have the option to make any -- any of the suggested changes that came from OAAPN because the rules have been filed, is that right, and so that option is off the table since they were filed through medicine?

MS. FISCHER: Yeah, the Medical Board's rules haven't been filed yet with JCARR. They have been approved by the office of CSI. So normally once CSI approves them, the next step is a rules hearing, and if there would be a change to the Medical Board rules at the hearing level then I would bring that back to see if we would need to update our rule accordingly, but right now I don't have any information that anything would be changed so I have

to assume that everything is as it will be when it's filed.

Any -- anything else from anybody?

CHAIRWOMAN KEELS: Now, I guess my rule was -- or my question was sort of to OAAPN's point, some of their comments and suggestions. Is there an avenue for that at all only if something came up through the CSI process on the Medical Board side then that would give us an opportunity to potentially tweak that language?

MS. FISCHER: Well, the Medical Board has already gone through CSI so that is --

CHAIRWOMAN KEELS: Okay.

MS. FISCHER: -- so that process is done. So the next step would be a rules hearing.

CHAIRWOMAN KEELS: Right.

MS. FISCHER: So even though the association that we're working with is governing, you know, advanced practice nurse practice, if they wanted to try to change something it would -- one avenue would be to go to the Medical Board directly and provide that information.

Now, this Medical Board review process has gone on for, gosh, it's been about at least 18 months.

CHAIRWOMAN KEELS: Uh-huh.

MS. FISCHER: So I'm not aware that OAAPN made comments on the Medical Board rules.

CHAIRWOMAN KEELS: Okay.

MS. FISCHER: That would have been the place to do that, really, because our rules then follow the Medical Board rules.

So I would say most likely at this point we're locked in to this language but if, for some reason, something changes at the hearing level with the Medical Board rules, then we would maybe need to push pause and come back and review our language so that we're all in the same place.

So it is difficult to try to have two different agencies adopting rules and then one agency is supposed to follow suit with the first agency and we just kind of have to be on our toes and see what happens with the Medical Board rule hearing, but normally, once it gets through CSI, there wouldn't be any big changes.

CHAIRWOMAN KEELS: Okay. I see. So OAAPN would need to make those recommendations at the Medical Board hearing.

MS. FISCHER: I think that would be the appropriate venue at this point.

CHAIRWOMAN KEELS: Okay. Got it. Thank you.

MS. FISCHER: Uh-huh.

MEMBER GRAHAM: So, Holly, let me just -- this is Margaret Graham again. So the question that I have is on the letter that came from Ms. Singleton that was dated, I think, July the 2nd.

MS. FISCHER: Yeah.

MEMBER GRAHAM: On point 9 there, they're suggesting that all would be allowed to train staff maybe not just the APRN. So in the Medical Board rules is that the physician then --

MS. FISCHER: Yeah.

MEMBER GRAHAM: -- and then in our rules it's the APRN.

MS. FISCHER: Yeah.

MEMBER GRAHAM: So things like that I think would be really warmly received by physicians to allow other people and not to have the physician be the only person in that office to be able to train that, I mean, so that would be the place that OAAPN could go in and request those changes at that hearing because I think something like that would be very beneficial to all the people in the practice to be able to have more than just the physician, you know,

the prescribing physician or the prescribing APRN.

MS. FISCHER: Sure. And if -- I know the association attorney, I think, was planning to listen in on the meeting today or watch it. So to anyone in the audience, if you go to the Medical Board's website, they have extensive material on their rules and how they were developed and all the comments that came through. They have a policy committee that would have reviewed these a couple of times.

So you can go back and see historically if a particular comment or change was requested and if there was discussion on it. You can also see the documents filed with CSI and the rationale behind some of the language so that might kind of bring you up to speed before then approaching the Medical Board.

In other words, if something has already been addressed and it has been either accepted or rejected, you're not kind of trying to reinvent the wheel. So maybe do some of that work and then approach the Medical Board but I do know there's been a very robust discussion that preceded the Medical Board rule.

CHAIRWOMAN KEELS: Thanks, Holly.

Does anyone have any other comments?

MS. FISCHER: Okay. So that was that rule.

The other thing that we have, the Board of Nursing, at its May meeting, approved draft language for Chapter 8 and Chapter 9 of our rules and then we had a period of trying to encourage some public comments.

Basically we would normally have held an Interested Party Meeting but, because of the pandemic, we did it in writing. And last week I got some comments back from the Association, OAAPN, concerning rules in Chapter 8 and Chapter 9, and those were sent to you the same day we got them. They also provide a rationale for many of the changes.

So I wanted to go through that today. This may take a little bit longer in the agenda, I apologize, but I think it's important to go through those, so let me grab my materials here.

CHAIRWOMAN KEELS: Okay.

MS. FISCHER: Okay.

CHAIRWOMAN KEELS: I'm just -- for the Committee, we're essentially jumping down to the agenda item Review Public -- Review Written Public Comments.

MS. FISCHER: So I'm looking at a document that OAAPN's attorney, Jeana Singleton, submitted and she submitted first a shorter version with some rationale, and I took a look at that and I got back to her and said is there more rationale because this only covered maybe a handful of the rules, and she did another document on July 2nd. So you should have both of those and I'll be referring to those when I'm talking to you.

Attached to the rationale are redlined copies of the rules. One thing to keep in mind is this is a redlined copy of the current rule language but it's not the rules as they've been proposed for the Board review.

In other words, these don't have the redlined changes that the Board has already approved, okay? That is a little confusing but we can kind of just focus more on the substance and not get too caught up in the paragraph changes, the numbering changes that will result in the final version because of the other changes to the rules.

Okay. So I'm only going to address those rules that they had comments on and the first rule that I'd like to look at is 4723-8-04.

They had a number of changes to this rule

that covers the requirements for the Standard Care Arrangement and I think a lot of the rationale behind these are just that they found some of the requirements, you know, not necessary, the statute doesn't require it and it seems cumbersome.

So from my point of view, I mean as an attorney I'm not -- I'm neutral on, you know, whether the changes are helpful, not helpful, what direction you all want to go.

The only ones that I can comment on in terms of just the legality would be if something that is proposed conflicts with the law and the only one that I can see that really conflicts with the law is the change related to 8-04, paragraph (A)(3).

This one basically says that, during a declared emergency, if you have a new relationship, a new Standard Care Arrangement is not required. And I don't think that we can, by rule, say that you don't need an SCA in a declared emergency. If the Governor did an Executive Order saying that, then that would become the law but, otherwise, the statute 4723.431 requires a Standard Care Arrangement. So that's the only suggestion that The association had that I see conflicts with the law.

As to the others, you know, I don't see

anything that conflicts with the law. It's purely a matter of whether or not this body wants to recommend those revisions to the Board and then the Board would take your recommendations under advisement and consider them at its upcoming meeting this month.

There are -- there also may be some staff that have some experience in addressing practice questions that might want to chime in on their perspective as well. So, Erin, I'll open it up.

CHAIRWOMAN KEELS: Thanks, Holly.

My own personal opinion, if we just want to look at 04 right now, I had no concerns with the rest of the suggested changes.

Did anyone have any comments or questions or concerns? Sherri.

MEMBER SIEVERS: Yes. As a member or employee of a large institution, I would strongly encourage this committee to support changes which do not mandate that we have to redo it every two years if there's not any changes to the body or to the rules of the SCA itself. We experienced that this time, there was no changes from 2018 to 2020 but, yet, we had to redo SCAs for 450 people and the administrative burden on that is just quite difficult.

And I think that is in line with some other surrounding states like Kentucky you don't have to redo your SCA unless there's changes. Of course if there's anything that would change the body of the SCA, then it would be redone. I think that's what this is suggesting so I would be strongly in favor of that.

I would be interested to hear Pam's take, I'm sure she's in a similar position, and probably you too, Erin, being in a large institution. It's just the administrative difficulties with getting all of those SCAs re-signed has been really a lot to take on.

CHAIRWOMAN KEELS: Yeah, Sherri, I agree with you. I was wondering if that was something that was in statute that it has to be reviewed every two years.

MS. FISCHER: No.

MS. EMRICH: No.

MS. FISCHER: It does not.

CHAIRWOMAN KEELS: Okay.

MEMBER SIEVERS: It was our rules and so I think to Holly's point, we'll let Holly chime in, but I don't think that it was and that was something I think we did discuss briefly in March, too, about

if that was necessary, so I would be strongly in favor of that from a large-institution perspective.

MEMBER BOLTON: This is Pam. I agree with that and I also think that in the individual institutions, for those who are credentialed and privileged, they're going to be looking at the SCA during that time as well so there is a -- there is a tickler, per se, to say that, you know, you need to look at your SCA and make sure everything is in order.

CHAIRWOMAN KEELS: Yeah. I agree with you, Pam and Sherri.

MEMBER DIPIAZZA: I -- this is Pete. I have a quick question regarding OAC 4723-8-05(F) in regards to their ask around reviewing a physician, a collaborating physician's license.

I -- I don't disagree with any of their recommendations but I'm curious as to the intent of the Board when that was initially put out there. I kind of sense it's more of a check on the APRN's behalf to just validate that they're not doing something beyond what their physician is capable to do by their license and is there any concern about eliminating that requirement?

MS. FISCHER: Pete, this is Holly. I

agree, I think that the Board implemented some of these things, including the one you just mentioned, as sort of a -- a memorialized checklist for APRNs so that they don't get into some trouble by, you know, for example, practicing with somebody who doesn't have a current, valid license.

And is it legally required? Does the law require that? No. The law does require that if you're in a practice with a physician that they be licensed. So it's just, yeah, somebody should be doing the license-verification check, and I think the Association's perspective is that HR staff are responsible for that and it's a burden for the practitioner to need to do that piece of work, so.

MEMBER DIPIAZZA: Yeah. I guess I'm just -- I have seen this happen where APRNs can get in trouble by not checking a physician's license for one reason or another, and I was curious about the intent and I guess how do you protect people from getting in trouble other than it being brought before the Board and at that point it's probably too late.

CHAIRWOMAN KEELS: Thanks, Pete.

Does anybody else have any questions or comments on section 4723-8-04?

MS. DIPASQUALE: Yeah. This is Anita

DiPasquale. I just wanted to comment based on some questions the Board has received to the practice line that sometimes people who write are under the impression that law and rule require that they have an SCA with every doctor they practice with, and there isn't such a requirement in law or rule.

Now, an employer or a facility or, you know, a collaborating physician might have that requirement but there's nothing in Board law or rule that requires an APRN to have an SCA with every physician with whom they practice. So I just wanted to comment on that.

CHAIRWOMAN KEELS: Thanks, Anita.

MEMBER SIEVERS: Yeah, and we have gone to a system where we no longer do that. We have a designated physician representative in each of our divisions. The administrative burden falls on getting all of the APRN signature pages, getting all of those division-designated folks to re-sign, to get it all together.

We do require that we have a list of the physicians who are collaborating in that area so we update those. It's still a lot to get 450 signature pages but I appreciate, you know, your comment in pointing that out and that's, I think, good for

everyone to know.

For, you know, Pete's comment, I think it doesn't really change -- yes, it's important for the physician to have a license. It doesn't change our scope or change what we're doing and I think that there are good processes in place to have somebody checking those licenses because, you know, they're not going to be able to bill and run their practice.

MEMBER DIPIAZZA: Well --

MEMBER SIEVERS: So I think that --

MEMBER DIPIAZZA: I -- I -- I can appreciate that comment in regards to someone is always checking someone's license but I think it would be naive of us to think that a biller is checking whether or not a physician's prescribing practice has been taken away. That's just -- that's my thought on that.

CHAIRWOMAN KEELS: Thanks, Pete.

MEMBER ZAMUDIO: I have a question.

CHAIRWOMAN KEELS: Yes.

MEMBER ZAMUDIO: This is Michelle.

So with regard to what Anita was saying, you can have a designated physician representative, like what Sherri was discussing with her organization.

When I looked at it and it talked about the designated physician representative, it does say it can be a physician with legal authority that has been executed on the physician's behalf.

So some institutions are interpreting that as each physician who will be working with that APN. If the Department Chair, for example, will sign that, that's a legal -- they need to have executed a legal document giving the Department Chair that authority. And it says clearly in the rule that they must have legal authority executed on the physician's behalf. So I don't know if there's a way to -- to redline or eliminate that. That is huge if every physician we're going to work with has to then execute a legal document to the Department Chair who can then sign our SCA on our behalf.

MEMBER BOLTON: Michelle, this is Pam. I was going to bring that up that we have -- our attorneys have interpreted that as a Letter of Designee. And so, if you have, you know, 40 anesthesiologists and that -- or I'm sorry -- well, yeah, we had surgical -- we had surgical NPs that we were saying optimization, so if they were collaborating with anesthesia it was assumed that either they would have to sign the SCA or they would

have to do a Letter of Designee saying that this physician could sign off on that.

MEMBER ZAMUDIO: Right.

MEMBER BOLTON: So that is an interpretation that's out there.

MEMBER ZAMUDIO: Yeah. It states that they must have "an executed," so that's a legal document. So they can't just have a Department Chair sign for them. That's why I was curious about Anita saying we don't have to have an SCA with each person. How do we avoid that?

MEMBER SIEVERS: And we do do that too.

CHAIRWOMAN KEELS: Yes, us too.

MS. DIPASQUALE: So, Erin, this is Anita again. So we're talking about two separate things. I was not commenting on that section which is available to entities that choose to use it. Rather than having every physician sign an SCA, there can be, as you said, a designated physician. That's -- that isn't what I was referring to.

I was referring to the concept that we get APRNs who think they have to have an SCA executed with every physician whose patients they see or treat and with whom they work.

MEMBER ZAMUDIO: Oh, okay. Right, okay.

So I guess the second issue is the most important, how do we avoid them having to execute a legal document? Every single one of them must execute a legal document if you are under an SCA with them, before a Department Chair or another representative can sign it. I don't think it's necessary to execute a legal document. Is this an opportunity to eliminate that requirement?

MS. DIPASQUALE: I think what you're looking -- this is Anita DiPasquale again for the stenographer.

I think what you're looking at is statute, is required by statute; is that correct? Let's see, I have it out here. And you can't do anything through the rules to change that. Let's see. But that was not -- again, I was not referring to the ability, the convenience of having a designated physician.

MEMBER ZAMUDIO: Got it, yeah.

MS. DIPASQUALE: It's a separate, separate thing. Let's see here. Maybe it is just --

MS. EMRICH: I think it is in rule, Anita.

MS. DIPASQUALE: Okay.

CHAIRWOMAN KEELS: Yes, to Michelle's

point, it seems sort of counterintuitive that I really only need an SCA with one collaborating physician but, on the other hand, then you need to get the designated -- designation from the other physicians to allow this one physician to sign for you, but then do you really need that if you only need one SCA really? Does that make sense?

MEMBER ZAMUDIO: Yes, that summed it very nicely, Erin. Thank you.

MS. DIPASQUALE: If you're asking me, I would just say that is a convenience for those situations where you want 10 physicians to be collaborating physicians.

And I hate to bring this up but the statute does have the 5-to-1 ratio, so that might be another reason that you need for then just the Chair of the Department, so. And --

MEMBER ZAMUDIO: The 5-to-1 ratio -- I'm sorry, it's Michelle. The 5-to-1 ratio is for prescribing; is that right?

MS. DIPASQUALE: Yes. So if that applies to your practice, remember that's also in there, so it wouldn't be enough to have just the Department Chair signing an SCA with 40 APRNs.

MEMBER ZAMUDIO: So is that -- is the

requirement that they execute a legal document giving a Power of Attorney, so to speak, to that Department Chair? Can we eliminate that since we're looking at it and it's a rule?

MS. DIPASQUALE: Are you asking can persons be collaborating physicians but not have executed something saying that they are?

MEMBER ZAMUDIO: No. Can a Department Chair or another representative, a physician representative, still sign for you without all of the other providers executing a legal document giving them the authority to sign on their behalf? Because that's what's required right now in the rule it says that if one physician is going to sign as a representative, that can only occur if all of the other physicians have executed that legal document giving them the authority to sign for them. It's redundant to me.

MS. DIPASQUALE: Well, I would defer to Holly ultimately on her interpretation of this but, to me, I'm not sure how one person could sign for another without -- I see the provision that you're talking about as a convenience that allows for one person to sign on behalf of ten collaborating physicians. I'm not sure what authority the

Department Chair would have to sign on behalf of others without that, but I would probably ask Holly to chime in on that.

MS. FISCHER: Well, I mean I think it's a little beyond the scope of our rule to enforce whatever laws and policies different facilities have in place, but if you have, let's say, 10 APRNs and you have 10 physicians and so forth, if the physician did sort of a blanket document that said yes, our Department Chair can sign for us on any SCAs, it would be global as to all the APRNs and it would definitely save a lot of time because I'm not taking out my pen and signing 10 different SCAs, I'm just signing one approval saying the Chair can sign on my behalf.

And it is probably, as Anita mentioned, legally sound because ultimately I can't sign for Michelle on a document. A SCA is a legal contract. I can't sign that without something between the two of us that's some kind of an understanding that I have granted her the authority to sign for me or vice versa, so.

CHAIRWOMAN KEELS: Sherri.

MEMBER SIEVERS: We're just doing it at their hire so it does reduce the burden a little bit.

It is cumbersome to try to make sure that you, as soon as a physician is added, that we track them down and they sign these documents but we only have them sign the legal authorization one time and then in subsequent years, but it is like a notification that, hey, Dr. So-and-So is going to be signing for you and they're aware that they're in these relationships so, I mean, I see both sides but it's just a one-time thing.

CHAIRWOMAN KEELS: Pam.

MEMBER BOLTON: So now I just want to clarify, Anita, about what you said before. I'm a little confused if we need the Letter of Designee and we've determined that that's, you know, in play, then can you explain a little bit more what you said about an SCA not being required? Is that just an incidental, "Oh, I happen to be taking care of this patient, I don't have an SCA with this person but it's not something that happens on a routine and ongoing basis"?

MS. DIPASQUALE: So -- this is Anita DiPasquale. The -- I sometimes get questions where the nurse -- the nurse's understanding is that she can only care for patients of physicians with whom she has an SCA and that might be the term of her

employment, I don't know, that might be required by her facility, the hospital's policies and practices. I just wanted to point out that law and rule don't require that.

4723.481 says you have to have entered into an SCA with at least one collaborating physician. It doesn't say you must be in a collaborating -- in an SCA with every physician with whom you work, with every physician with whom you consult, with every physician whose patients you see, and I just -- I pick up from the questions that there is that understanding out there for some folks.

CHAIRWOMAN KEELS: Well, I think it goes back to the designated signature that then people feel like that's then necessary so why would I have a physician with a designation -- a designated signature authority for this group of physicians if I don't need a Standard Care Arrangement with these physicians. Does that make sense?

MS. DIPASQUALE: To me, kind of, except I think you have to remember that the statute is written for all APRNs, not only APRNs who are working in that formal hospital setting.

So there might be an APRN who enters into an SCA with one physician who has perhaps a private

practice, doesn't even work at the same place with that person, rarely sees -- rarely shares a patient with that physician. They can, as you know, there's a requirement for referral of the physician under certain circumstances, et cetera, but I think we have to remember that the statute is written very broadly to cover the requirements for all APRNs.

CHAIRWOMAN KEELS: Sure. Thank you.

Okay. Are we ready to move on to section 05?

MEMBER ZAMUDIO: Wait. So did we go through line by line on the OAAPN recommendations? It looked like there were seven. Did we agree with them?

CHAIRWOMAN KEELS: I'm actually -- so, Michelle, what I thought we'd do is just move through their redline suggestions --

MEMBER ZAMUDIO: Okay.

CHAIRWOMAN KEELS: -- sort of chapter by chapter or actually paragraph by paragraph so we don't miss any of them.

MEMBER ZAMUDIO: Okay.

CHAIRWOMAN KEELS: If that makes sense.

MS. FISCHER: So basically you're saying the consensus of the group is on Rule 8-04 that we

are in favor of the changes that the Association is making, with the one change that I identified as being a legal conflict excluded, but everything else the consensus is to recommend those changes to the Board; is that correct?

CHAIRWOMAN KEELS: Yes.

MEMBER ZAMUDIO: Yes.

CHAIRWOMAN KEELS: I see Michelle, Sherri, Pam saying yes. I can't see Pete.

MEMBER DIPIAZZA: Yes.

CHAIRWOMAN KEELS: Okay.

MS. FISCHER: Okay. So I think we can go on to Rule 8-05.

CHAIRWOMAN KEELS: Yes, please.

MS. FISCHER: Now, on 8-05 we had some discussion on the rationale behind the two-year license verification of the physician. We can come back to that.

As far as any problematic language, I don't see anything that, you know, really conflicts with the law, so again it's really up to your expertise as to whether or not you want to recommend these changes. And, you know, some of them, again, are getting rid of really primarily two-year review and then the semiannual review language is changed.

It preserves a review that is of prescribing patterns and Schedule II prescriptions but it eliminates the broad language that all types of prescriptions be reviewed on a semiannual basis.

CHAIRWOMAN KEELS: Any comments from the Committee or staff?

I'm in favor of their recommendations. I believe -- now I see Margaret. Good.

MEMBER GRAHAM: Hi.

CHAIRWOMAN KEELS: Okay. And then, Holly, to your point about the every-two-year review, that we could eliminate that or we could not?

MS. FISCHER: We can, yes. There's nothing in these changes that we can't make, if you're in favor of them.

CHAIRWOMAN KEELS: I see head shaking. I'm a yes. Michelle is a yes. I see Margaret is a yes. Pam's a yes. I'm assuming Pete is a yes; I can't see him.

MEMBER DIPIAZZA: Yes.

MEMBER SIEVERS: Yes for Sherri. Again, you have an administrative burden, I think, when you have a large group so that would be great.

CHAIRWOMAN KEELS: Yeah, I agree.

MS. FISCHER: Okay.

CHAIRWOMAN KEELS: Okay.

MEMBER ZAMUDIO: Erin?

CHAIRWOMAN KEELS: Yes.

MEMBER ZAMUDIO: So I have a quick question. Can I make a comment before we leave 8-05?

CHAIRWOMAN KEELS: Yeah. If it's about 8-05, then please do.

MEMBER ZAMUDIO: Okay. So this may be for Holly to make sure that this is consistent with the law but in 8-05(D)(2) it says subsequent to each quality assurance review, the APRN meets with the committee, either collaborator, et cetera, to do that annual review but it does allow for a QA committee to do that annual review for the APRN. It goes on to state that the individual must meet with that person each year after the review.

Well, if our review is being done by an institution or another committee, we don't always have the opportunity to go back and meet with them. Is there any way to wordsmith so that the annual meeting after the review is a requirement if there's any issues found? If the reviews are being done on all providers and there's no issues, I don't know why we would have to then schedule a meeting for them to talk to them to say good job.

MS. FISCHER: Well, so if (D)(1) is changed it would still say a periodic chart review, so then (D)(2) would say after the chart review, this conference occurs.

MEMBER ZAMUDIO: Correct.

MS. FISCHER: So if there was a chart review then there would be no conference, right?

MEMBER ZAMUDIO: So we're saying the chart review would only occur -- I mean isn't it going to occur, like, annually anyway?

MS. FISCHER: Well, it says subsequent to each chart review.

MEMBER ZAMUDIO: Right. So if there's a chart review that's going -- that would be an annual requirement, then the meeting wouldn't that be, by default, also an annual requirement?

MS. FISCHER: Well, (D)(2) is linked with (D)(1). So in (D)(1), periodic random chart review, okay, at least annually, and then subsequent to each chart review then there would be this meeting. So how would you want to change that? I mean do you want to eliminate the meeting, is that your proposal, or --

MEMBER ZAMUDIO: Or at least reduce it to where the meeting would only occur if there's any

issues that are found during the chart review, right? So our charts are reviewed annually by a committee, a quality assurance committee, and I think most of us have either an insurance or a hospital or someone that's doing periodic chart reviews. There's not an opportunity to meet with them annually. So is that meeting necessary for follow-up unless there's a problem?

CHAIRWOMAN KEELS: Okay. I gotcha.

MEMBER SIEVERS: To say, like, feedback provided because we -- we provide the written comments back, use a tool, and the reviewers write comments on there and that's provided back to the staff.

MEMBER ZAMUDIO: Yes.

MEMBER SIEVERS: So it's not an in-person meeting. I don't know if electronic communication can qualify as a conference but that's the way we have to do it because of our large numbers. There's no way you can sit down with 450 people and talk about their charts but we're calling them up if there's a problem for sure. So maybe a follow-up or feedback or something to that effect?

CHAIRWOMAN KEELS: Follow-up communication or notification?

MEMBER ZAMUDIO: Yeah, I like that a lot. That allows it to be electronic, it doesn't require the meeting, I think that would be beneficial not just for the APRN but for the organizations as well. There's documentation and that way there's not been just an assessment but you've closed the loop and given them feedback, not necessarily a meeting.

MS. FISCHER: So we could say subsequent to each chart review an opportunity to confer or provide feedback shall be provided, something like that, just more focused on an opportunity.

MEMBER ZAMUDIO: Yes.

MS. FISCHER: Okay.

MEMBER SIEVERS: Yes, that's great.

CHAIRWOMAN KEELS: Thanks for bringing that up, Michelle.

MEMBER ZAMUDIO: Thank you.

MS. FISCHER: Okay. Just a moment.

CHAIRWOMAN KEELS: Sure.

MS. FISCHER: Okay. Anything else on 8-05?

CHAIRWOMAN KEELS: No, not from me.

MS. FISCHER: Okay.

MEMBER SIEVERS: Did -- I'm sorry. Did we resolve the physician license verification, was

that in this one?

MS. FISCHER: Yes, it was.

MEMBER SIEVERS: Did we decide, can we eliminate that because again -- or, I mean, I don't want to call out or give special treatment to the organizations but there's no way that those folks could slip through our med staff because they're running reports but I don't want to also put the burden on folks in private practice who have systems as well.

I don't know if we can say something about establish a process so that way if the process is your office staff, I don't know, I'd look to Holly to help with that but it's a lot because what happened -- it's just you have to check multiple times because sometimes if they're up and then they're in review it's just -- it's not like us where we have a blanket time that they do it. They're all on their own cycle and you'd be, like, checking all the time if you had a lot of physicians.

CHAIRWOMAN KEELS: Yeah, I like the recommendation that a process shall be established that licenses are verified.

MS. FISCHER: Well, I mean, a process could be established by the institution or facility

but we can't adopt a rule directing that because we don't regulate those workplace settings.

And I think it goes back to Pete's comment, you know, are we trying to adopt rule language that is almost, I don't know, for lack of a better word, paternalistic? We're trying to protect the APRN and add this requirement so we make sure that they don't get stuck practicing with somebody who doesn't have a current valid license or we just get rid of the language and say, hey, you know, you better be aware of what your processes are, best practices are, and make sure HR is doing this for you or you're going to have to do it yourself. So it's more of a -- it's more of a philosophical point almost. I don't think it's so much of a legal, you know, legal point.

MEMBER SIEVERS: Yeah. If we could get rid of it all together because I don't -- I doubt the physicians have anything in their rules that they're checking ours but, yeah, getting rid of it would be great.

MEMBER DIPIAZZA: Yeah, I'm not opposed to -- I'm not opposed to eliminating it. I think that we need to just provide education then to the APRNs in Ohio that it's your professional practice

and it's up to you to review and make sure you're compliant with practicing in the state of Ohio.

MEMBER ZAMUDIO: This is Michelle. I agree with that. I think we need to eliminate it. I always feel like this is making me responsible for someone else's practice every time I read this. I think there's multiple checks and balances in Ohio from the State Medical Board, from insurance, from different organizations that they're confirming the licensure. I don't think it's our responsibility to make sure they're doing what they should do, so I would vote to eliminate it.

CHAIRWOMAN KEELS: Thanks, Michelle.

Any other comments?

MS. FISCHER: Do we have a consensus on that then? We'll strike the language or propose to?

CHAIRWOMAN KEELS: I agree.

Pete, are you good? Peter, do you agree?

MEMBER GRAHAM: This is Margaret. I think Pete's comment is well taken and I think that's something that, as we educate APRNs in the state, we do have to make sure that they look at their collaborator and look at any sanctions against their license, and that's something, I think, we should cover in education but I think taking it out of the

Administrative Code would be good.

CHAIRWOMAN KEELS: Thanks, Margaret. And to your point, Margaret, I think it could be moved into the FAQs that we'll get to later today. We have a section on that.

MEMBER GRAHAM: Yeah.

CHAIRWOMAN KEELS: Okay.

MS. FISCHER: I would move now to Rule 8-08. There were no changes recommended on 8-06.

8-08, at the very end of the rule there's a change under paragraph (I)(3) and it says by Executive Order by the Governor during a State emergency with fees waived. So basically they're saying if an Executive Order comes out and the Order says fees should be waived, then fees will be waived. You know, there's nothing wrong with adding that but it's not legally necessary; any Executive Order would take care of it.

It's not consistent with our other rules, we don't keep adding a caveat, you know, fees will be waived if an Executive Order says they have to be waived, you know; so, to me, just from a rule-drafting standpoint, I don't think it's necessary to add the language but I'll leave it up for you all to consider.

CHAIRWOMAN KEELS: It seems like we should be consistent with other rule language.

MS. FISCHER: Uh-huh.

CHAIRWOMAN KEELS: And it would be included in the Executive Order.

MS. FISCHER: Right.

CHAIRWOMAN KEELS: So I'm sort of neutral on the idea. Any other comments?

MEMBER GRAHAM: I think the point is to make sure that would happen, and I think based on what Holly Fischer said -- sorry, this is Margaret. I think, based on what Holly said, that would be the case that if the Governor's Order said they're to be waived then they would be waived.

MS. FISCHER: Right.

CHAIRWOMAN KEELS: Right.

MS. FISCHER: Okay. If we have an agreement on that one, then I would recommend to the Board that we not change and add that language for that reason.

CHAIRWOMAN KEELS: I think that's fine.

MS. FISCHER: Okay, okay. Then I'll move to the next rule that had some changes. This is Rule 8-11, the youth concussion rule, and the suggestion is under paragraph (B)(1). Throughout the

Association's recommendations you'll see that they have implemented the word "designation" at times.

When the law changed to have APRN licensure several years ago, it's structured so it says that, you know, an individual designated as a CNP, designated as a CRNA, so the designation is not the license, it's a designation of the license type, okay? And, yeah, I think that's -- that's understandable.

The only thing that's a little odd about this change is that they're saying that the nurse's designation, which is a license type, must be with the treatment of this population, and I think the word "specialty," which is used in the law to describe more their practice, is a word that is probably more legally correct.

So "specialty" is in 4723.43 when it describes the different scopes of practice and again "designation" is in 4723.42 where it's talking about the license type. So you could have a license type of a CNP but you don't really practice with youth, you know? That's why on that one I kind of would lean toward not making that change for that reason.

CHAIRWOMAN KEELS: Yeah, you know, to me

this all goes back to the careful use of words and how we confused ourselves where really we personally feel like we should use the word "role" for the four types of APRNs.

And then "designation," I guess if we could go back and do time over again, would mean your actual certification and we'd reserve "specialty" if you specialize in your certification. That's where a lot of confusion has come about, in my opinion, but I don't know if we can make those changes to be a little more consistent with Consensus Model language which, you know, not to get into that too much but, again, I think it's been a point of contention.

Any other comments or questions?

So, Holly, your recommendation is not to adopt the recommendation and continue to use the word "specialty" that would essentially equate to your certification.

MS. FISCHER: Right. I just think the -- I think the Association was trying to start using the word "designation" more for license type which I understand in many of the other locations but in this particular location I just think it's the wrong word choice.

I think the license type is the big,

global, "I'm a CNP" or "I'm a CNM," but that doesn't tell us whether or not they treat and care for youth, for example. That's more going to their scope of practice or the practice they're engaged in so I think the word here "specialty" is the appropriate word, rather than the word "designation." That's my rationale for it.

CHAIRWOMAN KEELS: No, I actually agree with you if we think the word "designation" -- well, yeah, if you want the word "designation" to kind of equate to your certification then that makes sense.

MS. FISCHER: It's -- it's the Ohio license type. It's unique to Ohio. It just happened to be when they adopted the licensure statute for APRNs, the word is "designated as a CNP," "designated a CRNA," so it's really essentially a license type. It's one of the big four license types.

Sherri, did you have a comment?

MEMBER SIEVERS: No, I'm good. Well, let me do ask, let me ask a question. Do we -- because I get lost in these two topics too. For "specialty" are we still using that to mean certification and we don't say "certification" because a certification doesn't always spell out the ages as we've gone through? So I guess we're still using "specialty" in

other areas to mean certification?

MS. FISCHER: Well, "specialty" is defined in 4723.43 in the law. It uses one rule --

CHAIRWOMAN KEELS: Uh-oh. You froze.

MS. FISCHER: Pardon?

CHAIRWOMAN KEELS: Holly?

MS. FISCHER: I'm sorry. Can you hear me?

CHAIRWOMAN KEELS: I can now.

MS. FISCHER: Okay. All right. Here I think the word "specialty" could be replaced with "practice." I mean I don't -- I don't think the word "specialty" is critical. I just think the word "designation" is the wrong choice of word here. So if you wanted to not say "specialty," you could say "practice" and I think that would be fine.

MEMBER SIEVERS: Yeah, that sounds good.

MEMBER ZAMUDIO: Yeah, I like that.

CHAIRWOMAN KEELS: I think "practice" is a little more clear.

MEMBER SIEVERS: I like that too.

MS. FISCHER: Okay.

MEMBER SIEVERS: Yeah, that would be great.

CHAIRWOMAN KEELS: Okay. Thanks,

everyone.

MS. FISCHER: All right. Just a moment.

CHAIRWOMAN KEELS: Sure.

MEMBER ZAMUDIO: I have a question.

CHAIRWOMAN KEELS: Yeah, Michelle.

MEMBER ZAMUDIO: So would this be an appropriate time to talk about 9 -- 4723-9-10? If we have a question that wasn't submitted, like, by the OAAPN, is it okay to still ask that question?

MS. FISCHER: Yeah. Let's put a -- put a pin in it until we get to that rule because we'll get there once we get through all of these.

MEMBER ZAMUDIO: Okay. Thank you.

MS. FISCHER: Okay. So that -- that's all I had on that rule. And now we will be moving to Chapter 9 to the comments that were submitted on Chapter 9, Prescriptive Authority.

Rule 9-01. I don't see any legal problem with the suggested changes. They all made sense to me. I don't have much else to say about that. If the group wants to discuss those proposals.

CHAIRWOMAN KEELS: No, I don't. Are we okay with removing the word "consultation"? I know we're not remanded to do that as far as prescribing goes and that's where the body of this -- that's

where that paragraph is in under prescribing, so I'm fine with removing that.

Sherry is okay. I see -- okay, everybody is good? All right. We'll remove that.

MS. FISCHER: All right. Lisa Emrich and Anita, if you have any Staff comments, or Tom, feel free to chime in. I'm okay with those for Rule 9-01.

MS. EMRICH: Okay.

MS. FISCHER: Rule 9-02, under (A)(2)(d)(i), it's on the first page of Rule 9-02. It starts out with "Indications and contraindications for the use of schedule II controlled substances...."

The only comment that I have on there is just more of the wording. If we want to change, I probably need to add definitions for "acute," "subacute," and "chronic pain" because those definitions are in a different rule, they're not global to the chapter.

And then I was wondering from a nursing perspective on the wording "management of pain" versus "treatment of pain," I don't know if anybody has thoughts on that, so.

MEMBER GRAHAM: This is --

CHAIRWOMAN KEELS: This is Erin -- oh, go ahead, Margaret.

MEMBER GRAHAM: So this is Margaret. I think we do talk about pain management versus pain treatment so I think that's consistent with pain management.

CHAIRWOMAN KEELS: Yeah, I think pain management speaks to some of the preventative things that you do as well so you can avoid getting to pain where you have to treat it, so I like the word "management."

MS. FISCHER: Okay. So other than just maybe doing a little wordsmithing on that change on 9-02, I think that's okay.

Then on the next page under the same paragraph but (iii), they're proposing deleting the specific reference to the American Academy of Pediatrics. I remember the discussion on this rule drafting originally where we're talking about stimulants for children and that kind of thing and the suggestion was to add this as an example. They're saying well, let's take out that specific example because, you know, it's just one of many, I guess.

So, again, I'm neutral on the change. I don't know if the group wants to go -- recommend going in that direction or not. If anybody else has

more back history on why that language was put in there, feel free to speak up.

MEMBER ZAMUDIO: Holly, this is Michelle. I think you're exactly right. That's what we were talking about was to use American Academy of Pediatrics as an example. Unfortunately, it could be construed as exclusionary to other organizations and we know we treat adult ADHD through other guidelines from our neurology folks, the different psychiatric organizations. So perhaps something more like the suggested language of national and state organizations or something more generic so that it doesn't become misconstrued as excluding the other organizations, I would support that.

MS. FISCHER: Okay.

CHAIRWOMAN KEELS: Thanks, Michelle.

Anyone else?

I think the consensus is fine to remove that.

MS. FISCHER: Okay. Then down on (e)(4) on the same page. This is permissive language. Essentially it's saying if you're going to be evaluating the participant's learning, that evaluation "may include" and it gives three examples. So the proposal is to delete those. I'm just

bringing it to your attention because any time things are set forth in a permissive manner and giving an example, it's, to me, not a burden because it's not a requirement, it's just illustrative, so I wanted to make sure we thought about whether or not to recommend that removal or not.

CHAIRWOMAN KEELS: Comments from the Committee?

MEMBER GRAHAM: I think if it's used as examples that might be another example of something -- this is Margaret -- that might be another example of something we could put in the facts maybe if it's to provide guidance but not really part of -- necessary for the rule. That might fit better in the fact document.

CHAIRWOMAN KEELS: Rather than in rule. Thank you.

MEMBER SIEVERS: I agree.

MEMBER ZAMUDIO: That's a great idea.

CHAIRWOMAN KEELS: Okay. Thanks, everyone.

MS. FISCHER: Let me just make sure. Okay. So, yeah, that's all for that rule.

The next rule would be 4723-9-08 and really some of these changes are again adding

language that -- I don't know that it's really necessary but it's just kind of rewording some language and including the "designation" word. I don't have a problem with that. I don't know if it's really, you know, necessary but it doesn't -- I don't think it hurts.

CHAIRWOMAN KEELS: So I think it cements the idea that designation equals your licensure, the type of APRN that you are licensed.

MS. FISCHER: Uh-huh.

CHAIRWOMAN KEELS: Which then the next step would be to cement the idea that specialty equates to your certification.

MS. FISCHER: Uh-huh.

CHAIRWOMAN KEELS: But then there's also the idea that the Consensus Model does not regulate specialty and we have had that conversation before that specialty in Ohio means something different than specialty with the Consensus Model, so I just see that confusion still persisting if we continue to use the word "specialty" to equate to your certification but, again, I'm not sure there's anything we can do about it other than the FAQ.

MS. FISCHER: Right. So, I mean, I would say, just addressing this rule at hand, if everybody

is in agreement, we could recommend that those changes are acceptable to the Board.

CHAIRWOMAN KEELS: Yes.

MS. FISCHER: Okay. Moving on to Rule 9-10. The Association is recommending that we take the references to the CPG out of the rule if the CPG is sunsetted as a Committee. And right now, yeah, I think that would be something to do but I don't know if, I think it's Senate Bill 331, I don't know when that might pass and then when it might be effective.

If, by the November rules hearing time period, the CPG has been sunsetted, then we can strike the language. We can also strike the language next year when we do rule review again.

If you have language in a rule about a committee that no longer exists, it's just obsolete language and every year we go through the rules and we clean up obsolete language, so.

Other than that, let me --

MEMBER ZAMUDIO: Holly?

MS. FISCHER: Yes.

MEMBER ZAMUDIO: So my question was about 9-10. Is it okay to proceed?

MS. FISCHER: Yeah, just let me see if there are any other items that they had that I wanted

to point out.

Yeah, so the only other one and, Michelle, I'm not sure if this is the one you wanted to talk about, was when we had the last rules hearing in 2019, OAAPN submitted a comment that is the same comment they submitted last week about the language on -- I wish these had page numbers, I'm sorry about that. It's paragraph (6)(a), referencing hematology, and, you know, their position was, well, there's no certification in hematology. So we responded to that last year and then I sent them that response again last week and I said I think we addressed this. And I haven't heard anything since, but I'll open it up to any comments or questions.

MEMBER GRAHAM: Is the difference, lots of time the specialty is hema-oncology and hem-onc together or -- and for nursing it's oncology but hem-onc is not necessarily added into our specialty; is that the question? I mean so when we look at Advanced Practice Nurses who are specialized in oncology, is it assumed that they're also going to be working with hem-onc but that's not necessarily the title of their certification? Is that the difference maybe?

MS. FISCHER: Lisa, do you want to

address that?

MS. EMRICH: Sure. So certainly there is an oncology certification for APRNs or CNPs and CNSs. They -- and oncology certainly takes into consideration hematology. But nurses -- APRNs may also practice hematology in the sense of you look at sickle cell disease and it's a prime, you know, pain-management situation and that may be their practice is hematology. So oncology/hematology, you know, so we didn't want to exclude those who are practicing hematology.

MEMBER GRAHAM: This is Margaret. I think my question is if their certification is oncology and it's assumed that it's hematology, I think that's -- so -- so maybe that just doesn't quite match. Or maybe if you just say certified in oncology and then the hematology is -- in the nursing world that's been kind of assumed so maybe that's why the question is there.

MS. EMRICH: It's about the practice of, it's oncology and hematology, correct.

MEMBER SIEVERS: I think that the -- the recommendations here just are more accurate because you don't want folks to think there is a hematology-certifying organization but then by adding

"hematology physician" in (b), that would also allow them to do it.

So I think it's just more accurate than listing hematology as a certification for the Advanced Practice Nurse. I don't think it changes the intent of it at all; it just makes it more accurate. Am I correct in what I'm thinking?

CHAIRWOMAN KEELS: Any other questions or comments?

MS. FISCHER: Yeah, I mean on this one I think by having hematology there, you're broadening the population of APRNs that can serve and provide this medication management. I think by taking it out you're restricting and, to me, I think that was the rationale for the Board including it; so I don't know if the Board would want to take it out because they just went through this whole review last year and decided to keep the language in, so.

MEMBER SIEVERS: My point is if there's not a certification -- oh, but is there a nursing certification in hematology and not just an APRN? What did we -- so the way it reads, it says hold -- for (a), "holds a national certification by a national certifying organization in hematology." I might be incorrect, I thought we were saying that

there was not a certification for hematology specifically.

Unless we put "oncology/hematology" and we assume that is included like the physicians because I think what Lisa was saying is true, the physicians are boarded as both but I think we were questioning whether the nursing certifications cover hematology as well. I do not know that. I'm not familiar with that certification.

MEMBER ZAMUDIO: And that was my --

MEMBER GRAHAM: This is Margaret. That was -- my question is the same, yeah.

MEMBER SIEVERS: Because --

MS. EMRICH: But the content, the content is hematology as well.

MEMBER SIEVERS: The certification --

MS. EMRICH: The oncology is -- the content is oncology and hematology.

MEMBER SIEVERS: So maybe can we leave the hematology on (iii) there, just slash it, because if it's inclusive but it doesn't specifically -- I just don't want folks to think, oh, I don't have a certification specifically in hematology so I can't care for my sickle cell patient because I'm not covered. So --

CHAIRWOMAN KEELS: Yeah, I like that.

MEMBER BOLTON: I would be a little concerned with slashing it just because the exam is advanced oncology certified nurse practitioner. Could we maybe just put parentheses and say it includes hematology content? Like, I wouldn't want to distort the name. I don't know.

MEMBER DIPIAZZA: Is it possible just -- is it possible just to word this as "holds a certification or practices in the following fields"?

MS. FISCHER: Well, I'm afraid that impacts the other parts, other subsets, and that would be a problem.

To me, I don't know that there's harm in leaving the word "hematology." For one thing, there could be a certification that is specifically in that at some point in time.

If you had a sickle cell patient and you were not certified in one of these areas, you wouldn't be providing -- exceeding the 120 MED level anyway. It doesn't mean you can't care for the patient. This is just for exceeding that dosage level.

So I feel like we take out "hematology," it's a possibility that we're restricting someone and

it's kind of the opposite direction of the direction that we wanted to go. And we'll also have to justify that with CSI because, by taking the word out, it's an adverse impact and then what's our rationale. Well, the rationale is because some people might be confused and wonder why is it hematology if there's no current certification in that. So we're trying to prevent confusion.

On the other hand, if they do have content in oncology certification in hematology, the Board's interpretation is they would be covered under this rule. So, I don't know, I see more downside in taking the word out, just to the population, than I do keeping it in.

CHAIRWOMAN KEELS: Yeah, I could see all of a sudden the APRNs that work in sickle cell being concerned.

So you don't think, Holly, it would be an idea to just put "oncology (includes hematology)"? You'd rather have it separate?

MS. FISCHER: I don't -- I don't know if that's proper or not. I mean I haven't had time to think about that. I think all of you probably have more experience than I do in that wording, so.

CHAIRWOMAN KEELS: Other comments? We

just leave it as is and include "hematology" so those APRNs practicing in that space know that they are included?

MEMBER GRAHAM: This is Margaret. I think that we want to be as inclusive as possible, and if that keeps it broader for those working in hematology, I'm supportive of that.

CHAIRWOMAN KEELS: Yeah, we do want to be as broad as possible.

MEMBER ZAMUDIO: This is Michelle. So --

MEMBER SIEVERS: So are we still suggesting that we add the board-certified oncology hematology physician in (b)? I think the rationale behind that was so for like our pain team folks, for example, they're a lot of times collaborating with those physicians in that division, not necessarily their pain folks because they're trying to work with what works best for the patient so they have that relationship with those physicians as well.

MS. FISCHER: I mean I think that makes sense.

MEMBER ZAMUDIO: This is Michelle. So is there anything wrong with the word "or"? Can it just be "Oncology or Hematology" and that keeps it open for both. I mean is that an option?

MS. FISCHER: Well, it is "or" now. It says "Oncology; or Hematology." So moving the word up one level probably doesn't make any difference.

MEMBER ZAMUDIO: Okay.

MS. FISCHER: Just out of curiosity, has there been any movement toward a certification in the hematology for APRNs or -- does anyone know?

CHAIRWOMAN KEELS: I don't know that.

MS. FISCHER: Lisa, do you?

MS. EMRICH: No, I have not particularly -- I mean there's a number of even subspecial, you know, like pediatric nurse practitioners who may subspecialization in hematology-type care, for example, but I don't know of a particular immediate subspecialization in hematology. Even the oncology, I believe you have to be an APRN first and then get your certification in oncology.

MS. FISCHER: Okay.

MS. EMRICH: So it's not a direct -- it's not a certification under which we would license someone directly as an APRN, so it's really a subspecialization.

MS. FISCHER: Okay.

CHAIRWOMAN KEELS: I guess I'm good with leaving it so that we don't want to exclude anyone

even though it's not technically accurate.

MS. FISCHER: Yeah, I mean I -- I like to be technically accurate.

CHAIRWOMAN KEELS: I know. It's a struggle.

MS. FISCHER: I'm just a little -- I'm just concerned about going to CSI and saying, "Oh, we're going to get rid of this word." And then "What's your rationale?" And it just seems like I don't want to shoot ourselves in the foot by doing this.

MEMBER ZAMUDIO: Yeah.

MS. FISCHER: If I can come up with another way to word it where the hematology is separately stated as the other ones require national certification but the hematology is based on coursework leading to certification in oncology or something like that, I can talk to Lisa, you know, after the meeting and maybe we can come up with something like that before the Board meeting.

CHAIRWOMAN KEELS: Okay. Just to be a little more technically accurate but keep it included.

MS. FISCHER: Yeah. Right, right.

CHAIRWOMAN KEELS: Okay. I'm good with

that. Everybody okay with that? Okay. We're good.

Michelle, you had a -- you had a comment about 10, if Holly is done with 10.

MS. FISCHER: Yeah.

MEMBER ZAMUDIO: Yes. And it's nothing that probably pertaining to what we were just discussing but I brought it up a few meetings ago. It seems like a good opportunity to put something in here. So 4723-9-10, under (N), it states that we "shall not prescribe any drug or device to perform or knowingly induce an abortion."

MS. FISCHER: Uh-huh.

MEMBER ZAMUDIO: And for those of us obstetrics it would be very helpful to make that clear by referencing the rule regarding the definition. Either to put the definition in there or to reference the rule 2919.11 where the law defines what an abortion is. That's simply because some of the medications cross over between these two events of labor and abortion.

So I think -- I get the intent of the law and I think to clarify that we could add "As defined in 2919.11" just to the existing rule.

So either spell it out because it says in 2919.11, it says the purposeful termination of a

human pregnancy with an intent other than to produce a live birth or to remove a dead fetus or embryo.

So I realize the word "abortion" can be inflammatory but in this case this is just simply to be adding those two things together so that the reader, who is looking at 9-10(N), would have a reference as to what the law says that that is.

So it says the word "abortion," I would like to just add the word "In accordance with" or "As defined by ORC 2919."

MS. EMRICH: So just a point and this is purely on my -- the definition that you just referred to, Michelle, --

MEMBER ZAMUDIO: Uh-huh, yes.

MS. EMRICH: -- it includes removal of, quote, a dead fetus or tissue as well? Because I'm thinking the published AG Opinion differentiates a living -- a live -- terminating a live birth from tissue that is no longer developing or is dead, it's not living.

MEMBER ZAMUDIO: Correct. So the current definition does include that. It says, and I'm just reading from 2919.11, it's a definition and it's for "abortion" and it says the purposeful termination of a human pregnancy with an intent other than to

produce a live birth or to remove a dead fetus or embryo. So that --

MS. EMRICH: Oh, okay.

MEMBER ZAMUDIO: Yeah, I just -- to make it clear when people read under 9-10, it says the APRN "shall not prescribe any drug or device," there are devices as well, "to perform or knowingly induce an abortion." And I'm asking that we add clarification to reference 2919; the definition of an abortion, legally, in Ohio.

MS. FISCHER: I mean the definition in 2919, which is in the penal code, applies to the Revised Code of which 4723.488 is a part.

MEMBER ZAMUDIO: Right.

MS. FISCHER: So basically that is saying that, for purposes of the Nursing Board Practice Act, this is the definition that applies. So if you think it would help nurses to be cross-referenced there, I don't see that that's problematic. I mean --

MEMBER ZAMUDIO: I think it would be helpful.

MS. FISCHER: -- you're just cross-referencing existing law, really.

MEMBER ZAMUDIO: It is or even just maybe listing it under "Definitions." I just think this is

always an area people begin to get uncomfortable, so I think saying here is the legal definition and this is what we, as APRNs, follow and that is the 2919. So if we either put it under "Definitions" or cross-reference it, I just think that would be helpful for clarity.

CHAIRWOMAN KEELS: Any comments from the Committee or staff? Are we okay with that? I'm okay with it.

MEMBER SIEVERS: I'm good.

MEMBER DIPIAZZA: I think it's acceptable.

CHAIRWOMAN KEELS: Okay.

MEMBER ZAMUDIO: Thank you.

CHAIRWOMAN KEELS: Thanks, Michelle.

MS. FISCHER: Anything else on 9-10? I think I went through everything.

Okay. Moving on to 9-11. There were no changes.

Rule 9-12, I don't think there were any changes.

CHAIRWOMAN KEELS: Except on (H).

MS. FISCHER: On 9-12?

CHAIRWOMAN KEELS: Hey, Holly?

MS. FISCHER: Yes.

CHAIRWOMAN KEELS: There was one. Removal of "their collaborating physician" to "a physician" --

MS. FISCHER: Oh, sorry.

CHAIRWOMAN KEELS: "prior to personally prescribing a reported drug."

MS. FISCHER: Are you on 9-12 or 9-11?

CHAIRWOMAN KEELS: Oh, gosh, I'm sorry. I'm on 9-12.

MS. FISCHER: 9-12. Okay. So on 9-12. Yeah, on 9-12(H), on that one this just kind of puzzles me because, you know, if you think that there's a diversion situation and there's red flags, I would think you'd want to consult with your collaborating physician rather than just some other physician in general, but I'm not sure, there wasn't a rationale provided for this change so I wasn't sure, you know, what it is that it's -- that we're trying to address there.

CHAIRWOMAN KEELS: I wonder if it goes back to you really only need to have one physician sign your Standard Care Arrangement. So does this paragraph as it reads "shall first consult with their collaborating physician," does that mean you need to consult with the physician that actually signed your

collaborating physician -- your Standard Care Arrangement or any one of the physicians that you're working with today? I think that's what their concern is.

MS. EMRICH: This is your collaborating physician. And if you have a Standard Care Arrangement with a collaborating -- any physician with whom you have a Standard Care Arrangement is your collaborating physician.

CHAIRWOMAN KEELS: Right. But if you work with a group of physicians in a clinic and you only have one of the physicians sign a Standard Care Arrangement in lieu of a designated legally-executed document, does this paragraph now mean I'm not -- that physician is not even on today, the physician that signed my Standard Care Arrangement, so does that mean I need to consult with that physician who is not working today but who signed my Standard Care Arrangement, rather than this other docs -- this other team of docs that I'm working with today that did not sign a Standard Care Arrangement or a delegated signature but whom I work with?

Pam.

MEMBER BOLTON: My understanding is if you have that letter of designee, then --

CHAIRWOMAN KEELS: Right. If you have that.

MEMBER BOLTON: -- they are your collaborative physician. They may not be the signature, the sole signature on your SCA, but they're still your collaborative, right?

CHAIRWOMAN KEELS: Right. If you do the designated signature. But if the State only requires a Standard Care Arrangement with a collaborating physician but you also work with other physicians in the same setting, it kind of gets back to our first conversation on, you know, I just really need, if I'm working in a clinic, in a practice, do I only need the one physician's signature or do I really need a designated signature to capture all of these other physicians, right?

If you have a designated signature then I guess, to Anita's point, you're covered either way, you don't have to worry about it, because they're all on your collaborating physician list. A physician has, you know, been designated through the paperwork that he or she may sign the Standard Care Arrangement.

But if the State only requires a Standard Care Arrangement with a collaborating physician but

you can work with other physicians, what if you're on night call and you don't have this SCA with that person and this is happening? So I think that might be where this required change is coming from.

MS. DIPASQUALE: Erin. This is Anita DiPasquale. I just want to jump in for a quick second to read the rest of that. And I do not have a strong opinion one way or the other on the change but I do want to note it's not an immediate consultation with the collaborating physician. It's "prior to personally furnishing," dah-dah-dah, "at the patient's next visit."

So it doesn't mean, you know, you have to call that physician who is your collaborating physician but who isn't on site that day. It just means at some point prior to the patient's next visit.

But, again, I don't -- I just want to point that out but I'm not commenting on whether the change should occur or not; I'll leave that to all of you.

CHAIRWOMAN KEELS: Yeah, and I don't know how burdensome this current rule is in practice.

MEMBER ZAMUDIO: Erin, this is Michelle Zamudio. So the one thing I keep thinking about

because I work in a primary care setting is perhaps the intent is that you wouldn't -- you could notify your collaborating physician but you might want to notify that person's primary care provider. They're not on your SCA, right?

So there are other physicians that you would notify and that you might work with. You can't have an SCA with everyone. So you might want to call that person's primary care provider, their family doctor and say, hey, these are the red flags I've seen, et cetera. They're not on your SCA but you would want to notify them. So I think if it's specific to notifying only person, that's going to be a problem in real practice.

CHAIRWOMAN KEELS: Thanks, Michelle.

MS. FISCHER: Well, this one is not a notification, it's a consultation --

MEMBER ZAMUDIO: Right.

MS. FISCHER: -- which is a little different but it sounds like most of you are saying that it's -- it's acceptable to you to delete "collaborating physician" and just say "physician."

CHAIRWOMAN KEELS: I think it's more broad.

MS. FISCHER: Okay. All right.

CHAIRWOMAN KEELS: Okay. Thank you.

MS. FISCHER: All right. And I don't believe there was anything in 9-13, Rule 9-13, other than this whole "designation" wording and, you know, I kind of went over that.

In paragraph (B), I'm on Rule 9-13, paragraph (B), you know, it says their suggestion is an Advanced Practice Registered Nurse, who has designations as CNS, CNM or CNP, may provide MAT. So really we're -- they're using "designations" in place of "licenses." Really what we're talking about is you hold a license as a CNS, a license as a CNP.

I think the word "designations" here, it's not wrong but it's kind of a little misleading because a designation is not a license. You have a license and you're designated as.

I don't know why, when the legislature came up with the new licensure statute, they picked the word "designation" but that's what they did, but I don't want, as time goes by, people to start thinking, "Oh, I've got a designation. I don't have an APRN license. I have an APRN designation." It's a subtle thing. I just wonder, as time goes by, if it might cause confusion. So I'm not sure about the change in (B) because of that reason. And then the

same thing you'll see in paragraph (C).

So, I mean, I don't have a big problem with it. I'm just a little concerned that as -- we've had experiences going through the years with the Nursing Board that people thought that if you had a certification that's not a license, you had the word "certification." If you're a dialysis technician, you have a certification, you don't have a license.

Really, here, now we're adding another word, a "designation." Really, it's just a license. So it's a small point but little points can sometimes bourgeon and become bigger points later. I don't know if anybody has strong opinions on that.

CHAIRWOMAN KEELS: My opinion would be to be very consistent through the entire Nurse Practice Act and call it a license --

MS. FISCHER: Yeah.

MEMBER DIPIAZZA: I agree.

CHAIRWOMAN KEELS: -- and, you know, get rid of the word "specialty," but maybe one baby step at a time. Are we able to do that, get rid of the word "designation" and use "license"?

MS. FISCHER: Well, I mean, that's what it is, it's a license. It's just here, instead of

saying that you hold a current, valid license, they're saying you hold a designation.

CHAIRWOMAN KEELS: Yeah.

MS. FISCHER: Okay?

CHAIRWOMAN KEELS: I mean that's consistent through the entire Chapter 8 and 9.

MS. FISCHER: Right. I think sometimes when they add the word "designation" it's not as problematic. I think here in paragraph (B) and a couple of the other paragraphs, I think you're trying to replace the word "license" with the word "designation" and I just see that going down a little bit of a slippery slope as time goes on.

CHAIRWOMAN KEELS: No, I agree, we're on that slippery slope. We're already there. I -- I mean, again, I would love to call it what it is which is a license.

MS. FISCHER: All right. If we're okay with that, I'd recommend that we just stick with "current valid license" instead of trying to incorporate a new word.

CHAIRWOMAN KEELS: But would we use that throughout Chapters 8 and 9 and go and change all the words "designation" to "license"?

MS. FISCHER: Most of it already is

"license." I think it's just that the Association is inserting the word "designation" in place of "license" at certain points and so I would recommend not going in that direction.

CHAIRWOMAN KEELS: I recommend trying to make it as clear as possible.

MS. FISCHER: Okay.

CHAIRWOMAN KEELS: What does everybody else think?

MEMBER BOLTON: This is Pam. I would agree. Just looking -- I just looked up the definitions of "license" versus "designation" and they really, you know, "license" makes it more clear. You have to have certain stipulations in order to be granted that privilege of acting in that role, so I like "license" better.

MS. FISCHER: Okay.

MEMBER DIPIAZZA: It's consistent with what we know.

CHAIRWOMAN KEELS: Everybody else okay? So we will change "designation" throughout 8 and 9 to the word "license"?

MS. FISCHER: We won't add "designation" as suggested.

CHAIRWOMAN KEELS: Oh.

MS. FISCHER: 8 and 9 already say "license." Their suggestion is to change it to "designation."

CHAIRWOMAN KEELS: Oh. OAAPN is requesting that. I see, I see.

MS. FISCHER: Yes.

CHAIRWOMAN KEELS: Okay.

MEMBER SIEVERS: This is Sherri. I just had one question. So are the -- I only know my license but -- and I would have to go to e-license to recall what it says but are there different licenses? I mean, does it say APRN or does it just say -- or does it specifically say CNS, CNP? Are they different? They are specific?

MS. EMRICH: It's -- your -- it says APRN CNP, CNS, CRNA or nurse anesthetist. It gives it on your license lookup.

MEMBER SIEVERS: Okay. So their license would be specific.

MS. EMRICH: Uh-huh.

MEMBER SIEVERS: Okay.

MS. EMRICH: Yeah. A person can hold more than one designation of an APRN license but you have to get two separate licenses.

MEMBER SIEVERS: Okay.

MS. EMRICH: So somebody could be a CNP and a CRNA but those are two separate licenses.

MS. FISCHER: So, in other words, when you look at the comments that we received, in some places where they're adding the words "designated as" I think it's appropriate because the wording is, you know, an APRN designated as a CNM or CNP, et cetera.

But in this instance here they're saying that they hold designations as, so they're really substituting, they're taking out the word "license" and putting in the word "designation" and that's where I think it gets a little tricky.

So I would go through and at some points I would recommend using "designation" but at other points, like in this rule, I would say no, we don't want to go down that road for the reasons that we've discussed, so.

MEMBER ZAMUDIO: Holly, I have a comment.

MS. FISCHER: Yeah, Michelle.

MEMBER ZAMUDIO: So we -- so I'm licensed as an APRN.

MS. FISCHER: Yes.

MEMBER ZAMUDIO: I'm not licensed -- I'm not technically licensed as a CNM, right?

MS. FISCHER: You're --

MEMBER ZAMUDIO: It's a license.

MS. FISCHER: You're licensed as an APRN designated as.

MEMBER ZAMUDIO: Right.

MS. FISCHER: So the designation isn't like a subtype of. You have an APRN license designated as a CNP.

MEMBER ZAMUDIO: So would it be clear to put in there a licensed APRN, designated as CNM, CNP, et cetera?

MEMBER SIEVERS: Or say licensed designation. Just put "license" before "designation" because that's really what it is. It's a licensed designation as, right?

MS. FISCHER: I think that would work too.

MEMBER SIEVERS: And then you could kind of leave it as it is but just clarifying license designation.

MEMBER ZAMUDIO: Uh-huh, right.

MEMBER SIEVERS: Just a thought.

MS. FISCHER: "Licensed designated as" would be a proper way to describe it.

CHAIRWOMAN KEELS: Okay.

MS. FISCHER: Okay. That sounds good.

CHAIRWOMAN KEELS: Thanks, everyone.

MS. FISCHER: So that was our last rule, I believe.

Anything else? I think I understand your marching orders and what I will do is do a memo for the Board members that lists your recommendations based on the comments received. And then the Board will meet July 22nd and 23rd and review everything.

And then the next step would be to take the language and file it with CSI. Once it's approved by CSI, then we would have a public rules hearing at the November Board meeting and then we would final file the rules in December. So that's the rest of the process for the year.

Any questions about that process or anything? All right. Well, thank you all for your patience. I appreciate it.

CHAIRWOMAN KEELS: Thanks, Holly. We really appreciate your time.

MS. EMRICH: Thank you, Holly, very much.

CHAIRWOMAN KEELS: Nice work, everyone. Okay. So on our agenda we were to break for lunch at 11:30. We also have Tom Dilling in the wings to give us the Legislative Report.

Tom, can I move CRNAs and COVID and the

Legislative Report to after lunch?

MR. DILLING: Sure. You can do whatever you wish. Whatever is best for the Committee.

CHAIRWOMAN KEELS: Does everyone want to take a break now or did you want to go through legislative updates first?

MEMBER ZAMUDIO: I'm okay proceeding if everyone else is.

CHAIRWOMAN KEELS: I'm sorry, you're okay with what?

MEMBER ZAMUDIO: With getting the legislative update done now if that would be helpful.

MEMBER GRAHAM: Same here.

CHAIRWOMAN KEELS: Okay. Why don't we proceed then. Tom, if you want to merge those two topics together, the update on COVID-19 and CRNAs as well as the Legislative Report.

MR. DILLING: Sure. I guess they kind of go hand in hand to some degree in the sense that 197 had both of those as part of the bill. And in my memorandum to you, dated June 29th, there's a section on 197, and I tried to be reflective of the information that we've already placed out on the website for our licensees and also the inclusion of a summary of the CRNA practice that was approved and

authorized through House Bill 197.

You'll recall that there were separate bills in both the House and the Legislature on House Bill 224 being the primary that included the CRNA language. Because of the COVID-19 and the fact that it had been extensively discussed in committee, House Bill 224, the legislature rolled that language into 197.

I think that my summary is reflective, too, of the language that's in the LSC summary for the most part. I hope that it gives a thorough overview. I don't know if it's necessary to go step by step through that, but it, you know, in essence, we talked about it before.

It clarifies that now there is certain prescribing that a CRNA is able to do during certain time periods within the facility and they are able to designate RN, LPN -- or RN and respiratory care therapy LPNs to do certain things, including administering meds if they are so authorized to do that.

So, I don't know, that's a long time coming, so we're happy that the CRNAs and everyone else has moved forward with respect to that.

197 also had some language for these

temporary nursing licenses for applicants who had recently graduated but not yet taken the NCLEX. They are able to get this temporary licensure during the State of Emergency if they've met all of the other requirements of graduation in their education.

I think that was done in part because of the fact they had closed down NCLEX exam for some period of time, people were unaware of how long that would be, as well as there was this expectation that the hospitals were going to be overrun perhaps at the beginning.

Now, both of those don't seem to be true today in the sense that, bless us, we haven't been overrun to the extent that there was concern that we would be. And also the NCLEX testing, I believe within the next couple of weeks, should be back to full testing. They are partially testing here in Ohio but the numbers that I have seen in my job AND in my role here, when we're helping people out, seem to be within a couple weeks, so everything seems to be flowing well from the COVID point of view and the recent grads.

So this will come into play later in House Bill 673 which is, I think, about the fourth page of the memorandum that I distributed, and 673

was a more broadly-worded bill that had to do with some practices of other professions, had to do with some education issues, some professional education, continuing education issues and so forth.

And then part of 673 was to give a date certain to when this temporary-licensure exception would lapse. And instead of tying it to the State of Emergency, the legislation, which has passed the House but not yet been heard in the Senate, designates I think July 1st of 2021 as the outer date of the temporary licensure and with that there was also a paragraph that stated that the Board would recognize any hours that these temporary licensees would gather during their -- during their work under that temporary license and it would count towards any outstanding clinical hours required to take the NCLEX exam.

That may all sound well and good but in order to get this license you have to have graduated from the school and you have to have already taken your clinical education hours. So for us to recognize those hours, there is no reason that we can see or think of as to why you would need to do that. And we didn't really good get a good response from the legislature as to why that remains in there.

Hopefully, over in the Senate, people will look at this again and, you know, kind of rethink the necessity of that language.

We also questioned, under the background of the NCLEX licensing exam being so integral to the licensure process, it's a core foundation of that license, why would the legislature extend that date right now under the circumstances? Why wouldn't they allow it to, at the very least, be tied to the State of Emergency.

And, you know, they seem to tie it back to traditional graduation dates for certain schools. And while we testified as an interested party, the OA -- the ONA ended up testifying as an opponent.

And there was some language that was added on the floor in the House to clarify that, at the very least, persons who had already attempted to take the NCLEX and failed would not be eligible for temporary licensure, and then those who had obtained the temporary licensure but subsequently failed that examination, would lose the authorization to have this special temporary permit.

That passed on the House floor. That seemed to be some type of political middle ground to keeping the present language versus clarifying,

which, you know, seems to be an order as well, and then you still have that outer date there.

So, suffice it to say, I wanted to make sure that you and then the Board coming up in July was aware of this discussion and we'll see how that moves forward. You could go on to the State's website and gather copies of different testimonies with respect to those issues if you so choose.

Flipping back, I guess, to 177, the Standard Care Arrangements bill for the APRNs. There was discussions that I heard, people may be aware of, where it was supposedly imminent that another sub-version of 177 was going to be introduced in Committee. That has not happened.

I'm guessing from what I've heard and I'm just telling you through-the-grapevine stuff is that it was maybe COVID-related and they were -- the proponents of that bill were going to try to tie in the language saying that we shouldn't have the Standard Care Arrangement requirement in whatever degree during these COVID emergency times.

But, again, that has not happened to my knowledge and I had made some inquiries of the OAAPN but I am waiting to hear back yet from them, hopefully I will prior to the July Board meeting, but

we won't worry about what's not happened and just, again, work from an awareness point of view.

Also I wanted to make you aware of House Bill 611. This would establish a doula, the State doula registry within the Department of Medicaid and basically start reimbursing for doula services as far as, you know, Medicaid is concerned.

You know, doulas are not licensed, per se. This bill would establish a registry. I think the argument could be made that a doula could obtain, perhaps, a certification as a community health worker. I think some doulas might associate themselves with a community health worker. I've not yet delved that far into it to try to contact people within the community health worker realm, not because I don't think it's important but at the same time just in terms of lots of things going on and so forth, I haven't quite got to that yet.

But I think it's interesting. The doulas work with the certified nurse-midwives. I certainly wanted to make Michelle aware of it if she hadn't already been, but they've made some amendments in Committee, it's been heard a couple of times, so certainly someone seems to be -- in the legislature seems to be taking it seriously in terms of it being

an issue that may in fact move.

Senate Bill 303 is kind of an interesting one too. I'll bounce to that next. I think that's on page 4 as well, right above 673.

The rules -- the Pharmacy Board changed their guidance in terms of the pharmacist consult agreements and kind of broadened the ability of APRNs to utilize these consult agreements during the COVID period and the Board was supportive of that.

And then right after the Pharmacy Board did that, a bill was introduced and the bill basically said, hey, why can't an APRN or why shouldn't they just directly be a part of these pharmacist consult agreements, not limited to the physician themselves, tied in through the collaborative agreement, I think.

And boom. Within one hearing, I think, it gets taken to the floor of the Senate and taken out of the Senate and sent over -- approved and sent over to the House where then it proceeded to sit for several weeks and not be heard.

So while all that was happening, other bills, of course, become potential vehicles, as did 197 for 224 and the CRNAs, and this language was amended into House Bill 203, the Mobile Dental

Facilities Bill that seemed to be moving. And that, I think, got out of Committee with the 303 consult agreement language for the APRNs but I think that's where it stands right now.

In terms of timing overview, it seems for the most part the legislature has gone home for the summer because we have important elections coming up and they tend to take that summer break. So whether or not these bills are heard and voted upon prior to the fall when they return, it looks like they may not but they're certainly poised in a position to move rapidly if and when the schedule changes and they come back, you know, to deal with that.

I also, in the last Legislative Update to the Board, pointed out the recent introduction of House Bill 679. No, I'm sorry. Senate Bill 305, which talked about telemedicine during the emergency, because during these COVID times here we're on these Teams meetings, telehealth has taken off and there's a lot of momentum right now for making greater changes to the use of telehealth within facilities' individual practitioners.

Of course changes need to be made for reimbursement; that always slows things or it seems to, but, again, capitalizing on this momentum, House

Bill 679 was introduced shortly thereafter and had several hearings and was passed by the House at the beginning of June.

So, you know, clearly this is on the radar, people are talking. Again, when you start getting into the individual issues, maybe things slow just a bit but a lot of momentum riding on telehealth and 679 looks like the bill to follow and, you know, continue to take a look at.

In terms of bills that I had not yet placed into this memorandum but will prior to the Board meeting in July and so if people are interested out there about picking up, you know, further summaries and where the Board is on certain bills, wait for that July Board Member memo to come out, it will be posted and then I think we can have the memorandum sent on directly to the Committee Members, you know, for your information.

In that, I suspect I will have Senate Bill 311 which is the CPG being eliminated through that sunset review committee which I previously had reported to the Board that I testified on behalf of the CPG, and I think we talked about I testified on behalf the APRN Advisory Committee. They were supportive of the APRN Advisory Committee. The

Committee seemed to be supportive as well of that.

But picking up on the request of, I think, everybody, Board or Committee members for the CPG probably in the lead, stating that really there was nothing to be gained any more through that continuation of the CPG, there's other routes to making necessary changes, through this APRN Advisory Committee, through the Board, through the rulemaking process and so forth.

So it looks like it's been introduced, it's gaining some momentum. I talked with the sponsor and the chair, she is still gung-ho, wants to help out up there, so that's a good thing, I believe. If somebody has an issue or questions about it, certainly please feel free to contact me.

There is a House Bill 606 that would grant civil immunity to licensees during this COVID period of time. It does a lot more than that. It's more oriented towards businesses and lots of other professions but, you know, healthcare certainly is important and it's included as well. I don't have a summary as of yet of that.

That changed somewhat from the House over to the Senate. It started to gain some momentum. It looks like it didn't quite make it through. There

was proponent and opponent testimony on some of those other issues. I didn't think it was centered on healthcare, per se, but we'll see if, you know, because that's an important COVID issue so it could pop back at any point in time, I guess, if people feel the necessity to pass that into law but that's another good bill to take a look at.

I'm sure there a couple others that just recently got introduced that I missed here today but, again, will pick up here in the next couple of days.

I'm open to your questions here with respect to this report, with respect to the CRNAs and COVID-19, if you wish, but I think Anita and Lisa can also pick up on that because they have done some great work in terms of their communications, their FAQs and some of the summary language that they put into play for those documents because it did become law on March 27th and we've received some questions but I think, too, people changing their systems within practices, within facilities, really hasn't allowed us to see those changes as much in action or funnel back to the Board as of yet.

I've talked to the CRNAs' association, I reached out to them and said please let's keep each other informed of questions and so forth and, you

know, they've been great about that and perhaps we'll hear back more before the Board meeting in July.

MEMBER ZAMUDIO: Tom?

MR. DILLING: Yes.

MEMBER ZAMUDIO: Hi. Thank you so much for that. That was a really good review.

We're very excited about House Bill 611, very happy about it. Just to clarify for those of you who aren't familiar with doulas. They are trained birth attendants so they don't do any examinations or care for the patient. They actually will sometimes begin even at the house with the patient and it's like a very well-educated, good friend with you during the birth.

We have strong literature on improving outcomes not only by using nurse-midwives but with doulas as well. There's a strong push right now in the United States to try to improve our abysmal maternal mortality rate particularly among underserved populations as well. This bill will address that by having Medicaid reimburse for doulas.

Right now I work with doulas frequently but it's the patients who are of means and who are financially viable who can afford a doula.

The doulas also act as an advocate for

them so they are acting in our stead when they're interviewing with our providers. They come to appointments sometimes at my office so we can meet prior to labor.

They even go to the woman's house postpartum. There are postpartum doulas who will do their dishes, rock their baby while they take a shower and help during that time and we've seen less postpartum depression even by using a doula.

So looking at those outcomes, we're hoping those same benefits will now be available to women who are covered by Medicaid insurance. So we're excited about that bill.

MR. DILLING: Great. Thank you for saying that, Michelle. I've had friends who've used doulas as well and, you know, been very supportive of that.

They've been around for a long time, right, but I think that it's critical, especially in Ohio with these numbers being really bad, that we've had a lot of committee work being done within the legislature, within healthcare organizations and so forth, recognizing the tie-in and the need to, you know, to have people like this involved, so, yes, certainly a lot of momentum is built on the back of

that and the necessity to improve those numbers, so I'm glad everybody is -- has seen it and it seems like people are supportive as far as I can see.

I would be remiss too -- that reminded me, too, of a couple other things. One is the SC14 which is a resolution talking about racism as being a part of public health concern here and that had some testimony and will have further hearings and further, I guess, meetings around the state as well. And there is this tie-in, too, with what Michelle was just talking about in terms of the numbers and so forth. I will report on that, too, in the upcoming memorandum.

The other thing that's tied to legislation but is projected into the near future, sometime this year I believe we will see it, I have been attending, I think Erin may be attending as well, some focus groups, some informational meetings with respect to the practice of advanced practice respiratory care which became a Master's class at OSU starting in January of this year.

And proponents to the practice have basically stated this is to introduce all interested parties to this practice, to what is being taught there at OSU, which is part of a national movement,

as I understand, and they intend to have someone introduce legislation for the advanced practice respiratory care therapist sometime this year.

So I can't really get into all the details because we just had a kind of one week -- or one session overview of about an hour. It was very professionally done. You can Google and find out information from their national association if you're interested today. You can also Google it at Ohio State and see more about that program but it's certainly something that I wish all of you to be aware of.

And I'm sure we will come back to the Advisory Committee, as well as the Board, at a future time to discuss it more in depth with materials that we receive from the Committee and perhaps even some legislative language. To my knowledge none has been released as of yet.

Erin, did you want to add anything to that?

CHAIRWOMAN KEELS: No. Thanks, Tom. I was just in some interested-party discussion within my own organization just about what the curriculum is and how to accommodate clinical hours which is, as everybody knows, pretty challenging right now with

COVID, and then how we would potentially use that type of role within the organization, but to my knowledge I wasn't aware of any legislation yet.

MR. DILLING: Yeah. There was also, I should mention, a tie potentially into the recent CRNA bill, in that language, because there's a more direct supervisory tie, I guess, from the CRNAs who have some expertise in obviously airway management, maybe the most of any APRN, and clinical support functions within hospitals and so forth.

So that is not yet clear to me as to how that all interacts and how each professional interacts with each other's practice but those certainly are questions that hopefully will be answered as we go through this process. I can tell you it didn't come up in House Bill 197 or House Bill 224 in that -- in that CRNA bill itself.

CHAIRWOMAN KEELS: Thanks, Tom.

Does anybody have any questions or comments?

MEMBER BOLTON: Thanks, Tom.

MR. DILLING: You're welcome.

MEMBER ZAMUDIO: Thanks, Tom.

CHAIRWOMAN KEELS: Okay. Well, then I think it's break time if everybody is good with that.

MEMBER GRAHAM: This is Margaret. I just had one question of Tom if that's okay.

CHAIRWOMAN KEELS: Oh. Sorry, Margaret.

MEMBER GRAHAM: That's okay.

So on the doula bill, Tom, did you say that they're looking at making doulas an Ohio community health worker so there's discussion about that for them to be recognized as community health workers?

MR. DILLING: No. I'm sorry. I -- that was more Tom than anybody else. I don't know if anybody recognizes that as, you know, a potential tie-in.

MEMBER GRAHAM: Okay.

MR. DILLING: I mean if you went back and you looked at the community health worker language, there are so many different names for individual community health worker practices.

And as Michelle described, it's not actual -- the activity is not, you know, nursing or, you know, medicine, per se. It's assistive, very important, but more from that education being a caregiver in support of the CNM or the OB, you know, whomever, and that seems to be how community health workers --

MEMBER GRAHAM: Right.

MR. DILLING: -- are utilized. I'll do a little bit more research just because I'm curious about that and the Board regulates the community health worker.

I think the bill, though, is more tied to the desire to recognize this important person in the -- in the system here for their services as far as improving positive birth rate outcomes and so forth and support. From that perspective I think it helps them to be registered by the Department of Medicaid, to be recognized by a reimburser like Medicaid and, as Michelle said, you know, like friends of mine who might be in a better position to hire that doula versus somebody who is on Medicaid and can really also utilize those services and be helped from that. So hopefully that clarifies it.

MEMBER GRAHAM: Thank you. I just, I think the doulas are so important to be recognized by Medicaid, and I thought if it would help them to become CHWs or to work those together, I think that would be something that would be worth exploring, you know, if that would help the doulas be recognized because it looks a lot like their training time is similar just looking at the bill that you -- or the

briefing that you gave us from the bill.

MR. DILLING: Yes. You know, I should add, because of COVID, we had to postpone a session with the Board about community health workers and we were going to delve into that further, so that will occur I believe sometime here in 2020.

And, you know, it's a very different statute, the community health workers, because there's benefits to the fact that you don't have to be certified as a community health worker, to practice in Ohio as a community health worker. So they can practice without that but, yet, it's beneficial for some to, in fact, be certified. And this might tie in with the ability to get grants for facilities and others to use their services.

So if that would be helpful to doulas or anyone in the future, that may be a possibility, and that doesn't preclude the registry itself so I don't see them as competing with one another. I just wanted to point out this fact that the community health worker certification is not required, you know, to practice as a community health worker.

CHAIRWOMAN KEELS: Thanks, Tom.

MR. DILLING: Sure. You're welcome.

CHAIRWOMAN KEELS: Any other questions,

concerns, comments?

Okay. So let's take a break. Would you like to meet back at 12:45 or 1:00 p.m. or somewhere in between? Anybody have a strong opinion? Is 25 minutes enough time for everyone to take a break and grab something? Okay.

So Lisa suggested that you not actually leave the meeting but that you just go ahead and mute your microphone and turn off your camera so you can, you know, have peace, so that you don't have to log back in.

I, myself, my computer is going to shut me down, so I have to restart, so hopefully I have no trouble getting back in. I will see you all at 12:45.

(At 12:20 p.m. a lunch recess was taken until 12:45 p.m.)

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CHAIRWOMAN KEELS: Okay. Everybody is back? All right. So let's get restarted and, of course, I need to go find my agenda.

So, okay, there we go.

Next on our agenda is a review of the Draft APRN Summary/FAQ Document. All of us on the Committee that have been here, and I think, Margaret,

I'm going to include you because you came in and provided testimony, are familiar with this journey.

We started out with some questions in 2016 about some practice and scope-of-practice questions and, combined with the monthly questions the Board receives, felt it was necessary for the Board to help make more clear the rules and statutes in Ohio that govern APRN practice.

We heard loud and clear that more rules were not desired. In fact, even today we're trying to make those as general as possible. So then we were starting down the route of an interpretive guideline which raised some concern around the title of that and its intent. So then we sort of moved on to this helpful document to help sort of clarify some of the Board language, provide links to some important areas, and answer some FAQs that are fairly common to the Board.

And so I want to -- once again thanks to Lisa and her staff who do a lot of work on this and have continued to work on this, so I appreciate your work very much.

And with that I think I'll leave it open on general comments, concerns, or questions, and then we can probably go maybe even page by page if we have

some specifics.

Lisa, do you want to add anything else? I'm sorry.

MS. EMRICH: Yeah, sure. Thank you, Erin. And thanks to Anita, who worked on this, and others at the Board.

I do want to bring your attention, earlier this morning you were distributed Tom's comments or recommendations about this and it pertains to page 3. And so, just when we get to that point, the language for the CRNA scope of practice is fairly new with the House Bill 197 so we had to -- we needed to adjust this and put that in there.

Tom suggested that we track even further the language that's in that statute. So when we get to page 3, we will likely switch over to Tom's version of that particular section is all. So that's my only comment there, so.

CHAIRWOMAN KEELS: Thanks, Lisa. And that was received this morning --

MS. EMRICH: This morning.

CHAIRWOMAN KEELS: -- by us, right?

MS. EMRICH: Right, right.

CHAIRWOMAN KEELS: Because somebody was up and couldn't sleep last night.

(Laughter.)

CHAIRWOMAN KEELS: Okay. In general, any comments or do we just want to kind of go page by page? Page by page? Okay. All right.

So we first start out with just the intent of the document that this does not provide or establish any new rules, this tries to provide clarification.

We talk a little bit about the APRN Consensus Model. We didn't want this document to be about the Consensus Model. We wanted it to just provide a little context and then -- and I don't know why I'm saying "we," Lisa, because it's you doing all the work.

MS. EMRICH: Oh, sure. And, Erin, if I may?

CHAIRWOMAN KEELS: Sure.

MS. EMRICH: This is Lisa again. You know, we rewrote this, we rephrased this particular paragraph about the APRN Consensus Model to more broadly state what it is, so you might see that it's a little more broadly worded --

CHAIRWOMAN KEELS: It is --

MS. EMRICH: -- than the last one was.

CHAIRWOMAN KEELS: It is.

And the words in blue that are in parentheses, that will be a link to the NCSBN website? Okay.

And then we go down to some definitions and we start with my favorite word "designations" and then "nursing specialty," "the practice of nursing" and "APRN licensure." Any concerns or questions or comments around those areas?

MEMBER GRAHAM: This is Margaret. The question I have is where it's bold "in practice" under "Definitions."

CHAIRWOMAN KEELS: Uh-huh.

MEMBER GRAHAM: So they're designated, right, as CRNAs or clinical nurse specialists or nurse-midwives? So "to mean a specialty in practice" --

MS. EMRICH: Uh-huh.

MEMBER GRAHAM: So I guess the first question I have is I wondered why "in practice" is bolded and, second, how is that definition different than a designation as one of the -- one of the four designations?

MS. EMRICH: Thank you, Margaret. So under -- so the definitions, the only definitions we've provided here are "Nursing specialty" and

"Practice of nursing as an advanced practice registered nurse." Above that is the designations of APRNs in Ohio. So we did talk about the Nurse Practice Act recognizes four designations of APRNs which are the four types.

Then we come into definitions and these definitions are in both statute and rule and they mirror each other. So "nursing specialty" is a specialty in practice. And this definition has always been there but I think persons have missed the idea that nursing specialty is about your specialization in your practice.

So as a CNP, for example, you have a specialty in your practice and that specialty may be as a family nurse practitioner or whatever your national certification is, that is your specialty in your practice or how you may do that. So "in practice" is bolded to emphasize that. It's not -- it's specialty in practice as. It's a specialty in practice as a certified -- as a CRNA or as a CNS or as a CNM.

CHAIRWOMAN KEELS: Do we want to make it more clear that the nursing specialty in Ohio actually refers to your national certification? I think you've tried to do that on the next page.

MS. EMRICH: Yeah, we sort of tried to link the words as we went through. If you want it up front, we could.

CHAIRWOMAN KEELS: I feel like if we're going to have an area for definitions, this is the opportunity to be clear about that, what a designation means and what a specialty means as far as Ohio goes.

MS. DIPASQUALE: Erin, this is Anita. I just would like to jump in. I just wanted to point out that the .01(V) language that we're talking about is in statute; so, yes, something can be added to the page or moved up or emphasized but just any change in .01(V) would require a change in law not just rule.

CHAIRWOMAN KEELS: Okay. Yeah. Maybe not change it but add an additional sentence there that, in Ohio, the word "specialty" equates to your national certification.

MEMBER SIEVERS: I think that would help because I think this is confusing as is.

MEMBER ZAMUDIO: This is Michelle. So I have a question about the first page under APRN Consensus Model. I remember all of that and so I am very grateful for all of this being in one place, thank you, this is awesome.

I'm not sure about the very last sentence. This is just a question. Where it says "The APRN Consensus Model includes certification in one or more specialized areas...." Is that another use of the word "special" that maybe we don't need to have in there?

CHAIRWOMAN KEELS: "...specialized areas of one or more population foci...."?

MEMBER ZAMUDIO: Yeah. Or even "areas" or something because I think throwing in the "specialized areas of population," that's going to take a lot of folks back to where we started the discussion.

So we agree to follow the model, I just think the word "specialized" in that sentence might not be needed.

MS. EMRICH: So can we -- shall we delete the word "specialized"?

MEMBER ZAMUDIO: I would vote yes just from a reader's perspective but maybe didn't know the history.

MEMBER BOLTON: I agree with that.

MEMBER DIPIAZZA: I would agree especially since there's advanced practice specialty certifications out there, exams, in oncology and

ortho and et cetera.

CHAIRWOMAN KEELS: Okay.

MEMBER SIEVERS: I just have one question for the group. I might know the answer but I just want to ask explicitly about this Consensus Model paragraph.

So if the first paragraph says that this is to provide the public an overview of license and practice requirements established in the Nurse Practice Act, I mean do we -- is everybody adamant about leaving in this paragraph about Consensus Model since it is not law or rule?

MEMBER ZAMUDIO: Honestly, on this point, I think it's helpful to have it there and just from somebody who came into this never having heard of the Consensus Model before and not maybe someone who followed laws and rules, I think the everyday person, honestly here, if they're looking at this, might learn something by reading about what is the Consensus Model is and how Ohio does follow the Consensus Model.

It may also be helpful as we progress and realize that there is still components of the Consensus Model that we don't follow yet but it's a sign of hope to say, well, we do follow it, we

recognize it, we hope to achieve it, but if anything it would just be accurate to say we don't follow all the components but this is like our framework, so I kind of like having it there.

MEMBER BOLTON: Well said, Michelle. I agree. This is Pam.

CHAIRWOMAN KEELS: Okay.

MEMBER ZAMUDIO: It's just my opinion. Everybody else -- it's just an opinion.

CHAIRWOMAN KEELS: No, it's okay. Is everybody okay with leaving it there as an FYI?

Okay. Thanks, Sherri.

MEMBER GRAHAM: This is Margaret. I don't know, I mean we do say the APRN Consensus Model and then -- I mean our draft, the title of the draft is "Licensure and Practice in Ohio" and then in the first sentence of that we say it's not an Ohio rule. So we say it's licensure and practice and then our first sentence says this isn't a rule.

I agree with what Michelle said that it's helpful and it's hopeful that, you know, we would like to be on the Consensus Model.

I don't know, if we have a new person moving into Ohio, if it would be helpful to say where we aren't in concert with the Consensus Model at all,

if that would make it any clearer.

I don't think -- I don't think we want for the Consensus Model to cause confusion. I think we would like, I think we aspire certainly to that but I just, you know, if this is what we're going to talk about as far as practice and if a new person moves in and you say, "Well, here's the Consensus Model but in Ohio that's not law or rule," should we state where it isn't? Would that --

MS. EMRICH: One item we -- if I may suggest. We could remove -- this is just a very well defined paragraph, it explains why it's inserted here. We could actually move it to an FAQ and say "I've heard about this Consensus Model. What is it?" And then we can insert the paragraph there.

CHAIRWOMAN KEELS: Yeah.

MEMBER ZAMUDIO: Yeah, that's great.

CHAIRWOMAN KEELS: I like that because I was actually thinking that and you can provide, maybe to Margaret's point, I don't know if you want to put that in the document because you may have to change it over time but how Ohio stacks up. Although there's that state-by-state map.

MEMBER GRAHAM: I think what Lisa said, if it was moved to the FAQs, then I think that would

make perfect sense.

I'm just afraid that it might be somewhat confusing to a person to read this, the first paragraph, when we're saying it's licensure and practice in Ohio but then we say we don't do all of these in Ohio. But I do think, knowing what the Consensus Model is and people wondering where we stand on that, it would be a positive thing, maybe just in a different document.

MS. EMRICH: Yeah. In here where we're talking about the Consensus Model, at this point we're only talking about the licensure part of it and what we require for licensure.

Certainly the Consensus Model really calls for independent practice for APRNs as well so that's, you know, we're not there as far as our current law but, yes, what we're talking about here is mostly alignment of how APRNs are certified and how it's used as licensure as a schematic across all states, so we can move that.

MEMBER ZAMUDIO: So we would move it. This is Michelle. Sorry. So that way it's still there, the reference which I love, so that way people can learn about it, we can provide a link to it, and then we'll take out the word "specialized" at the end

of it?

MS. EMRICH: Uh-huh, yeah, I've already got the "specialized." So move to this an FAQ.

MS. DIPASQUALE: This is Anita. Another thought is in the next-to-last sentence where it says "and the Board agreed, that the APRN Consensus Model would be followed," you could add a phrase such as "as to role and population focus."

MS. EMRICH: Good point.

MS. DIPASQUALE: Something like that because I think that is actually what the discussion was, we had the four roles.

MS. EMRICH: Uh-huh. That are now known as designations.

MS. DIPASQUALE: Designations, annoyingly. So you can add something like that in order to make clear what that discussion was about through the APRN Committee that was then adopted by the Board. I believe that's a fair way to represent it.

MEMBER ZAMUDIO: This is Michelle. Did we agree to only follow the Consensus Model for that, those issues though? Because I think if we say we agree to follow it, that allows us to progress towards following all of it, and I think if we put

into writing only the exclusionary language like we're going to follow these parts, I don't think that would be helpful. I think it's better to leave it broad.

MS. DIPASQUALE: Yeah, I'm just describing something that -- this is Anita again -- something that historically, factually, has already happened. If you read the sentence --

MEMBER ZAMUDIO: Right.

MS. DIPASQUALE: -- it says the APRN Committee discussed and recommended to the Board. And so if we just capture however it is accurately described, what was recommended by the Board a few Board meetings ago.

CHAIRWOMAN KEELS: Yeah. Yeah, we did, we agreed to the Consensus Model as it pertained to role and certification, population focus, certainly.

And then the Board, because the Board can't necessarily be advocates for full practice authority, right, but the Board does support nurses, all nurses to work at the top of their scope and that was, you know, a statement that the Board has on the website now.

So I think to be completely accurate, yeah, the Board supports the licensure piece of it

because that's what the Board is charged to do, right, and then the other piece is, of course, the Board is supportive but can't necessarily impact; is that accurate?

MS. EMRICH: Correct.

CHAIRWOMAN KEELS: I'm okay with either way, either leaving it there with that additional sentence or moving it to an FAQ. I think in an FAQ you could actually expand on it a little bit about what is actually within the Consensus Model, not just licensure but the rest of the elements with the link, and especially the link to the state map that kind of shows where all the states are in their progress.

MEMBER SIEVERS: This is Sherri. I love Lisa's idea to move it to the FAQ. I think it keeps this clean for Ohio and it keeps that out of it so it doesn't get murky.

CHAIRWOMAN KEELS: Okay. I think most people say move it to an FAQ. Michelle, are you all right with that?

MEMBER ZAMUDIO: Oh, definitely. I just didn't want to completely eliminate it.

CHAIRWOMAN KEELS: Yeah.

MEMBER ZAMUDIO: It would be helpful in this future. And I appreciated it when Lisa gave us

the information in the link and I was able to research it and learn about it.

CHAIRWOMAN KEELS: Okay. Great. Any other comments on page 1?

Okay. Let's go to page 2 then. Starting with APRN licensure, working our way down.

MEMBER GRAHAM: This is Margaret. I have a question about the top bullet on page 2. I know that the requirement is an earned master's or doctorate but we still have some people, right, who are practicing under the grandparent law, so I don't know if that needs to be stated there or not.

MS. EMRICH: Well, we have so few now who are -- so when we're talking about those that do not have a master's or doctoral degree, we're talking about grandfathered CNPs who have certification but no graduate degree. There are so few out there and this is -- we look at this more like prospectively to inform persons who are looking towards being a CNP or an APRN.

I -- I -- we chose not to put grandfathered persons in here. We would also be putting in grandfathered CNSs who have a graduate degree but don't have certification. Again, those are few.

CHAIRWOMAN KEELS: Do you want to maybe put a date on there as of two-thousand-and -- well, 2000 and an earned master's degree or doctoral degree with a major, blah, blah, blah, so people knew that it kind of implies that before that date there may have been people --

MS. EMRICH: As of January the 1st, 2001. Is it -- maybe -- I'll get the date.

MEMBER GRAHAM: But then -- then -- I don't want to split hairs here, this is Margaret, but did women's health nurse practitioners, didn't they get to be grandfathered in until 2008 or not?

MS. EMRICH: No, I'm not familiar. The only grandfathered provisions were, as far as getting their initial certificate of authority were CNPs who did not have a graduate degree and then CNSs who did not have certification.

MEMBER GRAHAM: Okay.

MS. EMRICH: And I do go back to what we're doing here is more just summarizing what's in current law and rule. We're not trying to rewrite all the laws and rules as well, so we did have to sort of pick and choose. I still, I defer to you all as far as if you want to put "grandfathered" in there.

CHAIRWOMAN KEELS: I think the date --

MS. EMRICH: I'm just giving you my rationale.

CHAIRWOMAN KEELS: Yeah, no, I mean to Margaret's point, I mean I know I personally have a few grandfathered people. They always feel -- they'll notice that they're excluded. Honestly they will. They'll be like "What about me?"

So having either a little bullet that, you know, very few grandfathered, you know, something about a few folks are still grandfathered, or as of blank date you needed to have --

MS. EMRICH: We could do a footnote. I just thought about that. We could do a footnote.

CHAIRWOMAN KEELS: Okay. Footnote it.

MS. EMRICH: Grandfathered individuals, et cetera.

CHAIRWOMAN KEELS: You know, it may save a few e-mails, a few worries, a few acid indigestions.

MS. EMRICH: Yeah. Okay.

CHAIRWOMAN KEELS: Any other questions or comments on page 2?

MS. EMRICH: So it would be actually two different footnotes because the degree would be

grandfathered CNPs and then the national certification would be grandfathered CNSs.

CHAIRWOMAN KEELS: Okay. Thank you.

Okay. Page 2. This is where Tom has some input as well on CRNA scope of practice.

Okay. You're up, Tom. Oh, you're muted.

MS. EMRICH: You're muted, Tom. Tom, you're muted.

CHAIRWOMAN KEELS: There he is.

MR. DILLING: Am I back?

My apologies for coming in late in the process. I've tried to stay away from this document. Everyone has encouraged me to do so and I've been good up until this point.

The only reason I got involved really is that, you know, being involved in the legislature, it being new legislation, I read through it and it is very difficult, I think, to piece and part out some of the changes that are happening because some of it lines up with what the facilities are doing in their written policies and so forth.

So what I tried to do, instead of referring back in a certain area to the legislation, I thought let's put the language right out of the statute.

So this is not dreamed up language by Tom. This is statutory language that hopefully somebody will read, understand, and I think it flows.

I broke out the clinical support function into a separate dot because it's a separate-dot type of an issue in terms of people who have questions and so forth.

Hopefully somebody reads this and they don't have to write in to Lisa or Anita to have a question answered and they also don't have to go back and necessarily look up other laws. I couldn't do that for everything, obviously, but I think it flows, I think it reads well.

I put in, at the top, .43 along with those other sections because -- well, I did not notice that 43(B) was in there, so that could be taken out. My apologies. I was reading it 43, 433, 434, but, you know, whether or not 4723.43(B) at the end needs to be up front just so that sequentially follows, that might be, you know, a good way to address it.

If anybody has any questions, please feel free to ask but, again, I have not generated my own language here other than to combine aspects of a sentence.

MEMBER ZAMUDIO: Tom, I have a question. This is Michelle.

MR. DILLING: Sure.

MEMBER ZAMUDIO: So because I haven't looked at that piece of legislation yet. When it says with the supervision in the immediate presence of a blank, the CRNA can perform anesthesia. Are the words "immediate presence" also in the rules or in the law?

MS. EMRICH: Yes.

MR. DILLING: Yes, they are.

MEMBER ZAMUDIO: Okay. Do they define "immediate presence"?

MS. EMRICH: No.

MEMBER ZAMUDIO: Okay.

MR. DILLING: No, and no one wants us to.

MEMBER ZAMUDIO: Right. Just that's why I wanted to be sure.

MR. DILLING: Right. Exactly.

MEMBER ZAMUDIO: Thank you.

MS. EMRICH: We've been asked that multiple times over the years.

MR. DILLING: I'll only go so far.

CHAIRWOMAN KEELS: I like the clarification because the rule is so new, it made it

a lot more clear for me. We don't do that for the other pieces of this but this is a new practice change or practice legislation so I was okay with that.

Did anybody else have any concerns? No? Okay. Okay. Anything else on page 3? No?

Thank you, Tom.

MR. DILLING: Thank you.

MEMBER SIEVERS: I do have a question. I do have a question. So -- oh, I'm sorry, my dog is going to bark. It was about the term "evaluation."

CHAIRWOMAN KEELS: Are you on page 3?

MEMBER SIEVERS: Yeah, I'm on page 3. The second bullet, it says immediate presence, anesthesia and perform induction, maintenance, and emergence and may perform with supervision preanesthetic preparation and evaluation. Do they have to be supervised to do an evaluation?

MS. EMRICH: Yes.

MEMBER SIEVERS: They do?

MS. EMRICH: CRNAs are supervised in their evaluation and in their practice.

MS. DIPASQUALE: This is Anita jumping in. I just want to be sure that you're clarifying, Sherri, between immediate supervision and just

general supervision. There are kind of two tiers of supervision and this is not -- and that aspect is not new.

MEMBER SIEVERS: Okay.

MS. EMRICH: Yeah. When they actually -- when they have a patient under and when they're doing the induction and all, they have to be in the immediate presence of the physician, but everything else that they perform is with supervision.

MEMBER SIEVERS: Okay. All right.

CHAIRWOMAN KEELS: Would it be hard to make that -- would it be worth making that distinction somehow? I'm trying to think, I'm trying to look at this.

MEMBER SIEVERS: Well, it does say it, so maybe it's just me not being familiar.

MEMBER ZAMUDIO: Sherri, I agree with you. This is Michelle. I was curious about that, too, because they make post-op rounds on patients, et cetera, the next day.

MEMBER SIEVERS: I think it's going back to the statute definitions of supervision and immediate presence which that's -- but it's fine. Thanks.

CHAIRWOMAN KEELS: Okay.

MEMBER ZAMUDIO: I have a question about page 3. It's Michelle.

CHAIRWOMAN KEELS: Uh-huh.

MEMBER ZAMUDIO: At the very bottom of the page, only because I know it's moving the scope of practice, but midwives were first. Where it describes exactly what's in the law at the bottom of page 3, is it possible to add anything from our national standards of practice that it doesn't touch so much scope expansion but it just says that nurse-midwives work by consult, collaboration, and referral. Is that an okay sentence to put in there? That's our national standard from our organization.

MEMBER BOLTON: Can you repeat that, Michelle?

MEMBER ZAMUDIO: Sure. So the nurse-midwifery standards say that we can work by consult, collaboration, or referral, and I didn't know if we can put that sentence in there. I can give the exact verbiage here, too, from the Standards of Practice from the American College of Nurse-Midwives. I don't know if that's okay to write in there. I think it explains more about what we do.

MS. EMRICH: Well, we address that the practice here is by collaboration because with the

statute.

MEMBER ZAMUDIO: So just stick with the statute then, instead of --

MS. EMRICH: This is about scope of practice. So, you know, we did include, you know, the immediate newborn care, we did bullet that out.

MEMBER ZAMUDIO: Yeah, yeah.

MS. EMRICH: We talk about that.

MEMBER ZAMUDIO: Yup. Okay. I was just curious if it would help to say how we work -- for example there might be a time where a physician is managing a patient's insulin drip and you're delivering the baby --

MS. EMRICH: Oh, sure.

MEMBER ZAMUDIO: -- which is part of our scope. So if we put in there that we can also work by consult, collaboration and referral, I mean you're right it is collaborating, it can also be just with a consult or referral. We have defined times, per SCA, when those things happen, but if that would muddy it, I'm happy to leave it off. It was just a question.

MS. EMRICH: Yeah, that would be the same for CNSs and CNPs too.

MEMBER ZAMUDIO: Right.

MS. EMRICH: And I don't have those in

here. I think it's inherent --

MEMBER ZAMUDIO: Okay.

MS. EMRICH: -- but I don't want to -- I don't want to stymie it either. I just want to --

MEMBER ZAMUDIO: No, I think that's good. I appreciate that. Thank you. I'm good.

CHAIRWOMAN KEELS: Okay. Page 3 done.

Move on to page 4. And I'm going to assume that we don't want to define "immediate newborn care" just like we don't want to define "immediate presence."

MEMBER ZAMUDIO: No.

MS. EMRICH: Yeah. And I was looking at the Nurse-Midwifery Council and they're starting to phase out "extended newborn care" because of --

MEMBER ZAMUDIO: It's up to day 28.

MS. EMRICH: Yeah.

MEMBER ZAMUDIO: The reason we would want to not phase it out is because in some communities, particularly our rural communities, that midwife is the only one there.

MS. EMRICH: Right.

MEMBER ZAMUDIO: So that's why when we train, a large chunk of our education is about newborn care.

In my prior practice in other states, I delivered the baby, did the history and physical, did the admission, took care of it for the first month and then, you know, after those 28 days you transfer it to peds, but that person might have to drive a long way to find another provider, so.

MS. EMRICH: I just saw that discussion that they had talked about, that there were several they might want to.

MEMBER ZAMUDIO: No, I appreciate it.

MEMBER GRAHAM: This is Margaret. Under the "CNP Scope of Practice," I was thinking of a way that we could include NPs that go through these, you know, year-long residency programs that we have in the state. So I wondered if the second bullet down, it starts with "consistent with the nurse's education," can we say "Nurse's education, clinical experience and training and certification"?

CHAIRWOMAN KEELS: So I guess, Margaret, I -- I -- so there are some very well-defined nurse practitioner residencies and then there are extended orientations and transition-to-practice programs. I guess I'm wondering and not that I'm disagreeing with your recommendation but how that's different from education and training and clinical practice?

MEMBER GRAHAM: Education and training maybe can be the same. I mean I guess I was thinking of education as being the more formal education, their master's program. I think what you're saying, Erin, is that education include additional training like a residency, you know, post-master's program. So maybe we say "nurse's education, clinical experiences, certifications," maybe?

MEMBER DIPIAZZA: I would just -- I guess I would just be cautious of that because they have to be population-specific, right, and that's what this whole discussion has been about over the years. That might be too vague or too broad.

CHAIRWOMAN KEELS: Well, you know, here again we say "promote patient wellness within the nurse's nursing specialty" so I think that's referring to the population-focused certification which, of course, I would rather see that because I think "specialty" is confusing. Because then, yeah, if it's within your population focus, your formal education, your transition to practice or residency program, your certification, your clinical experience all help you determine your scope, right?

MEMBER DIPIAZZA: Yeah, I mean that's agreeable if it's population focused if we change

that wording from "specialty" to -- is that what you're saying, Erin?

CHAIRWOMAN KEELS: Or clarify it in some way that we're talking about within your population foci.

MEMBER DIPIAZZA: Okay.

MEMBER ZAMUDIO: Erin?

CHAIRWOMAN KEELS: Yeah, Michelle.

MEMBER ZAMUDIO: So, you know, I immediately went back to our previous conversations and we did vote to follow part of the rules, it's 4723-8-01 and it's paragraph (F) and it says that our practice as an APRN is obtained from advanced formal education, training, and clinical experience. So to stay consistent we should probably put those things in here and that would include our formal education, training -- and they don't define, they said just education, training, and clinical experience.

CHAIRWOMAN KEELS: Right.

MEMBER ZAMUDIO: That was consistent.

CHAIRWOMAN KEELS: What was left out of the rule was it's meant to be within your population focus and that's where a lot of confusion came about, so we were just trying to clarify that.

And, you know, I think maybe back in the

FAQs is where we talk about the role of ongoing education and training after you've transitioned to practice and how that continues to form and inform your scope of practice So yeah, I'm fine, I'm totally fine with including "residency" in there as long as we make sure it's within that population focus, right?

MEMBER ZAMUDIO: If it's the word "training," that would cover the residency education; is that right, Dr. Graham?

MEMBER GRAHAM: I think so.

MEMBER ZAMUDIO: If we put "education, training, and clinical experience," that would keep us consistent with the existing sections plus clarify it a little bit.

CHAIRWOMAN KEELS: Well, so that sentence could be "consistent with the nurse's formal education and certification, training and clinical experience."

MS. DIPASQUALE: So this is Anita just jumping in for one moment, if I could, on two things.

One is kind of to recognize Pete's point about this has to all be tied into the national certification, which you're doing, which you're doing.

The language -- so the language that's paraphrased here is out of the statute that's cited, 4723.43(C). This is paraphrasing -- well, I mean it's really quoting. "May provide preventative" -- I'm reading from the statute, not from the document -- "May provide preventative and primary care services, provide services for acute illnesses, and evaluate and promote patient wellness within the nurse's nursing specialty, consistent with the nurse's education and certification and in accordance with rules adopted by the Board."

So I was reading that just from my only little statute book. I mean you can Google, just Google the statute.

So of course you can write this any way you want and certainly the rules that Michelle read from are the rules that were adopted by the Board. I just think if you go that way then you might want to add a citation to the rules so the people know the source of what you're referencing.

I just kind of wanted to point that out that this is kind of a summary of .43, the scope as defined by the legislature, and the words that you were reading were the rules that kind of amplify the statute. So we might want to add, if we amplify

this, we might want to add a citation to the rule.

MS. EMRICH: And we did include that definition in 01(F) in the first page here too, so that definition is in the paper.

MS. DIPASQUALE: Oh, on page 1, yes.

MS. EMRICH: Uh-huh.

MEMBER ZAMUDIO: So my suggestion would be to put "manage healthcare within the APRN's," not necessarily "nurse" but "within the APRN's certification, education, training and clinical experience, in accordance with the rules adopted by the Board." Would that make sense?

Because we're going down that road again with "specialty" and if you're certified, you know, we talked about licensure and certification. So if we took out that word "specialty" and put "the nurse's certification, consistent with their education, training, and clinical experience" and then we reference the rules, "in accordance with the rules," and like Anita said we could even put that rule in there.

MS. DIPASQUALE: I guess my only caution is that the word -- and this is, I mean, Erin has repeatedly referred to this and I know I have for several years, the word "specialty" is in the

statute. So if someone bothers to look at the statute that defines your scope legally, that term -- and maybe there could, as Erin referenced earlier today, maybe there could be kind of a top-to-bottom realignment to use the terms as we understand them, you know, using "role" and not "specialty" and tying in very explicitly the national certification, but currently that -- I mean this is legislation passed by the legislature so that's where that "nurse's nursing specialty" is.

MS. EMRICH: Right. And then "nursing specialty" is defined as your specialty within your practice as a CNP, so this would be your certification and your area of practice.

MEMBER ZAMUDIO: So can we -- this is Michelle. Can we take out the word "nurse" in front of "nursing specialty"? Can we make that "APRN"?

MS. DIPASQUALE: That's part of the statute but you can do what -- you can recommend what you --

MEMBER ZAMUDIO: Yeah, because we're not -- I mean I'm just trying to keep it clear so if someone reads this the first time and they don't know all the history, if we said the "APRN's" I would recommend putting "certification," but to really

follow the Consensus Model and the law, we would need to put their "education, training, and clinical experience," and those three things are addressed in both of those documents.

MEMBER BOLTON: I think if we put the "clinical experience" in there, we have to include that it's within their population foci. I think that's really important because if you just leave "clinical experience" in there, anyone can make the assumption that I can do midwifery even though I'm not a midwife. You know what I'm saying? So I think it has to be defined that it's within their population foci.

MS. DIPASQUALE: Yes. This is Anita again. You don't want the leave the impression that I have done something, I have the clinical experience to do X, therefore it is within my scope and do something that is not within their scope. I understand what you're saying.

MEMBER ZAMUDIO: Right.

MS. EMRICH: I can look at, instead "nurse's nursing specialty," since this is about CNPs, I could say the "CNP's nursing specialty." How about that?

MEMBER ZAMUDIO: Excellent.

MS. EMRICH: Would that be all right?

MEMBER ZAMUDIO: That sounds better.

Again, with the "education, training, and clinical experience," I'm not actually asking that we make that up, just that we mirror those sentences out of our own laws and in the Consensus Model. They both, they recognize those things, and I think by quoting the statute I think we're fine. It already says that. We're not going to be making this up.

And I think putting "within their certification," well, if they're not certified to do it and see a different population, do we need to put their population in there? It's fine if you say yes, but I'm just trying to keep it consistent with the rest of the statutes and the Consensus Model.

CHAIRWOMAN KEELS: So I think initially we were trying to answer the question or the issue of because I was an ICU nurse, now that I'm certified as a primary care NP, I can take care of, I can manage the care of acutely-ill, you know, critically-ill patients in the ICU, right? So we were trying to help even, you know, employers understand that that would not be appropriate.

MEMBER ZAMUDIO: Yeah. That's why I wanted that word "nurse" taken out.

MEMBER GRAHAM: Right. I think -- I agree. I think right now when it says "within the nurse's nursing specialty" then that makes it a little questionable. I think if it's "within the NP's specialty or certification" and then "the nurse's education, clinical experience, and training."

MEMBER BOLTON: I think what you were referring to, and correct me if I'm wrong, is that there needs to be, that we wanted the foci in there, the population foci in there because we didn't want someone to assume that because they were a nurse in this particular area that they could extrapolate that to the graduate education and practice moving forward. So I think it covers both. I think taking the "nurse's" out, taking that word out, but then adding the "population foci" also adds clarity around that.

MEMBER DIPIAZZA: Right.

MEMBER ZAMUDIO: So for the end of that sentence that would be the same, right? We would write consistent with the NP's, the CNP's education, not the nurse's education, training and experience, because otherwise, again, the end of the sentence, someone might think, "Hey, I did this as a nurse, I

could do it now." But after the word "consistent" if we write "with the CNP's education, training, and clinical experience in accordance with the rules." So both of the words "nurse" should be taken out of there, I think.

MS. EMRICH: Okay.

MEMBER ZAMUDIO: And also just to respect the CNPs, you know, their work and their attaining that certification.

MEMBER GRAHAM: And it is showing it's their training, their education, and their experience as NPs.

MEMBER ZAMUDIO: Yes.

MEMBER SIEVERS: Can someone read it back if they have a good summary of it? I got lost in there.

CHAIRWOMAN KEELS: I think what we're saying is -- okay. "CNPs may provide preventive and primary care services, provide services for acute illnesses, and evaluate and promote patient wellness within the CNP's specialty, consistent with the CNP's education and certification, training and clinical experience, and in accordance with the rules adopted by the Board."

MEMBER ZAMUDIO: Correct.

CHAIRWOMAN KEELS: Is that right? Is it a little redundant or does it feel a little clearer?

MS. EMRICH: The only -- this is Lisa. The only -- the only other comment I would make is that the definition of practice of nursing as an advanced practice registered nurse, which is in .01(P) of the statute and rule 801(F) of the rules, those apply to all APRNs. So we can either say upfront that this applies to all APRNs or we can insert that same language into each one of the APRN's scope of practices as we've talked about and then cite that particular statute and rule with each scope of practice.

MEMBER GRAHAM: You can cite it, I think.

MEMBER BOLTON: Put it up front.

CHAIRWOMAN KEELS: Wait a minute. I heard one person up front, one person within each.

MEMBER SIEVERS: I think within each because you're going to be more likely, if you're a CNP, to maybe look harder at this section just to reiterate it, but you can open it up.

MEMBER ZAMUDIO: I have a comment.

CHAIRWOMAN KEELS: Yeah, Michelle.

MEMBER ZAMUDIO: So I think they're both right, to be the middle ground. I think putting it

at the beginning would be very helpful with the words "APRN." And then for the person that just looks at their own area in the document, I think Lisa is right we should -- we could spell that out for them.

So -- so it would be both. It would be at the beginning, which is a great idea, but then the person that just goes to where it says CNM or CNS to maybe put the same verbiage under each one, it would keep it consistent.

MEMBER SIEVERS: And I just have one more question about "specialty." So if the purpose of this document is to clarify, should we qualify that or I mean do we have to use that word? Do we think it's still clear what we're talking about? I mean this is -- this is to clarify law and rules so it has to be consistent but I think the point, the bottom line is to be totally crystal clear what we're talking about here. Just open it up.

MEMBER GRAHAM: If we take out "specialty" and just use "certification," that might be clearer.

MEMBER ZAMUDIO: That's a good idea.

MS. EMRICH: So --

MEMBER SIEVERS: Can we qualify it and say what we're talking about if you --

CHAIRWOMAN KEELS: Or even use parentheses.

MEMBER SIEVERS: What is "specialty." We need to be crystal clear.

MS. DIPASQUALE: Remember, it is a term that is statutorily defined. I just want to give this caution and this was what I was trying to say before, maybe not very artfully. Just to echo what Erin said earlier if I understood you correctly. Wouldn't it be great if we could go through. So I just want to tell you, so you could take it out in one place but then when an APRN looks at or whoever looks at .431 about SCAs, well, that term is in there. So "nursing specialty" is in 01(V), I think.

MEMBER SIEVERS: We could maybe say that, couldn't we?

MS. DIPASQUALE: So it seems like -- pardon me?

MEMBER SIEVERS: We could maybe say that, like, say what we want it to really mean and then we could say in parentheses "is defined as 'specialty' in statute or something" just so they make that connection next but they understand one-hundred percent what we are talking about.

MS. EMRICH: And I -- if I may. I

think -- and maybe we didn't do as well in conveying this as what we maybe should have done. Everything in the first few pages it's like giving you a quick go-to about what's in law and rules. It is. It's sort of a one-source kind of reference document. Instead of going through pages and pages of law and rule on the website, here is a quick reference just to know what is required of each.

But the practical application comes when you get to the FAQs. Does that make sense? I mean that's sort of where we were going with this, I think, and we can certainly add more FAQs if we need to do that, but that's where the application comes in, it's a lot within the FAQs. It's like how -- what does all of this mean. Well, it means this when you are actually engaging in practice and this is what you want to do, this is -- these are the things you have to consider.

MEMBER SIEVERS: Yeah, I'm just trying to be sure it's clear because we say "specialty" on the first page is nurse anesthetists, clinical nurse specialists, nurse-midwife, nurse practitioner, but I think in this little explanation we're meaning it to be certification, right?

CHAIRWOMAN KEELS: Exactly.

MEMBER SIEVERS: That's back to where we were and they say "Well, my specialty is a nurse practitioner," broad, and so maybe that's when they could, like, I mean that's where you got that scope creep because you're not saying certification which is a family nurse practitioner and not acute care or pediatric.

So I'm just playing devil's advocate because I think "specialty" is still confusing in this thing and just maybe understanding what the law says because we said that on the very first page, but in the particular first paragraph I think we're meaning "certification" as like an FNP or whatever, right?

MS. EMRICH: Because we say your specialty is consistent with your education and your certification; so there's your certification.

MEMBER GRAHAM: Could we say your certification is consistent with your education, clinical experiences, and training? Would that be clearer?

MS. DIPASQUALE: "Certification" is referring, I believe, to the national certification.

MEMBER SIEVERS: Right. So could we take out "within the nurse's nursing specialty" and just

say "patient wellness consistent with education, clinical experience," or whatever you were putting in there, "and certification"?

Because we already define the specialty in statute which was the CNP, so we already know that's what we're talking about here from the first page, right? So we're saying specialty is those four designations, so we know we're talking CNP in this little section.

MS. DIPASQUALE: So you would delete -- this is Anita. You would delete "within the CNP's specialty." What currently reads as "within the nurse's nursing specialty."

MEMBER SIEVERS: Yes.

MS. DIPASQUALE: Because that really means the national certification.

MEMBER SIEVERS: "Certification" is in there. We're adding "clinical experience" so --

MS. DIPASQUALE: Would you want to add the word "national" in front of "certification" to make very clear since there are so many areas of certification.

MEMBER SIEVERS: Sure, yeah, that's a --

MS. DIPASQUALE: I think that is, Lisa, that is how we read "certification" to mean the

national certification.

MS. EMRICH: Uh-huh.

MS. DIPASQUALE: I've always read that in there in my mind. Let's see. So does adding -- so does keeping "consistent with the nurse's education" and whatever other words are then inserted, "and national certification," that would necessarily include, I think, what is being defined in (V) as the nurse's nursing specialty.

It's been very unfortunate that same word is used in so many places. I believe, Lisa, correct me if I'm wrong but I believe you told me that our Ohio statutes that use many of these words predate --

MS. EMRICH: Predate the Consensus Model.

MS. DIPASQUALE: -- the Consensus Model. So it wasn't like the legislature intentionally -- these words were in here before it was adopted. So, anyway.

MS. EMRICH: We -- just since we're summarizing this if it's going to be more of a summary, we could actually, just a suggestion here, take out -- sort of reorder it and to say, you know, within the nurse's nursing specialty, to say "consistent with the nurse's education and certification, which is the nurse's nursing

specialty" and just say "national certification." I mean you're still defining it as this is what the specialty is.

CHAIRWOMAN KEELS: Are we taking out the words "nurse's nursing specialty" --

MS. EMRICH: I meant "the CNP's nursing specialty."

CHAIRWOMAN KEELS: Okay.

MS. EMRICH: I'm sorry. I have it replaced.

MEMBER SIEVERS: Can you say that -- Can you say that together again?

MS. EMRICH: You can reword it to --

MEMBER SIEVERS: You're cutting out.

MS. EMRICH: It may be my thing.

CHAIRWOMAN KEELS: Oh. Still not good.

Oh, Lisa, you froze. Now I can't hear you.

MS. EMRICH: Can you hear me?

CHAIRWOMAN KEELS: Now I can.

MS. EMRICH: So --

CHAIRWOMAN KEELS: Oh, you keep freezing off and on.

MS. DIPASQUALE: Can you back away from your computer a little bit?

MS. EMRICH: Is that better? Is that better?

CHAIRWOMAN KEELS: Yeah, I think so.

Anita, I can't hear you.

MS. DIPASQUALE: Sorry, I was muted. I muted myself after finishing my comments.

CHAIRWOMAN KEELS: Okay. So Lisa is going to paraphrase what we think we've asked for.

MS. EMRICH: Okay. "...and evaluate and promote patient wellness consistent with the CNP's education and national certification, which is the CNP's nursing specialty," we just turned it or rephrased it, "and in accordance with the rules adopted by the Board." It may need a little bit of tweaking but . . .

MEMBER SIEVERS: But, see, I thought we said on page 1 that the specialty is -- the very first definition of "specialty" says it's the CNS, CNP, specialty in practice, as certified registered nurse, clinical nurse specialist.

CHAIRWOMAN KEELS: I believe that to mean that the words "in practice" refers to your national certification.

MS. EMRICH: It is where you focus your practice as a CNP. Nursing specialty, as defined, is

the practice -- your practice as a CNS or CNM or CNP. For the CNSs and the CNPs, you have a very focused education and national certification. That is your nursing specialty as defined in that particular statute and rule.

CHAIRWOMAN KEELS: And you're going to add a sentence that states that, is that right, or a bullet underneath that "nursing specialty"?

MS. EMRICH: Correct. I have below it we said "this equates to your national certification" --

MEMBER SIEVERS: Okay.

MEMBER ZAMUDIO: I have a question.

MS. EMRICH: -- "and population focus" or -- yeah.

MEMBER ZAMUDIO: So here's my question. This is Michelle. If we're already addressing "specialty" on the first page, I don't understand why we need to define it again here. It seems like it would read very well if we wrote "promote patient wellness, consistent with the CNP's education, training, clinical experience, and certification in accordance with the rules adopted by the Board." That would be the exact verbiage from the law.

MS. DIPASQUALE: No.

MS. EMRICH: No, it wouldn't be.

MS. DIPASQUALE: No, it is not.

MEMBER ZAMUDIO: Well, it doesn't -- well, it says in here as far as the training -- education, training, and clinical experience. That would add it exactly as it is.

MEMBER SIEVERS: What she's saying is if "specialty" we are saying is "certification" and then we're saying "certification" again.

MEMBER ZAMUDIO: Again.

MEMBER SIEVERS: We're saying "certification" twice.

MEMBER ZAMUDIO: Right.

MEMBER SIEVERS: So for it to be clear, does it add anything to say "within the nurse's nursing specialty." Does it add any -- or does it alter the definition of it to not have it in there. I say no because you have "certification" specifically spelled out right there.

MEMBER ZAMUDIO: I just think putting the word "specialty" in there is going to completely derail what we've been trying to do. I like the summary on the beginning on page 1. It explained, look, our laws are old. It says "specialty" but we mean your certification. So if this isn't law that we're writing, if it's to explain it, can we just use

the word "certification"?

CHAIRWOMAN KEELS: I'm fine with that.

MEMBER GRAHAM: I think the way Michelle just wrote it -- I mean just stated it is good because then that does still pull in from the rule where we say "nurse's education, clinical experience, and training," and I think it takes away any question as to whether it could be the nurse's previous experience prior before they were APRN. So I think that -- I think the way Michelle just stated it is a great way to state it and it takes away the confusion.

MS. DIPASQUALE: So delete the phrase "within the nurse's nursing specialty." Add "national" to "certification" which makes -- kind of gets to that population focus and makes very clear which certification is being discussed. And then pick up the language from the rule that you were quoting, Michelle.

MEMBER ZAMUDIO: Right.

MS. DIPASQUALE: The language you quoted was from the rule adopted by the Board.

MEMBER ZAMUDIO: Yes, ma'am. And so it would be also the second time the word "nurse" is used, to eliminate that. Say "consistent with the

CNP's" --

MS. DIPASQUALE: Yes.

MEMBER ZAMUDIO: -- "education, training, clinical experience and certification." That's clear as to who they should be taking care of. If you're not certified to take care of them, don't do it. If it's within your certification, that's okay. Then it eliminates the confusion with the word "specialty," it eliminates the word "nurse" so there's no confusion there, and it mimics -- mirrors the law.

MS. DIPASQUALE: Right. And I just want to reiterate this is just a summary of the scope --

MEMBER ZAMUDIO: Yeah.

MS. DIPASQUALE: -- which is defined by the legislature in law using those terms, so.

MEMBER ZAMUDIO: And we should leave that in there where it says "in accordance with the rules" so that way we're not saying don't follow the rules.

CHAIRWOMAN KEELS: Okay. Do we think we're okay? All right. Great.

Moving on to page 5. Would we want to provide a link to the Exclusionary Formulary in the rule?

MEMBER ZAMUDIO: That would be great.

CHAIRWOMAN KEELS: I know you didn't want

to do too many links in case things change, then you have to go back and redo them, but I felt like that was probably an important one because I frequently get questions -- well, you frequently get questions about where is the Exclusionary Formulary and what drugs can I not prescribe and what drugs can I.

Lisa, you're on mute.

MS. EMRICH: There I am. Yes. So we can -- we can.

CHAIRWOMAN KEELS: Okay. You know, there's that bugger word "nursing specialty" again. "Prescribing must be consistent with the APRN's scope of practice, national certification in the nursing specialty...." I don't know if you want to say "national certification" and just leave it there, or "national certification in the population focus, Standard Care Arrangement, and standards of practice."

MS. DIPASQUALE: This is the fourth bullet down for anybody who is --

MEMBER ZAMUDIO: Oh, yeah.

MS. DIPASQUALE: Is that right?

CHAIRWOMAN KEELS: Sorry. Yeah. And I know APRNs, of course, are nurses, but, again, there's that "Well, I was certified as an ICU nurse

and now blah, blah, blah, blah, blah." Sorry.

MEMBER SIEVERS: Can we just take out "in the nursing specialty" because that is what your certification is, it's in a certain area. It already says "national."

CHAIRWOMAN KEELS: "In the nursing specialty" I would remove.

MS. EMRICH: Okay.

MEMBER SIEVERS: Okay.

MEMBER BOLTON: This is Pam. I hate to bring this up again but I am really struggling with the clinical experience without the population foci being in there.

It still is very unclear and it lends someone -- and I apologize for going back, I've just been sitting here thinking about it, but it just makes it unclear in that I'm afraid someone is going to think if they have certain experience that that allows them to do what they want to do without focusing in on the population foci.

MEMBER ZAMUDIO: Pam, I think that's one of the reasons I said -- they said the word "and" in there. So in the statute it does list all of those things but it's an "and." It says "education, training, and...." So they would already have to

have certification, they'd have to have the formal education, and then the clinical training adds to those. It's an "and." I don't know if that helps any.

MEMBER BOLTON: Well, I think -- I think where I struggle with it, Michelle, is that it goes back to the -- going back to the Consensus Model, that was one of the things that was really harped on in that whole discussion, you know, and I fortunately happened to be around the table during some of those discussions, and the population, that's so important. That's the basis for the education which is why we find ourselves sometimes in a very difficult position because we have acute care and family and primary care, you know, and so I'm just struggling with that and I apologize.

MEMBER ZAMUDIO: It's fine. I was just reading it out of the ORC.

MEMBER BOLTON: Right.

MEMBER DIPIAZZA: I would have to agree with Pam. I mean this is why we're having this conversation now for three years.

MEMBER BOLTON: Right.

MEMBER DIPIAZZA: It's -- it's -- we have to include population foci --

MEMBER SIEVERS: See that's another term --

MEMBER DIPIAZZA: -- or we're not offering any clarity.

MEMBER BOLTON: I know. I know, Sherri, and you probably want to slap me, I get it.

MEMBER SIEVERS: What if we just say --

MEMBER BOLTON: I just think that that's so --

MEMBER SIEVERS: Sorry.

MEMBER BOLTON: Sorry. Go ahead.

MEMBER SIEVERS: What if "after clinical experience" you just say "in area of certification" or somehow like -- and not bring another term into it. Like how would you link it? What words would you use to say the experience has to be in what you're certified for.

MEMBER BOLTON: I think what I struggle with is that I don't really want to make up another term. I think that the Consensus Model did that when they said "population foci" and so I feel like we should be consistent with those terms just like we are with the law and the rule, you know, we adopt it or we don't, and I think we have portions of it as the Board, as the Ohio Board of Nursing, and so I

just feel like there's so much open to interpretation if we do not include those words.

MEMBER ZAMUDIO: I have a question for --

MEMBER SIEVERS: I hear what you're saying but if you're -- like to Michelle's point if you're already -- if you're already not following your certification, you're already outside your scope, like that's already part of it, so if you're not -- if you're getting clinical experience outside of your certification that's just like a double -- now you're -- now you're wrong twice, so.

MEMBER BOLTON: It's not certification that I have issue with. I think you're right about that. What I have issue with is the clinical experience. The clinical experience needs to be within your population foci. And if you just say a blanket "clinical experience," what you're essentially saying is that it doesn't matter if it's within or not within that population foci and I feel like that is so vitally important.

MEMBER SIEVERS: I guess what I'm saying is the first part of it says consistent with the nurse's certification. So if you get -- like I'm family so I suddenly decide I'm going to take care of, you know, neonates in the NICU. That's outside

of my certification so it doesn't matter. Like, why do we have to define the clinical experience being within my certification because I already said I have to be within my certification.

MEMBER BOLTON: So I would go back to Lisa. Lisa, I think you've said in the past that you've gotten multiple questions about this, right, around clinical experience and that the Board has spent a lot of time or staff has spent a lot of time trying to clarify that for individuals which is why we're here today creating this document.

And one of the issues that we've had is that there wasn't, for example, there was a period of time when we had many more FNPs who were acute care nurses who went into acute care and I've had acute care nurses go into primary care, and I think that, you know, my primary care person would say gosh, I've had, you know, five years' experience in primary care, not recognizing that it wasn't within the population foci and truly believed that she was doing the right thing until we shared with her that that wasn't correct.

MS. EMRICH: Well, it's the idea that if you are -- if you hold a national certification in a particular population focus, there is not any amount

of clinical experience you can gain that will move you from one population focus to another one without also being certified in that other population focus.

So you can't expand your certification beyond that population if you don't also meet the educational criteria and pass that particular certification. So that's the concern. That's -- that's -- you can't change it by just adding on education that's not also associated with the certification exam.

MEMBER GRAHAM: This is Margaret. So is certification not -- does that not to speak to the population focus? I mean if we say "in conjunction with your national certification," for me that's family, for some that pediatrics, for others it's neonatal. So if we say that upfront, you know, national certification, your education which has to be consistent with your national certification, your clinical experiences and, you know, training.

I mean we've talked about the hematological nurse, we've talked the oncological nurse, you know, those are generally in addition too. So I think -- I guess I think that the certification -- that we are saying consistent with your population which to me that is your national certification.

MEMBER SIEVERS: Pam, do you think we could address it in an FAQ and just elaborate on it, instead of putting it right here and getting more terms in there?

MEMBER BOLTON: I think that's --

MEMBER SIEVERS: Still have a specific question about it with an example.

MEMBER BOLTON: I think that's a great alternative, yes.

MEMBER SIEVERS: Okay.

CHAIRWOMAN KEELS: Yeah, and I'm pretty sure we have a question or two back here in the back that addressed that. I think, speaking of that, we may want to put at the very beginning of this where we introduced the document, "See the attached FAQs for further elaboration."

MEMBER ZAMUDIO: Good.

CHAIRWOMAN KEELS: Just so that they're sort of more formally linked in that way so if people want more information they'll most definitely go to the FAQ instead of saying oh, you know, that's it.

MEMBER ZAMUDIO: That's an excellent idea, Erin. I like that. It would let them know to not stop reading yet, to go to the end of the document.

CHAIRWOMAN KEELS: Please read all of it. Because I didn't know if the FAQs would be a separate link, Lisa. I didn't know if it would be --

MS. EMRICH: It's all one document.

CHAIRWOMAN KEELS: Oh, okay.

MS. EMRICH: It's all one document.

CHAIRWOMAN KEELS: So it will be at the end. Okay. Thank you.

Do we have any more discussion on page 5?

MEMBER ZAMUDIO: No. Just I do want to say this because I feel very strongly about it, we've talked this whole time about making sure that we reflect what's in the laws and rules and I really do believe we should use the verbiage from there where it says "advanced formal education."

In other words, you know, you can't change your population by going to a weekend class, right? "Advanced formal education, training, and clinical experience," and we could reference 4723.801 if we wanted but I would write it out there.

CHAIRWOMAN KEELS: I would be okay to include that, Michelle, as long as we have that caveat of "clinical training and experience," to Margaret's point, because certainly ongoing your transition-to-practice program and then any

additional ongoing training and education that you do within your scope, you know, within your population continues to inform your scope.

MEMBER ZAMUDIO: And then the "and national certification" so that way they are clear on where they are.

MS. DIPASQUALE: Not to beat a dead horse but -- this is Anita DiPasquale -- I believe it was in this group that more than one participant said that sometimes students will approach to get their clinical experience, you know, precertification, before they sit for their national exam and they have to be -- they're seeking clinical experience in a setting that does not align with the national certification that they are training for. Does anybody remember this discussion?

CHAIRWOMAN KEELS: Yes.

MS. DIPASQUALE: And there was kind of a "Gosh, I wish we could get more to the educators about that problem." And I'm sorry I don't remember who exactly said it, I feel more than one person has said this, and that obviously that's an education piece. I don't mean -- I mean it's like a piece for everyone to kind of get out there to people, to students, to educators, to please align the

precertification clinical experience with the national certification the person is actually seeking. So I just want to throw that out there to kind of support Pam's point about people, rightly or wrongly, obtaining clinical experience and then feeling it supports their practice in that area. So we could, at the very least, do an FAQ.

MEMBER ZAMUDIO: Yeah.

CHAIRWOMAN KEELS: Okay. Ready to move on?

Page 6. Standard Care Arrangements. So given that we've made some recommendations to the Board around Standard Care Arrangements today, I don't want to really delay this much more but I'm wondering, so for bullet one, two, three, four down, "SCAs must be reviewed every two years...must be documented by the APRN and at least one collaborating physician," you know, we made the recommendation that that only needs to be done if any significant changes occur, right?

MEMBER ZAMUDIO: Lisa, just to -- or Erin, either one just to clarify because I'm not clear on this. When you say any, like, big changes, that would not include adding or deleting a collaborator, right? Like when you say if there's

any big changes, you'd redo your SCA, but those big changes wouldn't include the comings and goings of your --

CHAIRWOMAN KEELS: Well, we actually said changes, period, but I just inserted "significant."

MEMBER ZAMUDIO: I like it.

CHAIRWOMAN KEELS: I don't -- I don't -- we didn't clarify that.

MS. DIPASQUALE: Excuse me. This is Anita. On 40 -- law requires -- I'm turning to .431 in the statute.

MEMBER ZAMUDIO: We have to notify, of course, of the collaborator change but would it require a whole new SCA to be executed?

MS. DIPASQUALE: Well, a person can be added and notification must come to the Board. I want just to make that point that that's not flexible, that's in the statute.

MS. EMRICH: And I would recommend, although I know the recommendations for the rule, the rules that are being reviewed now would not go into effect until like February the 1st. We can easily, if this -- if the Advisory Committee actually, you know, gets to the point it's okay with this document, we can later remove a bullet point easily. So I

would not worry prospectively about what may happen. Just let us, you know, we can deal with that at the time.

CHAIRWOMAN KEELS: Yeah. Thank you.

All right. So, beyond that, any other points on page 6?

Okay. Page 7. Okay. Are we moving into the FAQs then? Yeah? Okay. So FAQ 1 which starts on page 7.

MS. DIPASQUALE: I'm sorry, Erin. I'm sorry. This is Anita. I don't know if people wanted to check the last paragraph just below -- just above, I'm sorry, the line "Below are FAQs...."

CHAIRWOMAN KEELS: Uh-huh.

MS. DIPASQUALE: I don't know if, given the conversation we just had, I thought I saw some -- I thought I saw that "specialty" language in there. Oh, there it is. It's in the first line. "APRNs who hold national certification in a particular nursing specialty/population focus, may further subspecialize their practice." I don't know if people wanted to --

CHAIRWOMAN KEELS: I would love if we did that throughout the entire document, "specialty/ population focus."

MS. DIPASQUALE: Okay. So --

CHAIRWOMAN KEELS: It would make it more clear to me that specialty does mean by population focus.

MS. DIPASQUALE: Okay.

CHAIRWOMAN KEELS: Actually it's population-focused certification but -- I don't know how other people feel about that.

MEMBER BOLTON: I agree, Erin.

CHAIRWOMAN KEELS: Okay. And I do like having that you may subspecialize within your population focus. For example, a CNS who holds a national certification in peds, may subspecialize in pediatric oncology.

MEMBER GRAHAM: And I think that kind of speaks to the residency or the additional training in clinical practice which is why I think it's supposed to be in there but it stays with their population.

CHAIRWOMAN KEELS: Yeah. I don't know if you want to add a sentence that those subspecialties may not be certifications but may be focused -- focused experiences such as a residency, you know, although not everybody goes through a residency to become, you know, go into hema -- hematology.

MEMBER GRAHAM: Maybe just leaving it the way it is, keeps it broader.

CHAIRWOMAN KEELS: Yeah, broad is good.

MEMBER GRAHAM: I think it does include residencies and things like that but I think it doesn't preclude others who don't do residency, and I don't think we want to start making everybody do a residency.

CHAIRWOMAN KEELS: Oh goodness, no.

MEMBER SIEVERS: This is Sherri. Can I -- what -- can -- tell me what your interpretation is or what we were thinking this paragraph provides. What's the question that you get that we're trying to answer? Like I don't really understand what it's saying. I know what it's saying, I just don't know what we're trying to tell people.

MS. DIPASQUALE: This is Anita. One of the things it tells people is that I always get in my mind that Consensus Model triangle. One of things I believe this paragraph tells people is that an APRN who has, you know, obviously at least one national certification, could further subspecialize their practice. That subspecialization is not regulated by the Board, so you don't need to come to the Board to get licensure certification, approval, et cetera, once you're in that, you know, that top third of the triangle that I'm always kind of picturing. That's

one of the things that I think the paragraph adds.

MEMBER SIEVERS: Okay.

MEMBER ZAMUDIO: This is Michelle.

CHAIRWOMAN KEELS: Yeah, Michelle.

MEMBER ZAMUDIO: So I hear what you're saying and I think it's -- I mean obviously we're going to have to see this through the lens of patient safety but when we're talking about sub -- we're using that word "subspecialize," there are people who may work in a certain area where there isn't a specialization yet because as these new degrees in population -- I shouldn't say that -- new certifications keep popping up, there used to not be a hematology. There's actually five of these types of NPs who have actually gone away, they don't even exist anymore.

So if someone is already working in an area and then a program develops, I'm just -- I'm hesitant because I don't want them to think they have to go get certified to work in this subspecialty because it suddenly develops. You know, they might have been doing this for decades already and then a program comes up to get certified in it to work in this subspecialty. I don't want them to think that a subspecialty requires some type of additional

certification or something.

MS. DIPASQUALE: Well -- this is Anita -- it explicitly says a hospital might require a certification or an employer or, you know, whoever but that was what I thought was one of the benefits of the paragraph. These types of subspecialities are not themselves regulated by the Board. So this kind of acknowledges that top, you know, that there isn't something else you need from the Board in order to go forth in that practice.

MEMBER ZAMUDIO: I love that but it says subspecialties and I'm like, well, in the Consensus Model it says specialties and it says boards of nursing don't regulate specialties. So are we, like, kind of substituting the word "subspecialty"?

MS. DIPASQUALE: Yes.

MEMBER ZAMUDIO: Okay.

MS. EMRICH: In substance, yeah, in substance the Consensus Model relates population foci to what we consider the national certification nursing specialty. The Consensus Model then talks about specialization which, for us, is below the national certification or population foci.

So in here in this last paragraph that Anita referred to, we don't even -- we don't

mention -- we do not associate a certification with a subspecialization.

MEMBER SIEVERS: This is Sherri. Do you think we could move this to the FAQ and just say "I am a family nurse practitioner and I wish to subspecialize in pediatric oncology. Do I need a certification or an additional license?" And then we just say, "No. These subspecialities are not themselves regulated. Practice must be consistent."

MS. EMRICH: Sure.

MEMBER SIEVERS: And just simply ask the question instead of --

MS. EMRICH: Yeah.

MEMBER SIEVERS: Because it doesn't have any law or rule associated with it, so maybe we just make it a question.

MS. EMRICH: That sounds good. We can do that easily.

MEMBER ZAMUDIO: Can we keep the way Anita wrote it because I do like that, saying that it's additionally not required to have a, you know, certification or something. I'm sorry, Anita. I don't know if you're the one who wrote that. I just gave you credit for it but I do like that.

MS. DIPASQUALE: I don't believe I did.

Perhaps Lisa. I'm not sure. This goes back and forth, doesn't it, and it goes back and forth awhile.

MS. EMRICH: It's a community project.

MS. DIPASQUALE: Yes, it definitely is, and many of you have had input over the meetings.

CHAIRWOMAN KEELS: FYI, Pete got kicked off and he's trying to get back in.

MEMBER BOLTON: Sherri, I'm going to get you a crown that's going to say "FAQ Queen."

CHAIRWOMAN KEELS: Me?

MEMBER BOLTON: Sherri.

CHAIRWOMAN KEELS: Oh, Sherri definitely.

MEMBER SIEVERS: I just think it helps people to understand and then they can find their question and exactly what they're trying to ask, so. Thank you.

CHAIRWOMAN KEELS: As long as they just don't look in the FNPs, if I'm an NP, I only look at FNP questions, you know?

MEMBER BOLTON: Right.

CHAIRWOMAN KEELS: But hopefully --

MEMBER BOLTON: I always thought about does the FAQ need to be at the beginning of the document rather than, you know, at the end. I mean, honestly, because I think people are going to go

there to get their questions answered, so.

CHAIRWOMAN KEELS: Quite possibly.

MEMBER BOLTON: Yeah.

CHAIRWOMAN KEELS: Okay. Let's keep moving on. We've got still some work to do.

FAQs. First one. Do you need a Standard Care Arrangement if you're not going to prescribe drugs. Any problems with that?

All right. How about page 8. Looking at prescribing and MAT.

MEMBER ZAMUDIO: This is Michelle. The only thing I thought that might be helpful is the second question where it says "Is there a limit on the number of physicians with whom an APRN may enter into a Standard Care Arrangement?" I really liked the answer on this one because it gave the flip side and said there is a limit to the number of APRNs.

CHAIRWOMAN KEELS: Oh, but we don't state what that is.

MEMBER ZAMUDIO: Well, no it says "in the prescribing component" which I thought that was good. Should we answer what that limit is though? Isn't it five?

CHAIRWOMAN KEELS: Yeah.

MEMBER ZAMUDIO: And then that way

they'll have that information answer because the explanation is perfect but then they might have to go to that section to see what number that is. Because we reference what the number is, we should just say 5.

MS. EMRICH: Okay.

CHAIRWOMAN KEELS: Yeah. Good point, Michelle. Thank you.

The Exclusionary Formulary is typed out there. Any comments or discussion around cross-coverage?

There's that word "designation" down in the next paragraph. The prescribing resource is there, so that will be a link to the prescribing resources on the website.

Then the DATA waiver, Standard Care Arrangement.

Page 9. Locate information on how to obtain specific drugs. I thought that was good to link in the Ohio Board of Pharmacy.

Next one. Cross-coverage. Any comments or discussion around cross-coverage?

Okay. At the bottom of page 9, medical diagnoses to prescribe.

Okay. Rest of page 10?

MEMBER GRAHAM: I just have a general question to ask about "medical diagnoses." Lots of boards of nursing, I understand, have moved to calling it "patient diagnosis" since care is being delivered by a team and we all certainly support team-based care. And so my understanding, I don't remember how many, maybe 20-some, have removed any prohibition from "medical diagnosis" and they just call it the "patient diagnosis." Do we have any movement in that direction at all?

Because if we called it the patient -- when a patient has hypertension and they're pregnant, we work with hypertension and, you know, I think Michelle could speak to that and so I think -- but that's not -- hypertension is something that a dietician and the nurse and the -- we all have different things that we do with that diagnosis but it's truly the patient's diagnosis versus the medical diagnosis.

And I think we could give such much better care if we weren't -- if there wasn't a prohibition. If we called this the "patient diagnosis" and then every member of the healthcare team works on that diagnosis. I think there's been research that shows there's less research [sic] and I

don't know if there's any movement in that, if we know of any movement of removing that prohibition and making it the "patient diagnosis" so we, as a healthcare team, can work at the top of our scope and deliver and we can all work on that patient's hypertension

MS. EMRICH: The only places in the Nurse Practice Act where "medical diagnosis" is used, it's really mostly in .151 which talks about the prohibitions, that a nurse cannot make a medical diagnosis, unless you're an APRN and that doesn't prohibit you from doing what you do as an APRN.

Outside of that, we use the term in Chapter 4 under the nursing process, we use "nursing diagnoses" but I don't think we use "patient diagnoses" but we mean that in terms of the plan of care, the nursing plan of care, of course. So, you know, Chapter 4 is -- I don't know when that's up for review again. For section .151, that would take a statutory change because that's in law and that's there.

The only other place is in Chapter 9 when it talks about the APRN has to make a, you know, a diagnosis and I think it's a medical diagnosis, determine a medical diagnosis. And those are the

only places.

MEMBER GRAHAM: But to move away from the prohibition, we have to have that statutory change in law, correct.

MS. EMRICH: Yes. Yeah. That -- that verbiage is in statute.

MEMBER GRAHAM: Somehow we have to get that fixed because I think -- I think there will be less errors and everything if we're all working on the patient's diagnosis.

CHAIRWOMAN KEELS: And I suppose that probably lives with the Medical Board, I'm assuming, to make that statute change?

MS. EMRICH: Well, this is part of the Nurse Practice Act. It would take the General Assembly to, you know, to do that, so.

MS. DIPASQUALE: The prohibition is in the section that's cited there. 4723.151(A) is the prohibition, and then (B) exempts APRNs from --

MS. EMRICH: That prohibition.

MS. DIPASQUALE: Prohibition within their scope. If that makes sense. So that's what you want to target if that's what you want to target.

CHAIRWOMAN KEELS: Okay. All right. Any other comments around page 10? Sort of getting to

some of the points we made earlier about practicing within your certification and your population focus.

MEMBER ZAMUDIO: Lisa, I just have a quick question on page 10. I had made a note to myself. I'm sorry. The -- I don't know where this would fall in here. Maybe Pam or Sherri would have some input. What about when it talks about the age range, so how will we address like the PNPs, the pediatric nurse practitioners, who are maybe caring in some of these facilities for adults who have a condition, like they continue with the same provider like at Children's Hospital, that continues to see someone with a heart condition, et cetera. So a lot of adults with a condition that they have in childhood still see the pediatric team as they get older. So do we want to address that for our PNP colleagues?

MEMBER SIEVERS: So I think -- are you saying that you don't -- well, back up.

I always told my folks it's consistent with the certification board. PNP, for example, has a white paper and a document about that and it says that you -- if you are the expert in the condition for which you're caring for. So you could care for the cystic fibrosis part of it, but if the patient

has hypertension and congestive heart failure that you must consult and document your consultation. So I think it's covered in the national certification information.

MEMBER ZAMUDIO: Okay. Thanks. I was just wondering.

CHAIRWOMAN KEELS: The paragraph -- the third paragraph down refers that back to your national certification.

MEMBER ZAMUDIO: Okay. Thanks.

CHAIRWOMAN KEELS: Okay to move to page 11? There's some CRNA language. I don't know if you felt like any of that needed to be tweaked based on some of the comments we had earlier or not. Circumcisions. Specific procedures or tasks.

Oh. Did Pete rejoin us?

MEMBER GRAHAM: Yes, he's there.

CHAIRWOMAN KEELS: I didn't see him listed. Okay. Is that Pete? You need to mute. Okay. I think he muted. Yeah. Okay.

All right. Nothing on page 11? You're good?

Okay. Page 12. Progress notes being reviewed. FNPs and scope. Primary care practice and scope. Exclusionary Formulary and prescribing.

MEMBER SIEVERS: I just have a question on the, I guess it's the second question. It says "National certification and 'Family' does not include the management of patients with high acuity unstable/ critical conditions." Is that where -- is that -- where is that from?

CHAIRWOMAN KEELS: That's the conversation we've had in the committee for the past several meetings.

MEMBER SIEVERS: Okay.

MS. EMRICH: And it's taken from the family nurse practitioner test plan, both AANP and ANCC.

CHAIRWOMAN KEELS: Remember we tried to define like where that limit is, that it was -- but we didn't want to call it "red" anymore, we just wanted to say, you know, you're basically going to die if that's -- that's -- that's where that is, without life-sustaining interventions.

MS. EMRICH: There's a difference between someone presenting to your clinic and they think they have indigestion but they're having an MI, and you get them, you get them taken care of and get them where they need to be, versus the family nurse practitioner running TPA in the ICU --

MEMBER SIEVERS: Right.

MS. EMRICH: -- and managing that, so.

MEMBER SIEVERS: Right. I like the "unstable/critical conditions" as long as they just don't think "high acuity" means "Oh, I can't take care of the elderly person who has diabetes, hyper-cholesterol, heart disease." I mean I would say that would be kind of a high-acuity patient but they're not unstable, right? They just have multiple conditions which makes them a very acute patient but I mean it's that whole acuity again.

MS. EMRICH: Well, that's a very complex patient, I think.

MEMBER SIEVERS: Right, complex.

MS. EMRICH: It's very complex but not necessarily high acuity if they've gone from their normal, yeah, unless they've gone from their normal state of health or stability to becoming very unstable.

MEMBER GRAHAM: Let me give an example. This is Margaret.

As a family nurse practitioner if I have a person who comes in who has a 600 blood sugar, they're high acuity but we may be managing them in primary care. I mean we're not necessarily going to

send them to the hospital. I mean we'll see them frequently, we'll check their blood sugar tonight, we'll check it again tomorrow but that's a person who's high acuity and I would say probably they're unstable at the moment if their blood sugar is 600, but we're not, you know, if they're not ketotic, we're not going to send them to the hospital.

So I guess I'm just a little worried about the "high acuity" and "unstable." I think that, as a family nurse practitioner, I do see high acuity, unstable patients. Sometimes they're critical and they have to be admitted to a hospital but many times a person in CHF or diabetic, those are the two that I think of who become unstable and then we stabilize them in primary care. Occasionally they may, you know, the next day, if that person's blood sugar is still 600 and we can't get it down, then they may be hospitalized, but I just want to make sure that if we say "high acuity unstable," I don't think they're necessarily critical.

I guess that -- that's a concern I have because I think family nurse practitioners do provide maintenance of their patients who are high acuity and unstable almost every day and then, you know, we bring them back more frequently and we see them and

we call them and we manage them closely but we don't necessarily turn them over.

MS. EMRICH: And I think that's why we've, over time, tried to use as many descriptors as possible here. You know, I don't think you can use the word "unstable" without "critical" to mean the type of patient we're talking about. We've also tried --

CHAIRWOMAN KEELS: Oh. You're cutting in and out again, Lisa.

MS. EMRICH: We've tried to define "critical" at different times too.

CHAIRWOMAN KEELS: Yeah. It's been really hard.

What about -- I understand Margaret's point because, you're right, there's a lot of fairly stable people with really high morbidity, complex issues that become acute that you can manage as an outpatient or even hospitalized but not necessarily like in the ICU, right? I mean we're really trying to get at that population which was critically ill, life-threatening, imminent death, is sort of where we were with that.

MS. EMRICH: Whole system involvement.

MEMBER DIPIAZZA: Multi-organ failure.

CHAIRWOMAN KEELS: Do you want to remove "high acuity" and put "critically unstable and/or life threatening"?

MEMBER SIEVERS: I like that.

CHAIRWOMAN KEELS: And it's management of, it's not -- so because we talked about FNPs that are in urgent, like a urgent care or even the ED to do the fast track but they may be the first responder for trauma, they may have to start but then call, you know, call for help and turn the patient over when help arrives, but we're talking about the actual management of the patient's care.

MEMBER SIEVERS: Yeah, I like what you just said. Can you say that again?

(Laughter.)

CHAIRWOMAN KEELS: No. You'll see it in the transcript in a couple of weeks.

(Laughter.)

MEMBER SIEVERS: "Critically unstable" --

CHAIRWOMAN KEELS: "Critically unstable and/or life threatening."

MEMBER SIEVERS: Yes, that's it.

CHAIRWOMAN KEELS: Because that really speaks to oh, you're not -- you probably aren't being managed as an ambulatory and you're probably headed

towards an ICU of some sort, right?

MEMBER DIPIAZZA: It -- it aligns nicely with the definitions that we've shared in previous meetings.

CHAIRWOMAN KEELS: Yeah, yeah. The WHO one that we ended up not using --

MEMBER DIPIAZZA: Yeah.

CHAIRWOMAN KEELS: -- but I mean that's really what we were just trying to make that distinction because we definitely want our primary care folks to know that, you know, they have this whole realm of acute illnesses that they're managing.

MEMBER SIEVERS: Dr. Graham, do you like that?

MEMBER GRAHAM: Uh-huh. Yes.

CHAIRWOMAN KEELS: Okay. Good. All right. Yay.

MEMBER ZAMUDIO: Can I ask question to clarify on that though? We're assuming if their critically unstable or life-threatening conditions are being managed, and someone is trying to treat it, how would we address palliative care where they have a life-threatening condition but they're choosing to not have that treated? Can the FNP in that role -- it seems it would be perfectly reasonable for them to

still address it.

MEMBER DIPIAZZA: Those are more --

MEMBER ZAMUDIO: I'm just throwing that out.

MEMBER DIPIAZZA: -- in nature, right?

CHAIRWOMAN KEELS: I'm sorry. Pete, your first part dropped off.

MEMBER DIPIAZZA: No, you're fine. I mean those tend to be more chronic in nature when you refer to the palliative.

MEMBER ZAMUDIO: But they're unstable and life threatening.

CHAIRWOMAN KEELS: Yeah. Unless you say "outside of palliative care." "Palliative/hospice care."

MEMBER ZAMUDIO: I just think that we --

CHAIRWOMAN KEELS: I don't know, are there -- do FNPs manage palliative and hospice care?

MEMBER ZAMUDIO: Yes.

MEMBER DIPIAZZA: Absolutely.

MEMBER BOLTON: Do we need to differentiate that? I mean because I -- even though they're life threatening, they're in a palliative-care state and I think either an acute care or an FNP could manage that, you know, and

that's one of those gray areas. I don't know that we necessarily need to differentiate that.

MEMBER DIPIAZZA: I agree with you, Pam. I don't think we need to differentiate it. I think, you know, the definition or how we're defining it that it's an acute, critically ill, end of, you know, end organ failure kind of event.

MEMBER GRAHAM: But that is the event of palliative care that FNPs do manage. I think Pam is exactly right, that can be managed by an FNP or an acute. I just don't want this to -- I don't want this to come back and be used against an FNP who is giving --

MEMBER ZAMUDIO: Exactly.

MEMBER GRAHAM: -- end-of-life care.

CHAIRWOMAN KEELS: Oh no. We need more people doing that.

MEMBER ZAMUDIO: That's why that was my question.

MEMBER DIPIAZZA: At that time are they managing the patient's symptoms or are they managing the patient's disease state?

CHAIRWOMAN KEELS: Well, I think it ends up being both, right, because palliative care can actually be a period of time.

MEMBER DIPIAZZA: Yeah.

CHAIRWOMAN KEELS: Maybe we have another FAQ around palliative care.

MEMBER BOLTON: I mean I think the difference is the ultimate -- what's the ultimate goal, versus, you know, stabilization or dignified death. You know what I mean? Peaceful and painless death process. You know, it's the outcome that's different.

MEMBER ZAMUDIO: Can we put a statement saying this does not include palliative care? I'm just trying to be inclusive so this is, you know, we don't -- if we're going to do this, let's try to do as much of it right the first time as we can.

MEMBER BOLTON: I think it would be a great FAQ. I think that would be perfect.

CHAIRWOMAN KEELS: Yeah, I would ask for an FAQ on that if that would be okay to add one more.

MS. DIPASQUALE: This is Anita. I wonder if we could also look at the test plans again to see how those -- the language that they're using because we're trying, I think, to always go back to what is the national certification about. So if this was presumably covered in some part of the test plan on the AN - ANTC or I forget which other one you said it

was, Lisa.

MS. EMRICH: AANP.

MS. DIPASQUALE: AANP. Sorry. Perhaps there's some language we can grab there to cover to address the palliative care to make sure it's not somehow excluded by the language you're choosing here. Just a thought.

CHAIRWOMAN KEELS: I would be okay with that too.

MEMBER ZAMUDIO: It would be after the certification, right? I mean I think if they're an FNP, I don't know if it's covered because I'm not an FNP, but I think that would be well within their licensure and certification to get that training and education after they're certified. They're still taking care of that adult. I mean we have a strong palliative care program that's run by family medicine where I work, so.

CHAIRWOMAN KEELS: Okay. Thanks. So we'll either have an add-on FAQ or we'll incorporate some language from the test plans here, depending on what you find.

Okay. Anything else on page 12?

All right. Page 13. Delegation. And then the rest were just some links.

MEMBER ZAMUDIO: A point of clarification on page 13. Under the paragraph that says "By contrast," on about the sixth line down towards the end of it, it says the APRN is on site during the delegated medication administration, which I know is already defined in law and rule.

How could they address a common question that I hear which is can unlicensed personnel, such as a medical assistant, give flu shots?

I mean a pharmacy gives them, other places give them, many offices run where the patient comes in, has a nurse visit, gets their flu shot. You may not be in that office that day; you might be somewhere else. Is that prohibited by this?

MS. EMRICH: So it depends on who is administering the flu shot. If you have a licensed nurse administering the flu shot, there's no requirement that the prescriber be on site when the flu shot is being administered.

MEMBER ZAMUDIO: Okay.

MS. EMRICH: And flu shots can be administered by protocol because it's an immunization -- to administer the flu shot and it's the --

CHAIRWOMAN KEELS: You're breaking up again, Lisa.

MS. EMRICH: Okay. The APRN -- if it's a medical assistant who is administering the flu shot in your clinic and you're the APRN who is ordering the flu shot, you have to -- the APRN has to be on site for the unlicensed person to administer the flu shot.

MEMBER ZAMUDIO: Okay. So it's not enough for the nurse to be on site. The APRN has to be on site. What happens in a lot of --

MS. EMRICH: Correct. It is not enough for the nurse, because the nurse cannot delegate that to the medical assistant. It's the APRN who delegates it.

MEMBER ZAMUDIO: Got it.

MS. EMRICH: Uh-huh. The nurse is not -- a registered nurse cannot delegate the administration of a medication to someone who does not have the authority to administer it. And they're not administering it by the RN's authority; the medical assistant is administering it per the APRN's authority.

MEMBER ZAMUDIO: Okay. I was just trying to cover immunizations. I don't want any barriers to immunizations, right, we have enough of those.

MS. EMRICH: Yeah, got it.

CHAIRWOMAN KEELS: Okay. So we have gotten through the document. We have a couple things to add, right? We're going to move the Consensus Model to the FAQ. We're going to add a couple tweaks. We were going to add an FAQ about --

MS. DIPASQUALE: This is Anita. I have a note here, we were going to add an FAQ saying that 47 -- turn it into a question but 4723-08-5 -- 8-05(F) has been eliminated -- or if this happens, so this is another one of those future ones, best practice would be to check that the collaborating physician's licensure is current and valid. Is that the one you were thinking?

MS. EMRICH: Uh-huh. It's an FAQ. And also the --

MS. DIPASQUALE: And also what happens if it's adopted.

CHAIRWOMAN KEELS: Yeah, yeah, that might come after. I mean hopefully this will be approved soon and we can actually post it, that would be lovely, but we wanted to move the --

MS. EMRICH: I also have --

CHAIRWOMAN KEELS: Yup, go ahead.

MS. EMRICH: I also have for the pharmacy course that that be added to the FAQ, too, about how

that is to be evaluated, the -- how those may be evaluated if it's going to be removed.

CHAIRWOMAN KEELS: Okay. And then you were going to move the national -- the subspecialization to an FAQ. And then we were going to make maybe a palliative care FAQ --

MS. EMRICH: Correct.

CHAIRWOMAN KEELS: -- or incorporate that into the answer.

MS. EMRICH: We have the two footnotes about the grandfathered.

CHAIRWOMAN KEELS: Yes.

MS. DIPASQUALE: And wasn't the consensus, no pun intended, to move the APRN Consensus Model question down or --

MS. EMRICH: Yes, to a FAQ.

MS. DIPASQUALE: Yeah.

CHAIRWOMAN KEELS: And then have the link to the website.

MS. EMRICH: Uh-huh.

CHAIRWOMAN KEELS: So we meet again in November and so we'll have the updated documents to review before then. I'm hoping we can simply, quote/unquote, review the parts of the document that we requested to be revised or tweaked or whatever, so

that perhaps we can be done with it at that time. Wouldn't that be lovely?

MS. EMRICH: Excellent.

CHAIRWOMAN KEELS: Nice job, guys.

okay. So next we have, you know, if I go back to the agenda that I put aside again, we had a discussion -- well, Brian had asked, Brian Garrett, who couldn't be here today, asked for us to have a conversation around the use of the title "Doctor," and I know Lisa sent out some documents around that. Do you guys want to keep moving forward and talk about that now or do you want to table that until November so Brian can be part of that conversation?

MEMBER ZAMUDIO: It's on our agenda, then I think we should talk about it.

CHAIRWOMAN KEELS: Okay. Can everybody stay on for a little bit longer?

MEMBER ZAMUDIO: It should be a quick talk, right?

MEMBER SIEVERS: Yeah, can you say what -- did he share what the background was, why is it coming up, what are his concerns?

CHAIRWOMAN KEELS: Well, his -- his perspective was he's a CRNA, right? Well, he's a CNP and a CRNA, and now a DNP or a doctorate is required

for entry upon practice and so there's a lot of doctorally-prepared CRNAs, and I think there -- he was -- and he works within an academic setting and just trying to be consistent with his advice to his colleagues on how should you identify yourself, what if somebody calls you "doctor" in public in front of a patient, how should we handle that, should the Board have a statement around that or any guidance around it. I think that summarizes it, Lisa, unless you have some other recollection.

MS. EMRICH: I think that captures -- that captures it.

So we've received this question over the years and our whole response is that the Nurse Practice Act itself does not prohibit any nurse from using an academic title, degree, with their name.

We do require that all licensed nurses make clear to the patient, and any health provider with whom they are working, to make known their licensure, whether it's an RN, LPN, APRN, and there should be no confusion on the part of the patient or with another healthcare provider as to what your licensure type is. That does not prohibit you from saying, "Hello, I'm, you know, Jane Smith, I'm a doctorally-prepared APRN." Or "Hello, I'm Dr. Smith,

I am an APRN." That kind of thing. "I'm a Ph.D." "I'm a DNP." You know, we don't -- we've never prohibited that.

We do have concern when there is some type of misguidance or inference that you are -- that an APRN or any nurse is a license type that they are not. So that's, for us, you know, an issue and that has occurred.

MEMBER SIEVERS: So if that is the same, did we share that with Brian that he just has to tell his colleagues to say "I'm Dr. Sievers, I'm a nurse practitioner." And was he not happy with that? He was looking for further -- I would be hesitant to do anything more than that, you know, not rocking the boat and bringing up this big issue. I -- I hear people doing that in practice, qualifying it, so is it that we just -- was he given that information and was not satisfied with that or do we know?

MS. EMRICH: No. I think he has --

CHAIRWOMAN KEELS: Go ahead.

MS. EMRICH: I think part of his concern, too, was the nurse anesthesiologist question that had arisen, you know, about titles, to be called a "nurse anesthesiologist," which that gets into not our issue so much unless you do have to make yourself known as

a CRNA if you are a CRNA but that gets into the realm of what would the Medical Board prohibit as well, if using the term "anesthesiologist" implies you're a physician, so I think that was more his issue than -- than -- than anything.

MEMBER SIEVERS: Maybe we should speak to him because I don't -- I'm not familiar with that term "nurse anesthesiologist," but as far as the "doctor" title, I think just continuing to tell people to qualify it with what you are.

MEMBER ZAMUDIO: I agree --

MEMBER GRAHAM: I think it's like a dentist or a -- sorry. Go ahead, Michelle.

MEMBER ZAMUDIO: That's okay. I was just going to say I mean I have some perspective having been in the military at the very beginning of this movement where nurses were DNPs and you might be working with a nurse on the floor who had a DNP, right, so it was a big topic and it comes around every once in a while in an academic setting and in a clinical setting like the one I work in now.

I frequently we hear, "Hi, I'm Dr. So-and-So. I'm the midwife on call." So you're following the law. You're used to that title that you've earned. Patients -- I think it's an excellent

time to educate patients, not cause confusion, because we can tell them what we are, it builds confidence in that provider. Like I said, I work with several of those. And so the same would apply, I think, to anesthesia.

We're in an inpatient setting but we always say we're the nurse midwife, we're the midwife that's going to take care of you today. And when we correct family members who say, "Oh, good, the doctor is here." "No, no, I'm the midwife." And so it takes a brief second but I think it's good for us to do as professionals.

I would also refer him to 4723-8-03. It does require an APRN to display and identify the applicable title and designation. So just display, identify, and you're following the law.

MS. EMRICH: And when you're talking with someone over the phone, you have to do the same as well.

MEMBER ZAMUDIO: Yes.

MS. EMRICH: Yes.

CHAIRWOMAN KEELS: Lisa --

MS. EMRICH: Again, there should be no confusion to the patient or to another healthcare provider. Yes?

CHAIRWOMAN KEELS: Do you think we could have an FAQ on this? "I've gotten my Ph.D. or my DNP. What is my title?" And then you can say essentially what we've said that the State, you know, the NPA requires that you identify yourself as an APRN-CNP but you, you know, you may say "Hi, I'm Erin, I'm Dr. Keels, but I am your nurse practitioner today" just to clarify that. I don't want to make too many waves, to Sherri's point.

MS. EMRICH: I mean this is one of those times where context is everything, isn't it? It is. If -- if you're walking into a patient's room who is just coming out of -- if you're in the PACU, the patient is just coming out of the surgery, it may not be a good time to use the word "doctor." It may not be. Seriously.

CHAIRWOMAN KEELS: Yeah. And I had a colleague who, you know, she encouraged the nurses to call her "Dr. Deb" all the time, but around patients, and I thought that's probably a little much because we have residents and interns and attendings and all kinds of different people running around and it was hard to not confuse them, but people should be proud of their doctorates as well and be recognized for that.

MEMBER ZAMUDIO: Dr. Graham, do you have anything to add?

MEMBER GRAHAM: I just think that people should be able to use their earned title and I don't think -- I don't think that dentists sit and decide whether they call themselves, you know, "doctor"; or psychologists don't discuss whether they can be called "doctor." They're a doctor but they're a psychologist; or they're a doctor but they're a dentist; or a doctor but they're a veterinarian, you know?

So I think it's fine for us to call people by their earned title and I think we should, and I think we should encourage people to use them, they've worked hard to get them.

I think it should never be confused, you know, with a physician, but physicians don't own "doctor," you know? I mean we have many, many members of the healthcare team who have doctorates: Physical therapists, OT, PT. So I think it's fine for and I think everyone should, who wants to, use that title.

Again, I think Lisa is right. We just have to make sure that they know it's a doctorally-prepared nurse, just as we know a dentist

is a doctorally-prepared dentist, you know, and so I think that every member of the healthcare team should be able to use their earned title and then we just have to make sure that our patients know that earned title is either a nurse-midwife or a nurse practitioner or a nurse anesthetist.

MEMBER ZAMUDIO: I have an interesting, just a little tiny fact because I was researching this and I found in the statutes, I was looking for prohibitory language to kind of put it in context, and they have grandfathered in, from the 1980s, the ability to use the "doctor" title for naprapaths and napratherapists --

MS. EMRICH: Yes, yes.

MEMBER ZAMUDIO: -- who work on soft tissues and joints.

MS. EMRICH: And the Medical Board regulates those too if there's any left.

MEMBER ZAMUDIO: Just a little trivia.

MS. EMRICH: I think there's one naprapath left. Last time I saw the stats, there's one. They don't -- those are not licenses they continue to issue.

MEMBER ZAMUDIO: Nope.

CHAIRWOMAN KEELS: Okay. Moving on.

Last -- last item are some announcements. Lisa, do you want to speak to those?

MS. EMRICH: Oh, it's past tense now. LPN renewal began on July the 1st and it's all online. We just wanted to make you all aware that we're in the midst or just the beginning of LPN renewal. We have over 50,000 LPNs who will be renewing this cycle, so it's very good.

CHAIRWOMAN KEELS: And then in your Board mailing you received summary questions that were posed to the Board. I'm trying to find them right now. Any questions or concerns or comments around that?

MS. EMRICH: These are more informational, FYI, and we did include the responses as well as the actual questions.

CHAIRWOMAN KEELS: Yeah, that was very helpful. Thank you very much.

MEMBER ZAMUDIO: That was great.

CHAIRWOMAN KEELS: They were sort of complicated questions. And I looked at those to try to see if we encompass many of them in our FAQs. We didn't about the certificate of death, the termination of death. I wonder --

MEMBER ZAMUDIO: Oh, that's a good one.

MS. DIPASQUALE: Would you like that one added?

CHAIRWOMAN KEELS: That -- that was a really good one. I felt like that was very well explained and could be helpful on the FAQ site.

MEMBER BOLTON: I agree.

CHAIRWOMAN KEELS: I thought the EEG and EMG, you know, we already addressed that through the decision-making. We already touched on some of the prescribing. I thought we -- I thought we touched on most of this. I mean some of it was COVID related, which, you know, knock on wood that never happens again but who knows.

Okay. Any final comments, concerns, questions, recommendations? We got a lot of work done.

Okay. So our next meeting is November 16th. Maybe we'll get to meet in person, I don't know, maybe not.

If nobody has anything else, then I guess we are adjourned. Thank you all for your time and your work and this was really great. Thank you.

(Thereupon, the Advisory Committee meeting concluded at 3:00 p.m.)

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CERTIFICATE

I do hereby certify that the foregoing is a true and correct transcript of the proceedings taken by me in this matter on Monday, July 6, 2020, and carefully compared with my original stenographic notes.

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Carolyn M. Burke, Registered Professional Reporter, and Notary Public in and for the State of Ohio.

My commission expires July 17, 2023.

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