BEFORE THE OHIO BOARD OF NURSING

ADVISORY COMMITTEE ON ADVANCED PRACTICE REGISTRED NURSING

MEETING
before the Advisory Committee on Advanced Practice Registered Nursing, via Microsoft Teams, called at 10:00 a.m. on Monday, November 16, 2020.

Advisory Committee on Advanced Practice Registered Nursing:

Erin Keels, RN, APRN-CNP, Chairwoman

Peter DiPiazza, APRN-CNP, Committee Member

Sherri Sievers, APRN-CNP, Committee Member

Michelle Zamudio, APRN-CNM, Committee Member

Margaret Graham, APRN-CNP, Committee Member

Angela Gager, APRN-CNM, Committee Member

Pamela Bolton, APRN-CNP, APRN-CNS, Committee Member

Also Present:

Lisa Emrich, RN, Program Manager

Anita DiPasquale, Staff Attorney

Tom Dilling, Public and Governmental Affairs Officer/Liaison

Chantelle Sunderman, Administrative Professional.

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Monday Morning Session,

CHAIRWOMAN KEELS: All right. Good morning. Good morning, everyone. I will call to order our meeting of the Advisory Committee on Advanced Practice Registered Nursing at the Ohio Board of Nursing.

Today is November 16, 2020. I'm Erin Keels. I am the Chair of the Ohio Board of Nursing Advanced Practice Registered Nurse Advisory Committee. The Committee charge is to advise the Board regarding the practice and regulation of advanced practice registered nurses and may make recommendations to the Committee on prescriptive governance.

This meeting is being recorded live via YouTube. The link is available to the public on the home page of the Board's website. Due to the nature of this virtual platform, there will not be an opportunity for the public to engage with the Committee in real time. Rather written comments and questions were submitted and received by 8:00 a.m. today, November 16, so that they may be distributed to the Committee Members to review prior to the meeting.

I believe we have one written comment from OAAPN that has been distributed to the Committee Members for review.

MS. EMRICH: Yes.

CHAIRWOMAN KEELS: Additionally, today's proceedings are being recorded by a court reporter. The transcript of the July 6 meeting has been distributed for review.

And, Committee Members, as I call your name, please introduce yourself along with your APRN title and the role that you hold on this Committee.

Pam Bolton.

MEMBER BOLTON: I'm a nurse practitioner and CNS, and I am the employer.

CHAIRWOMAN KEELS: Dr. Margaret Graham.

MEMBER GRAHAM: I'm a family nurse practitioner, and I represent education.

CHAIRWOMAN KEELS: Ms. Sievers.

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

CHAIRWOMAN KEELS: Piazza.

MEMBER PIAZZA: Good morning. I am Pete Piazza. I'm an FNP, and I represent primary care.

CHAIRWOMAN KEELS: Brian Garrett. And you are on mute, Brian.

MEMBER GARRETT: Sorry. I'm on. Erin, are you there?

CHAIRWOMAN KEELS: Yes. Can you hear me?

MEMBER GARRETT: Yes. Can you hear me?

CHAIRWOMAN KEELS: Yes. Would you like to introduce yourself.

MEMBER GARRETT: Yes, sorry. I am on two meetings at once. I have a work meeting, and I am doing this meeting at the same time. I have three work meetings today because of all the coronavirus increases, so. Brian Garrett, Director of the Otterbein University-Grant Medical Center Nurse Anesthesia Program. And again, I apologize. I will be listening on several meetings today, and I will try to jump in here when I can.

CHAIRWOMAN KEELS: All right. Thank you, Brian.

Angela.

MEMBER GAGER: Good morning. I'm Angela Gager. I'm a family nurse practitioner, and I'm representing nursing faculty.

CHAIRWOMAN KEELS: And again, I am Erin Keels. I am a nurse practitioner in Columbus, Ohio, and representing the Board.
CHAIRWOMAN KEELS: Hi, Michelle.

MS. EMRICH: Okay. Thank you. So with respect to HB 197 we -- we included this on the agenda today simply because it is fairly new law. It went into effect March with the -- which -- with the other COVID-related statutory amendments.

But this is particular to CRNAs and it permits CRNAs to provide orders to licensed nurses and to respiratory therapists within a specific time frame that begins when the patient basically enters the hospital and then leaves -- or wherever the surgery or procedure is being performed and then is discharged.

Tom, you may have some additional input with that, but one of the questions that has arisen particularly were CRNAs asking about whether they can obtain a DEA since they are ordering drugs which may include controlled substances.

And Cameron, I know, contacted us and also the Pharmacy Board put out some guidance about that which was included in your materials. Cameron, I don't know if you would like to speak to that directly or if you have any other updates besides -- that came after the guidance was issued.
MEMBER SIEVERS: Thank you.

MS. EMRICH: Effective in December

CHAIRWOMAN KEELS: Does anybody have any questions related to the CRNA practice changes in general while we have folks online?

MS. EMRICH: Erin, I know Brian is involved with some other work things now, but I don't know if he has any practical application or comments we were very interested in hearing.

CHAIRWOMAN KEELS: Maybe we can come back to him later when he is able to join us. Okay.

CHAIRWOMAN KEELS: Move on to the next agenda item which is APRNs and consult agreements.

MS. EMRICH: And Anita -- I will refer to Anita had -- did a very nice memorandum about that just to make you aware.

MS. DiPASQUALE: I think this will be a draft article in an upcoming Momentum, I believe.

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MEMBER DiPIAZZA: Absolutely agree, difficult to deal with. I just think it would be another level that would be paying for their collaborating physicians. I just have to get the pharmacist to have to have the relationship. I mean, we have some nurses who are having to get the pharmacist to have to have the layer of responsibility for the nurse to add that layer of responsibility for the nurse to have in this treatment regime. So I would strongly encourage us not to have in this treatment regime.

MEMBER DiPIAZZA: Absolutely agree, difficult to deal with. I just think it would be another level that would be paying for their collaborating physicians. I just have to get the pharmacist to have to have the relationship. I mean, we have some nurses who are having to get the pharmacist to have to have the layer of responsibility for the nurse to add that layer of responsibility for the nurse to have in this treatment regime. So I would strongly encourage us not to have in this treatment regime.

Mr. McNamee: This is Cameron from the Board of Pharmacy. We are in the process of updating our rules, and you will -- the Board of Nursing is responsible as well as the Medical Board is in the law required to provide updates to them. We don't intend to -- at least in our initial draft rules we had no intention of getting into the level of details where the collaborating nurse has to get the -- or the physician who's got the collaboration agreement with them, or the supervising agreement, I forget what they are called.

But anyway I think we were trying to take out as much of -- or take out -- provide as much latitude as we can in the agreements, so obviously ceding the practitioners is -- is important, but whether or not that practitioner's sort of supervising physician signs on is something that we're still -- that we -- we haven't really considered and that -- and we're probably deferring to medical or nursing as to whether or not that's appropriate in your -- in your space because we're just going to decide -- we're really governing what the pharmacists are doing on their end. And so in terms of specifics from the provider's side, I think that's where we'll defer to both medical and nursing as to what you think is appropriate.

MS. EMRICH: And currently there's no requirement -- I mean in the Nurse Practice Act there is no requirement that the APRN's collaborating physician have a prescriber relationship with the APRN's patient so that there's no requirement there so I can...

MR. McNAMEE: Yeah. The statute doesn't really get to that level of detail. They literally just crossed out physician and put practitioner in there.

MS. EMRICH: Very good.

CHAIRWOMAN KEELS: Sherri, do you have a question?

MEMBER SIEVERS: I do. So the agreement with the physician, is that currently a written agreement? I guess -- I think what my question is for Anita, when we hash this out, is what -- how is this operationalized and is there anything that needs to be officially on paper or how is this working with -- it says consult agreements only with physicians. Were those written?

MS. DiPASQUALE: Yes. If you look down at the -- this was me summarizing the current law, 4729.39, and then the proposed -- then the changes, pardon me, the changes. So if you look at the last paragraph on the page, on the first page of the memorandum, it says "The consult agreement" -- this is not about nurses. This is the existing framework. "The consult agreement must be in writing and must include." And so then it says what, you know, the diagnoses and diseases being managed, whether each disease is primary or co-morbid, et cetera. So, yes, it does have to be in writing.

CHAIRWOMAN KEELS: So on the physician's side, are they recognizing like a delegated signature process for that?

MR. McNAMEE: So the consult agreement themselves are -- is an effort to delegate. So if you think about it, it's -- it can be as broad as credentialing, so in the institutional facilities if you are appropriately credentialed as let's say our pharmacist that's doing, you know, the Coumadin clinics. If you are appropriately credentialed to manage that -- those patients, then you can go to Coumadin clinics, and the medical director really signs off for the whole -- for the whole institutional facility. So it can be done very
broadly if you are working in a wide institutional facility where there's credentialing. It could be done very locally, so far as you have a clinic pharmacy inside of a primary care clinic, and you want that pharmacist to manage, you know, these patients, you can do it that way.

So it's really -- it's really kind of broad in terms of how you want to implement it. You can have it as widely as sort of institutional credentialing identifying this practice group and this practice group or however you want to do it that way, or you can do it individually. So there's some latitude there in the rules about how we want to see it sort of structured.

But I think from our perspective and the Board's perspective, it's what are the -- what is the universe at which that pharmacist can operate? What is the universe to which they can adjust to make modifications, send you, you know, a follow-up report or whatever? Or how frequently do you want to see follow-up reports or do you want to -- once this point hits, do you want them to call you?

And so there is a lot of latitude there to the -- to the provider who is entering into that agreement with a -- with a pharmacist.

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CHAIRWOMAN KEELS: Thank you. Pete, you have your hand up.

MEMBER DiPIAZZA: Well, real simple question, Cameron, is there a template for this agreement or this consultative agreement that we could use from the Pharmacy Board?

MR. McNAMEE: There's no template. Obviously if you go to 4729 -- 4729:1-6-02, we specifically have stated some of -- we've tried to provide as much of the specifics for what's in the statute so, you know, what -- what is -- what is primary, what is co-morbid, you know, who do you have to list, how do you have to list them, and a description of this, a description of that, and so, you know, we do structure in the rule where it's easy to follow. And specifically, you know, if you are in a large institution and you have policies you want to reference, we also make allowances there where you are allowed to say, okay, we will manage in accordance with this policy and you can reference that policy; and as long as it's accessible for us to inspect, we are fine with that.

So I would say that many of your -- many of your large institutions probably have consult agreements you can borrow from, and I am happy to put

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you in contact with some of the folks that we've worked with initially on our rules many years ago at -- folks at OSU pharmacy that have been helpful in trying to -- they came in to explain to the Medical Board sort of how the structure works. So I'm sure the institutions are there that have those sort of templates in place that simply, you know, add on the -- add on nurse practitioners and PAs once it -- once the rules are ready to go.

MEMBER DiPIAZZA: All right. Thank you.

CHAIRWOMAN KEELS: Sherri.

MEMBER SIEVERS: I just have another question for maybe Anita. Do we anticipate that there will be language changes for the standard care arrangement, or do you think it's okay just to have this in policy? I only ask that because we just got -- most people probably across the state by the end of December will need to do an updated biannual standard care arrangement. We just did all of that for 50 people in July, and I'm just wondering if the language is going to need to be changed in the SCA itself, or do we think that we can manage it through a policy like Cameron suggested?

MS. DiPASQUALE: Well, I would say that that is something that will need to be addressed during the rule-making process. All I know currently is, you know, that it says it has -- may only enter into a consult agreement if doing so is authorized by one or more collaborating physicians. I cannot -- certainly I can't, as I sit here, rule out that being what I would call a side agreement or whatever. It says it has to be authorized.

Now, I'm sure the rules, the draft rules will come to this group at some point, of course go through the whole public process. The -- you know, the rules about SCAs do say that -- that they have to hold a statement of services that the APRN will provide. That would be a logical place for this to be included. Does that mean it has to be included there? I could not respond to that at this moment. I don't know, Lisa, if you have other thoughts but that's my current -- that's my response.

MEMBER SIEVERS: Okay. Thank you.

CHAIRWOMAN KEELS: Pete, do you have another question?

MEMBER DiPIAZZA: I do; I apologize. But, Anita, I'm curious then, this -- this goes into effect in December according to the memo. Will APRNs need to wait for rules to be drafted by the Board?

MS. DiPASQUALE: I mean, the rules are
supposed to amplify the statute, right? So the statute is law that has been passed by the legislature, so it is in effect when it takes effect. The rules are to amplify that statute. They don't -- a person doesn't -- you don't have to wait on the rules in order to act under a lawfully enacted statute.

MEMBER DiPIAZZA: Okay.

MS. DiPASQUALE: Tom may have his hand up and want to add something there being our legislative --

CHAIRWOMAN KEELS: Tom.

MS. DiPASQUALE: -- guru.

MR. DILLING: Yeah. I mean, we just all need to take a step back and understand that it's a new statute, goes into effect in December. There's rule-making direction to do rule making for all the Boards. The Pharmacy Board and the Medical Board, Medical Board just did their physician rules this month that went into effect. And they've been practicing for a year or two, right, you know, under these consult agreements or more? The Pharmacy Board made allowances for practice by APRNs with pharmacists in these consult agreements prior to this law passing during the COVID period, there's guidance that I think is in the materials, but it's also on the Pharmacy Board's website, and I think we copied that as well.

So what I'm saying is take that into consideration along with the fact that APRN and their prescribing is tethered to the standard care arrangement and the collaborating physician. Like it or not, that's where it's at right now. It can be done in accordance with your collaborating physician.

On into the future the need for that collaborating physician to also be signed up, you know, with one of these agreements I don't see as much, okay? I think that that's one of the reasons why this law was passed in the first place, so that you could cut that part of the tether. But they are -- there is still practices that in conjunction with your collaborating physician in a written standard care arrangement, that collaborating physician will always have some authority in the sense of the both of you all have to come up with an agreement that you can both live by and practice by. But as Cameron points out, I would guess the majority of this practice is more hospital based, so you have another level of oversight and involvement here in terms of, you know, how the pharmacist is interacting their employer, you know, with you.

So the long and the short of it is, yes, clearly you can practice without rules, but within the rules and statutes that are already in place which tie you to your agreement, say that you cannot exceed the authority of the person you are collaborating with, will have to give probably some more further guidance in the coming months with respect to some of these details.

So we wanted to put it on the agenda, bring it to your all attention, give a heads up. Cameron is here. I think he put your minds at ease that, you know, he's working with us on all these different fronts. We worked well with the Pharmacy Board. These guys know what they are doing over there. They put out some great materials, some great guidance. And by December 16, I think you'll have enough questions answered where you can begin these practices and continue the ones that are already in place during the COVID time period.

MR. McNAMEE: Yeah. We intend to have our rules, our draft updates to our rules out in the next two to three weeks, so you'll have a general sense of where we're coming from, although I will also be honest with you, it -- we did what legislature did with our rules and just removed physician and replaced it with practitioner, so we're not getting -- we are not doing anything that's going to deviate wildly from -- from what the process is now. I think the devil is in the details when it comes to the prescriber boards and what they want to see from their -- their licensees.

I think we -- we know exactly -- we expect to see from the pharmacists, whoever they are reporting to, and really it's going to come down to nursing and medical to work out some of the more nuanced approaches to this law change.

CHAIRWOMAN KEELS: Thank you. Any further questions?

All right. More to come on that.

MS. EMRICH: Cameron, thank you very much. We appreciate you being here today.

CHAIRWOMAN KEELS: Yes, thank you, Cameron.

MR. McNAMEE: Thank you.

CHAIRWOMAN KEELS: Have a nice day.

Next on our agenda are to review written public comments and we have one from OAAPN that was distributed to you. You've all had a chance to
review this, and does anyone have any question or comments? Would you rather reserve that until we get to the FAQ or the review of the FAQ document?

MEMBER GRAHAM: This is Margaret. I did go through the document and the suggestions, and I agreed with the suggestions; is that what you are looking for, to see if we are?

CHAIRWOMAN KEELS: Discussion and, you know, whether you would like to adopt these suggestions or not. Thank you, Margaret.

Anyone else?

MS. EMRICH: So, Erin, are we looking at the -- moving ahead to the summary document, or are we -- are you just discussing the comments?

CHAIRWOMAN KEELS: Comments from OAAPN, yes. My opinion, for what it's worth, is that suggestion to remove the word population foci -- or foci certification examination as it pertains to the CNS exam, I believe that there are certain populations now, not just a global CNS exam now; is that correct? There's one in pediatrics or is that a subspecialty?

CHAIRWOMAN KEELS: Comments from OAAPN, Margaret, would you say those are subspecialty examinations within your specialty, for lack of a better word, so as an adult acute care NP, you can then become certified in emergency care or something similar to that?

MEMBER GRAHAM: I'm not exactly sure. I know the one that I am aware of with the emergency room, I know that family nurse practitioners have been able to take the additional education. So I'm not sure which group that will apply to. I think that's -- I can't -- I can't speak about that because I am just aware that it's there, and I am aware of some people who have come back and done the additional certification, but I do think the psych nurse practitioners, that's not a subspecialty within a specialty. That is, the psych NPs, that's their graduate program. They come out of that, and I am aware of some universities across the country that have the same for emergency room nurse practitioners. You know, as we look ahead what is coming, I think -- I think that there will be other opportunities that we will see others' certifications that are not going to be based on the -- necessarily the population, that it's -- it's more based on the nurse -- the advanced practice nurse's specialty.

CHAIRWOMAN KEELS: Margaret, would you consider, I guess, a population --primary care through to acute care it includes that continuum.

CHAIRWOMAN KEELS: Okay. Which I -- I consider, I guess, a population --

MEMBER BOLTON: I would too.

CHAIRWOMAN KEELS: -- who describes who you are able to care for. For -- suggestion No. 2, removing the term "population foci" from the heading under currently available certification exams for CNPs. I think we talked about this before at our last meeting and agreed that we would keep the word population foci so that we were trying to be more clear on what were the exam or the -- the examinations that were regulated by the Board and not the subspecialty examinations that are not and so -- and to also try to remain congruent with the APRN Consensus Model. So I personally don't agree with that suggestion.

The next bullet point was to remove the word "resulting" prior to "national certification." I think again trying to be congruent with this -- the Consensus Model, we talked about that being the examination that informs your scope of practice, at least entry level, but then continued formal education and clinical experience shapes your ongoing scope of practice which I thought, Lisa, you did a nice job addressing in page 3 of the FAQ document that we'll review in a little while.

Again, with bullet No. 5, asking to remove the statement about references to the Consensus Model, I feel like we need to keep that in there. You do have a paragraph that states the Consensus Model is not law or rule and the purpose of that, so I thought that was a nice add, and we discussed that at our last meeting, so thank you for that.

MEMBER GRAHAM: And one of the reasons I think we should remove population foci is that if we think about psychiatric/mental health, that's not a population. People -- psych/mental health nurse practitioners take care of people who have -- who need counseling and other things, but it's -- you know, they do it across the age span. It's not -- it's not like women. I understand that, you know, we have women's nurse practitioners, and we have others that are, but psych isn't.

I think eventually, probably sooner rather than later, we will have emergency room nurse practitioners. You know, as we look ahead what is...
MEMBER BOLTON: This is Pam. I think the reason I struggle with removing it is that, you know, we still have the Consensus Model, is that -- is that go to document and that clearly identifies population foci at this point. You know, the article that you all sent talks about maybe -- maybe that needs to be relooked at, and I think in time, you know, that makes sense.

I think right now if you take that out, then you're -- you're taking away the -- I think really that's the core point of that -- of that document is looking at population foci which also lends itself to scope of practice. So it makes -- I'm not comfortable necessarily taking it out at this time.

However, I do feel like if there is a review of the Consensus Model, then it may be more about timing than it is whether or not it comes out, you know, depending on what the change in the document might be.

MEMBER ZAMUDIO: Erin, hi. This is through them one at a time though.

MS. EMRICH: You're on mute, Erin.

CHAIRWOMAN KEELS: Thanks, Michelle. I appreciate that. If you would like, we can wait until we get to the document and then go through it page by page and talk more in depth about this, if that makes more sense. I wanted to give people a chance to respond to the letter.

MEMBER SIEVERS: It's Sherri. I agree waiting until we go through so it's kind of in order. I'm like hopping all over on this document trying to remember what we talked about.

CHAIRWOMAN KEELS: Thank you. I wanted to acknowledge we received it and see if -- again if we had any comments. We can move forward and come back to this later. Thank you.

Okay. So that means that -- it's not noon, so we are not going to break for lunch yet. Is Tom available to go to the legislative report?

MR. DILLING: Yes, I'm available. Thank you. My apologies. I think that you all were sent a copy of the memorandum that I do for the Board, you know, in terms of legislation. I'm certainly open to, you know, questions having to deal with anything on that document.

Going down in order of the bills that appear on the -- in the memo itself, you know, make mention of the House Bill 203 which was just recently signed into law by the Governor and takes effect in December. And again, you know, I think that we have a number. The key aspect of this is that there are a number of different boards involved, and the Board of Pharmacy though is the one that governs these agreements. And I'm very confident that we'll be able to come to some -- some language in a relatively short period of time that is able to answer people's questions in a way which they can begin practice, and the rules will facilitate and not impede that practice. That's certainly the intent of this law as I understand -- as I understand it.

House Bill 611, there's also, excuse me, Senate Bill 325, I believe, and they both have to do with doula services. And 611 was introduced first, but actually Senate Bill -- the other Senate Bill is a substitute version and, look, they want to reimburse here in Ohio for doula services, and they are trying to figure out the proper way to do that.

In order to get reimbursed, you know, as an independent or as a practitioner, oftentimes you need some type of registration, certification,
licensure, something along those lines, and the
Senate Bill makes it into a kind -- a test model for
the next four years. You are going to answer
questions and going to come back and tell you how
effective this was versus the cost. 611 is more
let's implement this right away and get it going.

They're both based on the premise that
the doula is going to help -- help the care, the
maternity care here in Ohio which, you know,
obviously I think we are all aware that there's some
bad members out there in certain areas. The doula
there is articles, evidence, and so forth that shows
that they could be helpful and, in fact, maybe reduce
the costs of care.

So I think there are a lot of people that
are supportive of this. It is just a matter of how
far out do they go at the beginning. Is it, you
know, more of a four-year model, see if we go from
there, or are we all in right from the beginning and
then where is it housed?

So, quite frankly, we have had
communications, not that we initiated but that others
did, to see, you know, is there a fit here with the
Nursing Board and, you know, obviously we have the
certified nurse midwives, and we also interestingly
have the community health workers, both of which have
been bandied about as, you know, connectors to the
Nursing Board. There's also the Medical Board with
the OB-GYNs. There's the Social Workers Board came
into conversations. They have less to do with the
actual physical hands-on part of it, more with the
counseling.

And here we are going to be a lame deck
over the next month and a half and whether this can
be solved or not I'm not sure. Will it come back
next year it's not solved in lame duck? I'm pretty
confident that it will and that there are enough
people in support of this that it will find a home at
some point in time.

MEMBER ZAMUDIO: Tom, can I ask you a
question? It's Michelle.
MR. DILLING: I'm sorry. Go ahead.
MEMBER ZAMUDIO: Hi, Tom. It's Michelle.
I have a question or comment. We're very, very
excited about this bill. I do feel like there is
nearly universal support when you look at the
literature on the effect of doulas with the maternal
outcomes, and so they are all very positive.
I know you know probably more important
people than I do, Tom, so I will throw this out

there, a huge struggle that we're having is that the
doulas are actually being treated as visitors in the
hospital. So during the pandemic when people can't
bring a partner with them at all times, the doulas
are being excluded from the hospital and told they
cannot come in unless the mom would rather leave her
husband at home or partner at home. So that's a real
struggle.

So if you are in conversations with them,
it would be helpful if our -- especially if the Board
of Nursing, as an interested party, if we keep this
in mind. New York and several other states have
declared doulas essential healthcare providers just
with a -- with the power of the pen. You know, I
know in New York it was the Governor that did it.
That would be hugely helpful to our mothers who may
be laboring and giving birth alone or being forced to
choose between their partner and their doula. So I
just wanted to throw that out there.

MR. DILLING: Yeah. Thank you, Michelle.
That's great information to have and I will share
that with different people that I talk to. I don't
know how important those people are if they are
talking to me; but, you know, I certainly will pass
that on. It's good information and, you know, the
complexities of COVID and the operation of a hospital
and -- and so forth, when you get attorneys involved,
I can only imagine the complexities of that. But
certainly people are asking us all the time what are
you doing to help this situation and I see us being
as a conduit here, as you say, an interested party
passing along what we've heard here at the APRN
Advisory Committee. That's what you are all here for
and what we are all here for.

So, yeah, really appreciate those
comments and I will do my best to get them to the
right people.

MEMBER ZAMUDIO: Thank you, Tom.
MR. DILLING: You're welcome.
Yeah, House Bill 679, you know, is
telehealth. Gosh, everything is telehealth right
now, right? There's so many different bills, I
think, that weave in and out of the telehealth
service requirements. But here people want to
capitalize on the momentum that has been built here
for facilitating both reimbursement and actual
practice of telehealth, you know, during the COVID
period. I doubt that care could have been provided
as well and as broadly as possible, you know, without
some of those allowances.
At the same time, as it’s used more and more, people find more and more about it as, you know, even the practitioners I’ve read articles about, you know, like, okay, this was great at the start, but now, I am being asked to do X, Y, and Z, and I have never done that over the phone before or, you know, over the telehealth. What are my standards here? What are -- you know, how far out can we go? So there’s a certain experimental nature of what’s going on as well.

To add to the complexity, we are having the discussions about the compact licensure, and employers basically are placing on certain practitioners the all or nothing; if you want to work for us, you need to have a compact license bill which, you know, again is -- means a greater push to try to solve the problem of, you know, why can’t I practice in every state with one license.

And, you know, that’s the background of all these telehealth service requirements that are being mentioned here and I think that I’ve read a little bit of a pushback to say, hey, maybe we are going a little bit too fast here. I get that you want to move forward but let’s make sure that we’re all, you know, in sync, and again, reimbursement...

often rules the day. When people start giving out money, they want to know exactly how that money is being spent and what it’s being spent for so that maybe is the bigger prohibited factor here but there is no mistaking that this is, you know, at the forefront of both healthcare practice and healthcare legislation.

So this is the bill, I think, to kind of watch and learn from. As to how far they go in this bill, I’m unsure at this point in time. Again, we are going into lame duck session; and we are going into a time where, I don’t know, people might be told not to leave their house, so we’ll see how much gets done here in the next six weeks and then what happens on the backside of the change to 2021 and the new General Assembly.

673, I put that up there more as a segue for the Board to get into the extension of House Bill 197. But the exceptions, 673 mentioned specifically extending the date of these HB 197 RN and LPN licenses that were to be granted without the applicant having yet passed the NCLEX. They want to extend that date to July 1, 2021; and, you know, I don’t want to bore or confuse you further with going into a long explanation of all the work and effort...

that a seemingly simple provision, you know, can reek on the Licensure Department both here and in Licensure Departments around the country who are dealing with people who are coming to Ohio, getting their license without the NCLEX, and then immediately going to another state and trying to get in there without the NCLEX.

And our question back with respect to this was twofold; you know, one, there’s been some unintended consequences here around should somebody who is issued one of these licenses get to continue even if they have failed the NCLEX that they took? You know, at what point do you say maybe we ought to be backing off the pseudo nature of this license? It’s very real, but it’s not so real that it goes on forever without having passed that NCLEX exam.

The second part of it is we’ve been asking and not heard a lot of answers as to how is this utilized, you know, back in March when it was put into place? How many actual nurses without having -- having benefit of this license without the NCLEX actually were helping out during the COVID time? How helpful was that to hospitals? And how helpful will that be? What are the cost benefits...
thing I've heard from a couple individual schools, I
guess, supportive of the extension, I think maybe
even OCDD as a group was supportive of this
extension, yet at the same time very concerned about
the fact that they can't teach clinical like they
have in the past and then the NCLEX is being waived
doesn't quite go together. It doesn't sound good.
It's not necessarily a good look, I don't think, but
again, everybody wants to do whatever they can to try
to help out during the COVID time. So anybody who
has information and wants to talk later about how
this has been helpful and how we shouldn't be
concerned about it, more than happy to hear from you
on that front.

331, the Sunset review, Sherri is like
when are you getting rid of the prescribing group
there, you know. In our Committee, the CPG, this was
supposed to be the vehicle. It has a hearing this
week, so I think that their why moved. You know,
during this point in time we will see what happens.
But again, with all this flux and that, we'll kind of
have to play it by ear. But again, CPG has done a
wonderful job of transitioning to the law that we
have today. I think that that's kind of fallen on
deaf ears, or it's been missed -- missed to a degree,
but the people that put in all the time and effort
helping transition through the CPG, and the CPG is a
vehicle to you, you know, assure everyone in these
processes that -- that prescribing can be done by
APRNs and done safely, you know, I think the
contribution has been immense, and we'll miss them,
but we won't miss them too much now. I think the
time has gone where that it's being -- you know, it's
beneficial as it was in the past.

Senate Bill 341 and 765 is the nurse
licensure compact, has proponent testimony this week,
I believe, or at least I was just told that. And,
look, there's a number of different compacts out
there. It's interesting, they are all a little bit
different, and then there's a universal licensure
bill. This 246, the occupational licensing, you
know, which is right up next. You know, I've got to
be quite frank, I'm not sure everybody understands
how they interrelate to one another. And if you pass
occupational licensing, how does that affect the
nurse license compact and so forth?

Suffice it to say that we're talking with
nurse leadership, we're talking to ONA, a number of
interested parties trying to answer questions. We
are talking with the NCSBN. We're talking with NLC

but there. You know, you can say that there are 36 other
states that are independent or whatever the number
is, you know, right now, but they all do it a little
bit way -- that independence is defined just a little
bit differently in different places. And even the
ones where there is collaboration they are defined
differently.

This makes it taught when you are doing
universal licensing with universal, you know, initial
needs for that license in particular, let alone from
transferring from state to state. So again, it's
being pushed. It's, I think, some day a reality for
everybody, but when that some day is, it's still
unclear.

House Bill 177 is being heard this week.
It's up for vote. Standard care arrangements bill,
elminating those. We've gone through a number of
substitute versions of the bill. You know, the
proponents have couched this in terms of, hey, we
started out as, you know, an independent practice
bill, but now it's a transition to practice bill.

Last time we talked I think we talked about the 2,000
clinical practice hours over 12 months that would be
did before you kind of move off into that more
independent nature of practice and severed yourself

...
from the collab -- or the written standard of care arrangement.

Now, during this -- these last few months, it's been talked about, bandied about to raise that to 4,000 hours in 24 months and there being a greater transition. But I think the opponents to the bill have largely backed that, and I haven't heard different so, was I interested to see it was up for a vote. We will see if the vote is taken and see how that shakes up. But again, I'll be probably the most surprised person in the world -- in the room rather, not the world, most surprised person in the room if that bill passes in some form this year. But again, we are here at the APRN Advisory Committee. If someone has a better knowledge than that, I would be happy to -- happy to take that in.

House Bill 263, I don't want to bore you too much about licensing criminal convictions. You know, this is a revisit of what we did 15 years ago but much larger ramifications, really limiting the Board's authority over certain persons, their jurisdiction, and then requiring us to do all kinds of rule making to delineate certain licenses.

I wish life were easier and more able to be fit into different neat areas and ordered up as

such, but it isn't. And when someone is convicted of a crime that the Board has jurisdiction to take a license or to deny a license for, the Board certainly has rules that take into effect aggravating and mitigating circumstances. There are all kinds of number of nurses that have had some type of criminal finding on their record. This isn't something that's taken lightly.

However, you know, there are fields that people feel a need to increase workforce, and they take out the moral character, moral turpitude aspects of the licensure process. We'll see what happens. I think that the bill will pass in some form, and then we are going to have to figure it all out kind of after the fact.

Thomas Paine said a couple hundred years ago "Character is much easier kept than recovered." Still true today. This bill is not going to change that. It's going to shift more of a burden and more high stakes to the employer and actually to the student also so that a student that makes it through and still has a criminal record that the employer doesn't want any part of, that's not going to be the Board's issue. It's going to be the student's issue and will be the employer's. We'll see how they handle that, but I don't think I have heard an answer as to people thinking through that aspect of it.

That's my report here. There are other things that are going on. To Erin, Erin loves the advanced practice respiratory care legislation that isn't really legislation yet, but it's been talked about for six months, and people are actually going to school for that, you know, right now, but nobody really wants to share that bill unless you're on the inside willing to, I guess, negotiate or have answers -- or questions to have answered. We're kind of again an interested party, weighed in from time to time with questions.

You know, this has to go the -- despite the newness of their approach, as they say, it's gone down to an old time approach and that is who are the biggest names in the room and, you know, who wants what and what are you willing to do for it. And lots of that, I think, will be scope related as always and aspects of prescribing.

The Board also, you know, just briefly mentioned that -- I don't think this has been a subject area in what House Bill 177 discussions, per se, but 4723.481 of the Revised Code allows for, you know, you to prescribe in certain places. You know, the restrictions that apply generally don't apply if they issue a prescription to a patient in any of the following locations; and, you know, I get it. Again, that's legislation that had to be drafted that way so that APRNs could get the authority to prescribe, but nobody in their right mind would really want to draft a scope of practice statute that listed out 20 different places and locations in which certain rules and certain laws didn't apply.

And I think we're getting beyond that, and with telehealth practice and practice in general changing so quickly, you know, now we have people that are going out to these locations and wanting to -- as APRNs wanting to prescribe and issue prescriptions which there may be -- the way that the stuff is phrased, you know, ties back to, you know, hey, you are not in a hospital here when you are doing this, so you are going to have to get the physician to, you know, countersign this and so forth.

So just generally speaking we've been getting questions with respect to that, and we need to get some answers in the legislation, I think. So I've got to get out, talk to the interested parties, and see what can be done to -- you know, if we are...
not going to pass 177, then let's bring practices up to speed and as current as we possibly can, and again, all this stuff is very political right now. I don't think the proponents and the opponents on any of those scope issues are close to the center as they need to be to actually get things done. So again, just wanted to give you a heads up these are the kind of things that we are experiencing here, we are looking at with respect to legislation. Sorry for the long-winded approach but. MEMBER ZAMUDIO: Hey, Tom, I have a question.

MR. DILLING: Sure. I'm sorry. Go ahead.

MEMBER ZAMUDIO: Tom, it's Michelle. I just have a really quick question. I had heard whispers about draft legislation regarding certified midwives and certified professional midwives, the CMs and CPMs. It's been an ongoing issue in our state because obviously the legislation addresses certified nurse midwives.

And just for some background information for the rest of the team, the certified midwife doesn't have a background in nursing. Their undergrad degree might have been in chemistry, biology, or some other program, but they do take the same certification exams the certified nurse midwife does. So they have the same -- we have the same way to test their knowledge base as the certified professional midwives. So I had heard some whispers about that. I don't know another forum to ask. Have you heard anything?

MR. DILLING: Yeah. Yeah, thanks for that question. If I don't have to deal with it today or in the next month, I kind of push things to the side.

MEMBER ZAMUDIO: Yeah. No, it was just -- it was -- it was suggested when I was talking to this person that the Board of Nursing would be the venue. So I was curious if anyone had heard those whispers yet.

MR. DILLING: Yeah. So I have heard whispers, and from time to time I have gotten questions. Legislature office will call, and they send them to, you know, different places. Again, this is Tom, who has been around for about what, about 33 years now, so I'm seeing different iterations of this in terms of the nurse midwife and the professional midwife or the lay midwife in some form.

Suffice it to say when the nurse midwife came from the Medical Board over to the Nursing Board, they were changing, you know, laws and so forth. They didn't change them all really well, and these remnants that left over caused some confusion in terms of the ability of both the Nursing Board and the Medical Board to exercise jurisdiction over certain aspects of lay midwifery.

Certain aspects were clear like prescribing drugs and so forth and, you know, again, over the years you've had problems with hospitals calling up and saying, hey, baby has been dropped on my doorstep by a lay midwife and it went really south and, you know, just terrible stuff. 10 years ago there was a study committee formed and there was a hearing and, gosh, you had people riding down from all over the state for these.

So suffice it to say that it never leaves. It always lurks in the background, and I think there have been -- there's been movement in other states. There's been articles in other states about bad stuff that's happened too. And so I think in 2021, the General Assembly would come forward and see if we can finalize this, and I would say that if you really looked into what each and every other state was doing, I am not sure everybody has a model where we're taking the biology student and getting them commensurate education and training as the nurse midwife, and they are taking the same exam and so forth.

To me who has been in the licensure business and has great respect for education and the examination part of it, two both historically key aspects of licensure, I think that if proposed, there will be a greater deep dive needed into, you know, who are you bringing into the state and I think you are going to get some education standards set and then you are going to have the proverbial grandfathering fight, you know, put up and, you know, and were these tests actually measured and, you know, geared towards the professional midwife versus the others? You know, and how does that alter the grading of these exams, you know, into the future? It's not as complex as just, hey, we'll find --

MEMBER ZAMUDIO: Well, certified midwives also take the graduate education.

MR. DILLING: Yeah. There has been a lot of support nationally. The midwives, both groups are surprisingly really work -- seem to work well together and that's the strength of it. The weakness is that I think you have a lot of different states.
with a lot of different, you know, ways they've dealt
with it up until now. And so if you can get to, you
know, more of a common exam, common education
patterns, then I think you have a greater -- greater
hopes for that.

MR. DILLING: Okay. Thanks, Tom.

MEMBER ZAMUDIO: Okay. Thanks, Tom.

CHAIRWOMAN KEELS: Tom, I had a question.

This is Erin. I heard that physician assistants were
going to introduce some legislation for -- around
their scope as well including authority to provide
sedation. Have you heard anything more about that?

MR. DILLING: Sure. They've had bills,
and recent bills, and involving sedation as well.

And, look, you know, it's been pretty clear over the
years that the APRNs have led in legislation, and the
PAs have followed. Today the PAs and the APRNs have
never been closer in terms of what they actually do
and practice and so forth and yet, again, you have
this different level of education, different testing.

Everybody does the same thing though.

You know, it can get confusing; and I
doing this doing that, and we have RNs who are
administer this and that, and we have RNs who are
deep into the sedation process, right? You know,
it's terribly confusing, so all you really have to
hang your hat on now, well, traditionally we've not
seen this stuff being written in a different statute
or it's being written in a different bill but, you
know, the same parties are parties to -- to those
questions. And I'm just telling you that they -- the
actual practitioner may want these things added to
their scope, makes them more employable.

To me these are employer driven. It's
the reality of medicine and changes in medicine, and
more focus should be put into looking at why is
everybody all a little bit differently and seeing how
we can all work together to educate in the same way
and have the same competencies. We'll eventually get
there. I'll be retired by then; but, you know, I'll
be watching.

CHAIRWOMAN KEELS: Okay. So to your
knowledge, nothing new has been introduced?

MR. DILLING: I think there's a PA bill
out there somewhere. I haven't looked at it. And is
everybody going to try to make a rush? Hey, if the
APRNs have 177 up for a vote today or this week,
right, if you were the PAs, why wouldn't you be
running your bill too at this same time? You know,
that's what you do. And then I'm just telling you
that in six weeks, that seems like a big bite, you
know, in that period of time, but the next General
Assembly, people make some changes, modifications,
not quite as big a bite.

That's what I -- that's what I foresee
but, yeah, I'm sorry, I don't have any inside
information that somebody has got this on the fast
track. Again, I would be surprised.

CHAIRWOMAN KEELS: Okay. Thank you.

Tom, you have one more bullet that you were going to
discuss, major in nursing specialty or related field,
that language.

MS. EMRICH: I can take that.

CHAIRWOMAN KEELS: Or Lisa.

MS. EMRICH: I would appreciate for the
Committee comment or information so we -- we were
looking at this as we were working through the
summary document and some other information. And we
wonder if this language may be currently obsolete.
So when you are looking at the requirements for
practicing nurse midwifery or other specialties, and
this requirement's for APRN licensure, in Section (A)
(1)(b), it says that the individual has an earned
Master's or Doctoral Degree with a major in nursing
specialty or other -- or in a related field.

What would a "related field" be? And is
that in a related field more obsolete now with the

MS. EMRICH: I can take that.
more current formalized system of accredited APRN
programs with the related national certification.

MEMBER SIEVERS: Lisa, can you say where
this language is again? I'm not clear.

MS. EMRICH: It's in Section
4723.41(A)(2). It's about the minimum qualifications
to be an APRN when it's discussing the educational
preparation, that there has to be a Master's or
Doctoral Degree with a major in a nursing specialty
which -- which is obvious, you need to. But it also
says or in a related field that qualifies the
applicant to sit for the certification exam. So we
are just -- in a related field, we're not sure that
there would be another related field other than a
nursing major.

CHAIRWOMAN KEELS: Right. The only thing
I can think about that came to mind was the grad
entry program, you know, where someone with a
Bachelor's in biology would enter the APRN program,
but you are still going to then major in nursing, to
get your Master's in nursing.

MS. EMRICH: Uh-huh, or Doctoral. Or
Doctoral.

CHAIRWOMAN KEELS: Or your Doctorate,
yeah. So that didn't even apply really.

MS. EMRICH: But that -- that graduate --
or Doctoral Degree would be with a major in nursing,
in a nursing specialty. It would not necessarily be
in another field. So right. So we're wondering if
in a related field should be removed.

CHAIRWOMAN KEELS: And my recommendation
would be yes.

MEMBER GRAHAM: I can't think of a reason
not to unless we started looking at the professional
nurse midwives. That -- the thing that Michelle
brought up, would that -- would that pertain at some
point. And I don't know. Michelle would have to
answer that because I don't know, but as far -- from
the education perspective, I think now it used to be
that some of our certifications did not require
graduate degrees, now they do, and so I'm wondering
if that's leftover language where people did have
Master's in another area, but they were certified
nurse practitioners.

You know, they maybe went to a
certificate program and had a Master's in another
area. I think there was a few years that we had
that, so I can't think now of -- I think -- I believe
the certification programs do require people that
have graduate degrees in nursing.

MS. EMRICH: Yeah. I'm with you,
Dr. Graham. I thought this might have been very,
very early on when the graduate programs were not
as -- and the system of education was not as
formalized in the process it is now.

CHAIRWOMAN KEELS: Right.

MEMBER ZAMUDIO: The certified midwives,
first of all, I would recommend leaving that until I
can get clarification, but the certified midwives
aren't nurses, but they do have a Master's in
midwifery, not always nurse midwifery, so they have a
Master's Degree in midwifery and they do graduate
from the ACME certified course and sit for our exams.
So if there is no danger to leaving it in there, I
don't see an advantage to striking it for now.

MS. EMRICH: So a registered nurse who
goes on and becomes a professional midwife could take
the exam and then become a certified nurse midwife.

MEMBER ZAMUDIO: No. So the -- the
difference is the certified midwife, their practice
is identical to a certified nurse midwife. Their
educational path is different in that there are
programs that are Master's in midwifery. They don't
say -- it's not a Master's in nursing.

Now, the CPM, the certified professional
midwife, doesn't have those same requirements. They
don't have the Master's Degree. They don't take our
Board exam, et cetera, and so I can't speak really
intelligently to the CPM, the professional midwives.

Some people used to use the word lay
midwives. The certified midwife is a Master's
Degree, but it's a Master's in midwifery which may
not be in this area available, but it is. So they
have a Master's as a midwife, and they have taken the
national certification exam. So I guess if there's
no danger to leaving that interrelated field, I would
recommend leaving it.

MS. EMRICH: So the certified midwife,
just sort of help me flesh out for purposes of this,
so a certified midwife, do -- does their program
discuss -- have the advanced pharmacology course and
everything that we would expect of a certified nurse
midwife?

MEMBER ZAMUDIO: I would have to get that
information to speak intelligently on that. I have
not -- the one thing I haven't done is look at their
curriculum, but I can certainly do that.

MS. EMRICH: Because I do agree that's an
example so if someone is a registered nurse, which
they have to be before they can be an APRN, but if
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<td>they have a major in a related field which could be nurse -- could be midwifery, not necessarily a CNM, but if they are permitted -- if the Nurse Midwifery Council allows them to take the nurse midwife certification exam, or if it's the same exam, then, you know, the question is would they be recognized as a certified nurse midwife.</td>
<td>MR. DILLING: No, no. I think that just for everybody's own informational purposes, they want to go back and take a look, I will stand by my comments, you know, earlier, this is not new stuff and, yes, they -- they are pursuing some movement on the sedation front; and then they have their own practice issues as well. It's -- it will always be there. You've just made it easier to find.</td>
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<td>MEMBER ZAMUDIO: Their credentials would be certified midwife, CM. So that's where a lot of this draft legislation is going. And that is to say, so what about this other group of people? I know on a national level it's the American College of the Nurse-Midwives and Midwives. So that did not include CPM but it did include the certified midwife and certified nurse midwife. And I can actually over break, if you want, I can get answers to that question and circle back.</td>
<td>MS. DIPASQUALE: All right. So it's HB 492 if you want to Google it and see what the provisions are.</td>
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<td>MEMBER GRAHAM: Michelle, a question I would have is the certified midwives, when they get their Master's Degree, are those from colleges of nursing or schools of nursing or might they be from another -- from outside a college of nursing which would then go back to make it that we would need to leave this in, I think?</td>
<td>MR. DILLING: Thank you.</td>
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<td>MEMBER ZAMUDIO: Right. I will get that detail soon.</td>
<td>CHAIRWOMAN KEELS: Thanks, Michelle.</td>
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<td>We'll come back to that.</td>
<td>Okay. Any others questions for Tom?</td>
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<td>MR. DILLING: Yes, I do want to leave you with I misspoke earlier. I think I said 325 on that Senate Bill for the doulas and that's Senate Bill 328 and that bill did pass the Senate. Again, House Bill 611 is not its exact duplicate but on the same -- same subject matter. And Anita, I think, sent me a -- something popped up here. You said you had a PA bill number for that, that bill that I was saying that was out there?</td>
<td>492 if you want to Google it and see what the provisions are.</td>
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<td>MS. DIPASQUALE: Let's see there. Okay.</td>
<td>MR. DILLING: Thank you.</td>
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<td>I'm back. I just did a quick search to see, and I have -- now, this is only current as of 3-2020. I didn't dig further but there is an HB 492, the PA bill that was introduced to the Ohio General Assembly. What I found by just Googling physician assistant bill, it says it has not yet received its first hearing. Again, that was -- this information is effective as of 3-2020. I just did a quick search while you were talking. I could tell you what it says, if you would like.</td>
<td>CHAIRWOMAN KEELS: So how about if we skip down to general information/updates and then potentially take a break and then come back and do the APRN, the FAQ and summary? Does that sound okay to everyone?</td>
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<td>MS. EMRICH: Okay. Sure.</td>
<td>MS. EMRICH: Lisa, do you want to give us?</td>
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<td>MS. DIPASQUALE: Sure. LPN renewal, with the implementation of House Bill 197, LPN licenses that were due to expire on October 31 did not do so. Those licenses have been extended to an effective date of 12-1 of 2020. So all of those LPNs were notified and they have the opportunity to renew up and until December 1 and their license will lapse after December 1 if they do not renew.</td>
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<td>Okay. So just wanted to, you know, remind everyone of that for those that may be impacted by LPN licensure.</td>
<td>In addition, the -- the HB 197 license holders, and these are individuals for whom a license was issued prior to the individual taking the NCLEX, both RNs and LPNs, they have -- at this point we're letting them know that they have until March 1 of 2021 to pass the NCLEX, or their license will no longer be valid.</td>
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| So if they have already passed the NCLEX between the time they were issued the license until now, they are good to go. They have regular licensure. If they have not passed the NCLEX by March 1, again, the license will be invalid after | **Note:** This text is a continuation from Page 61 to Page 64.
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<td>1 that date.</td>
<td>1 gives us half an hour? Is that okay with everyone?</td>
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<td>2 CHAIRWOMAN KEELS: And if they have taken</td>
<td>2 MEMBER ZAMUDIO: Erin, it's Michelle.</td>
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<td>3 their NCLEX and did not pass, then they are no longer</td>
<td>3 Just super fast note, you guys, I did get some</td>
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<td>4 permitted to practice.</td>
<td>4 clarification because there is a document on the</td>
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<td>5 MS. EMRICH: Yes, they are. We don't --</td>
<td>5 American College of Nurse-Midwife site about</td>
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<td>6 we do not currently have authority to invalidate or</td>
<td>6 certified midwives if you guys are interested in</td>
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<td>7 inactivate an HB 197 license.</td>
<td>7 looking at it. It's like what is the CM? What's the</td>
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<td>8 CHAIRWOMAN KEELS: Okay.</td>
<td>8 pathway?</td>
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<td>9 MS. EMRICH: If they were issued the</td>
<td>9 And to address Dr. Graham, it's actually</td>
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<td>10 license and then subsequently failed the NCLEX, they</td>
<td>10 through a college of allied health sciences, not</td>
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<td>11 do have opportunity to attempt the NCLEX again or for</td>
<td>11 through a nursing college, so they have the exact</td>
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<td>12 as many times as they can between now and March 1,</td>
<td>12 same core competencies that they have to meet</td>
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<td>13 but we do not have statutory authority to inactivate</td>
<td>13 clinically, et cetera, and then they sit for the same</td>
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<td>14 the license before the expiration date.</td>
<td>14 exam. They are recognized in Delaware, Hawaii,</td>
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<td>15 CHAIRWOMAN KEELS: They just have to get</td>
<td>15 Maine, New Jersey, New York, and Rhode Island, so</td>
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<td>16 it passed by then.</td>
<td>16 several other states are trying to do that, and I</td>
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<td>17 MS. EMRICH: Yes.</td>
<td>17 think Ohio will be one of those soon.</td>
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<td>18 CHAIRWOMAN KEELS: Okay. Then it's</td>
<td>18 So I just wanted to give that background</td>
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<tr>
<td>19 invalidated. Okay. Good to know.</td>
<td>19 information. CM has that undergraduate degree in a</td>
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<tr>
<td>20 MS. EMRICH: Just as an FYI.</td>
<td>20 different area, and then the Master's in the</td>
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<td>21 CHAIRWOMAN KEELS: Thank you.</td>
<td>21 midwifery through the allied health, so they are</td>
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<td>22 MS. EMRICH: Thank you. We have -- we've</td>
<td>22 identical practices but without the word nurse in</td>
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<td>23 had to do a lot of looking at dates and there's a</td>
<td>23 there. So if -- if we're all okay with that, just</td>
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<td>24 number of moving parts with the HB 197 licenses so</td>
<td>24 letting the information on the site stand as is would</td>
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<td>25 that's been something we've had to do. There have</td>
<td>25 be appreciated.</td>
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<td>1 been close -- a little over 45,000 LPNs who have</td>
<td>1 MS. EMRICH: To be -- if my understanding</td>
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<td>2 renewed, and every year we expect there may be about</td>
<td>2 then is that an individual is a registered nurse</td>
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<td>3 7 or 8 thousand who choose not to renew just due to</td>
<td>3 and they obtain a Master's Degree through an allied</td>
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<td>4 they've either gone to another state and are</td>
<td>4 health program of an institution and get a Master's</td>
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<td>5 licensed, or they have chosen not to maintain their</td>
<td>5 or Doctoral Degree, then they can take the certified</td>
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<tr>
<td>6 license, so we are close to getting close to that</td>
<td>6 nurse midwife exam and could be licensed as a</td>
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<tr>
<td>7 number now.</td>
<td>7 certified nurse midwife.</td>
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<tr>
<td>8 Okay. As usual, we have included a</td>
<td>8 MEMBER ZAMUDIO: Their Master's Degree</td>
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<td>9 sample of -- or summary of APRN practice questions</td>
<td>9 would need to be a nurse midwifery, I believe, but I</td>
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<td>10 we've received, and this time Anita included the</td>
<td>10 don't know the answer to that clearly. I just know</td>
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<td>11 responses to those as well as understanding you all</td>
<td>11 leaving -- I don't see an advantage to striking that</td>
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<td>12 have found that helpful so.</td>
<td>12 out.</td>
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<td>13 CHAIRWOMAN KEELS: Yes. Thank you. A</td>
<td>13 MS. EMRICH: I think my --</td>
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<td>14 few new topics this time so that was -- that was</td>
<td>14 MEMBER ZAMUDIO: Right now in Ohio, we</td>
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<td>15 interesting to me.</td>
<td>15 don't have a program available for them through</td>
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<td>16 MS. EMRICH: And then we did include two</td>
<td>16 allied health but not to say it couldn't happen.</td>
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<td>17 articles of interest that we -- it's more for</td>
<td>17 MS. EMRICH: Okay. I just want to make</td>
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<td>18 informational and of interest. As they come along,</td>
<td>18 sure, I'm -- if that is left in as being in a related</td>
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<td>19 we will continue to provide you with articles that</td>
<td>19 field, those persons, I'm thinking, and we would</td>
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<td>20 cross our desks that may be of interest to the APRN</td>
<td>20 discuss -- can discuss at the Board, but those</td>
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<td>21 Committee.</td>
<td>21 persons could indeed become certified nurse midwives.</td>
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<tr>
<td>22 CHAIRWOMAN KEELS: Thanks, Lisa. Does</td>
<td>22 MEMBER ZAMUDIO: There would be that</td>
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<td>23 anyone have any comments or questions?</td>
<td>23 pathway if that program existed in Ohio.</td>
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<tr>
<td>24 Okay. So I recommend that we take a</td>
<td>24 CHAIRWOMAN KEELS: Pete, you have a</td>
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<td>25 break here until, what, about 10 after noon? That</td>
<td>25 question?</td>
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MEMBER DiPIAZZA: Yeah. Michelle, do you know if the CPMs fall under the Board of Nursing in those states?

MEMBER ZAMUDIO: I do not.

MEMBER DiPIAZZA: Through a different board?

MEMBER ZAMUDIO: It's different state by state, and it's a huge topic.

MS. EMRICH: Okay.

MEMBER ZAMUDIO: I was actually part of that program in the past that Tom was talking about, came to Columbus, gave testimony, the Board of Medicine was there, et cetera. I remember those days. And then it was dropped, and it seems like it's going to circle back around.

MS. EMRICH: Yeah.

CHAIRWOMAN KEELS: Okay. Let's break until 12:15 to be fair. Give everybody half an hour and we will see you back here soon.

MS. EMRICH: All right. 12:15 then.

(Thereupon, at 11:43 a.m., a lunch recess was taken.)

CHAIRWOMAN KEELS: Okay. Let's break now.

MS. EMRICH: All right. 12:15 then.


CHAIRWOMAN KEELS: I think we have a quorum to get started.

So this brings us to the draft summary document and FAQs that Lisa and her team have been working on, that we have been working on as a Committee for over two years, so I'm hoping that we can finalize something, getting closer to that brand new, slick website to help assist practitioners as well as public and others on some questions they may have around APRN practice in Ohio.

So I think probably the easiest way to do it is just go page by page to see if anyone has questions or issues with the current draft.

Again, Michelle, your hand is up from the last time so you might want to put that down. If you have questions or comments, then just raise your hand or -- although I can't see some people, so I guess just shout out your name, and we'll get you called on.

On page 1 under the introduction piece, anyone have any comments? Pam.

Michelle, is your hand up?

MEMBER ZAMUDIO: Yes, it's still up, but it was up again. Sorry. So it was a question/comment under the second category where it says the following summarizes the license renewal, the CE requirements on there, and just I just want to throw this out in case we want to address it, I know several states have given allowance, if you will, during the pandemic regarding CEUs. I know for our CEUs, the RNs can use a one-time exemption during their lifetime for their portion of it, but supposedly the APRN cannot use that.

I didn't know if we wanted to address that at all because of the pandemic. Because, you know, a lot of employers aren't obviously paying for CEUs at all, or people don't have the time or money to go do them. So if we allow maybe some type of exemption, it's just a thought, and I thought it would fit under CEUs. So just throwing that out there.

I love the way this is organized, by the way.

MS. EMRICH: Well, APRNs there's no -- there's no waiver for APRNs'

MEMBER ZAMUDIO: I know.
MS. EMRICH: -- CEUs so.

MEMBER ZAMUDIO: I didn't know if we want to think about that just because of the pandemic changes.

MS. EMRICH: Well, it would take a law or rule to allow that though.

MEMBER ZAMUDIO: Oh, it's in the law.

MS. EMRICH: Yeah. That's not a decision that the Committee itself can make.

MEMBER ZAMUDIO: Sorry.

MS. EMRICH: Yeah, you know, just as policy because it's in law and rule so.

MEMBER ZAMUDIO: Withdrawn.

MS. EMRICH: But thank you. Good thought.

CHAIRWOMAN KEELS: Okay. Good with page 2?

MS. EMRICH: Moving on to page 3, anything on page 3 that you have comments about?

I am going to make the assumption that folks have reviewed this before today, so if you don't have any notes written to yourself, then we are going to move on to page 4 where our first OAAaN comment is made as well.

MS. EMRICH: Erin, if I may, just speaking to under the currently available exemptions for CNSs, besides mental health is a separate exam. I think it got omitted or inadvertently not added but there is a -- ANCC has a -- there is a psych/mental health exam for CNSs.

CHAIRWOMAN KEELS: So you'll add that.

MS. EMRICH: Yes.

CHAIRWOMAN KEELS: Okay. Thank you. Okay. So this brings us to the first suggestion to remove the words "currently available population foci certification examinations for CNSs." And we would remove population foci, and it would stay "currently available certification examinations for CNSs." That was the suggestion, I believe.

MEMBER GRAHAM: Yes. And I will speak to that. If we look back on page 3, at the top of that page, there we speak to the certifying examinations and resulting national certifications and we don't speak to the certifying exams based on population, available population. So I feel like we just will be consistent in our document, and I don't think -- I mean, I think the psych -- the psych NP being across the age span, I just -- I think we -- I think we confuse the issue when we add that when we are talking about new -- new CR -- APRNs.

CHAIRWOMAN KEELS: That seems fine to me. Lisa, that's not a problem, right?

MS. EMRICH: Yeah. I just -- we'll go back to see if -- what we were tracking on that.

CHAIRWOMAN KEELS: I felt like we probably mentioned that before too so maybe that was an oversight.

CHAIRWOMAN KEELS: Okay. Thank you.

Other comments?

Now that I am looking at it, I mean, I -- you know, I want to -- as much as I want to make sure we are congruent with the Consensus Model, you're basically stating these are what's available, so I'm okay if we moved it out. We've got population focus in several different areas in the document which may or may not be confusing to people, but I would be okay if the group feels like that's what you're leaning towards.

I know, Sherri, you said you agreed with removing it.

MEMBER SIEVERS: Yes. I don't think it adds anything.

MEMBER GAGER: This is Angela. I agree with removing it.

MEMBER ZAMUDIO: Hi, it's Michelle. I agree with removing it. I just think it -- it stands alone to say the certification exam, that's the title of it. It's a certification exam, not necessarily called a population foci, and like you said, it is mentioned several other areas, so it speaks more to maybe scope of practice than to certification.

MEMBER BOLTON: I am going to agree with that since the certification exam doesn't have that in it. Going back to several different certifying bodies, they don't include that, so I think it's -- I think it's appropriate to delete it.

CHAIRWOMAN KEELS: Okay. So the majority of us have stated to go ahead and remove that. So we'll flip over page 5.

MEMBER ZAMUDIO: I had one thing on page 5 on the very first paragraph where it says "consistent with the CNP's formal education and clinical experience." Just to keep it consistent with the statutes, we should probably put formal education, training, and clinical experience. I don't know if it matters but just to keep it -- and that's the same with all of the other -- I don't want to say specialties, all the other areas that are mentioned, I'll say education, training, and clinical experience.

CHAIRWOMAN KEELS: That seems fine to me. Lisa, that's not a problem, right?

MS. EMRICH: Yeah. I just -- we'll go back to see if -- what we were tracking on that.
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| **Okay. So moving down to the second request by OAAPN, is the same thing, is to remove "population foci" from "currently available population foci certification exams for CNPs." Now, NCC does call these population focused examinations; is that, is that accurate?** | **board for the APRN. I don't know if it matters but.**
| **MS. EMRICH: I will defer to Angie being the educator or.** | **It would change what type of formal education putting the word "advanced" in front of it.**
| **CHAIRWOMAN KEELS: Or Margaret.** | **MS. EMRICH: Advanced formal?**
| **MEMBER ZAMUDIO: I would have to look that up to see exactly how that's stated, but I think the problem that still stands out is the psych/mental health CNP.** | **MEMBER ZAMUDIO: Yeah, which is, I think, how it is written for everybody.**
| **CHAIRWOMAN KEELS: Yeah, yeah. I agree, and I think actually now that I am thinking about it, it's the not competencies. They are population-based competencies, not exam so.** | **CHAIRWOMAN KEELS: Yeah. Another thought, not to make this terribly complicated but, you know, if we remove that word "resulting," whatever, national certification, and then actually the national certifications are listed below, do you want to now call those "currently available national certification examinations for CNPs" so it ties back to that sentence?**
| **MEMBER ZAMUDIO: So along those lines --** | **MEMBER ZAMUDIO: Yeah, I think that's good. This is Sherri.**
| **MEMBER SIEVERS: Okay.** | **CHAIRWOMAN KEELS: That would probably be for all four types of APRNs, right? So "currently available national certification" and so that kind of ties back in when you are talking about the formal education.**
| **MS. EMRICH: Oh, sorry, this is Sherri. The certification bodies themselves don't call it that so, you know, I think this is pretty clear. Again, it doesn't really add anything. It does potentially add confusion to leave it in but, I mean, this is pretty clear. These are the certification exams available.** | **MS. DI PASQUALE: This is Anita. In all four headings remove "population foci," add the word "national" before "certification."**
| **CHAIRWOMAN KEELS: Yeah, yeah. I agree, and I think actually now that I am thinking about it, it's the not competencies. They are population-based competencies, not exam so.** | **CHAIRWOMAN KEELS: Yes.**

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| **MEMBER GRAHAM: Right. And I do have a question up about -- up on the first paragraph on this page. That's where the word "resulting" was. I am not sure what "resulting national certification" means. I don't know -- I don't know what we -- I am not sure what "resulting" --** | **MS. DI PASQUALE: Just to keep it, okay.**
| **MEMBER ZAMUDIO: So along those lines --** | **CHAIRWOMAN KEELS: Just to keep that clean.**
| **MEMBER SIEVERS: Yeah, I agree. I was going to ask. That's the next point. I just don't know what that means.** | **MS. DI PASQUALE: And then no consensus yet on whether "resulting" is in or out in paragraph 1 on page 5.**
| **MS. EMRICH: Yeah. I think it was from the drafters. From our perspective, I think we were looking at the national certification being the knowledge, initial knowledge accumulated from your graduate program, from the program itself.** | **CHAIRWOMAN KEELS: It feels like "resulting" doesn't have to be there because you're -- have to have the national certification.**
| **MEMBER ZAMUDIO: So along those lines --** | **MS. EMRICH: Okay.**
| **MS. EMRICH: You have your formal education and everything and then you go and you take your exam and you become nationally certified.** | **CHAIRWOMAN KEELS: So that's fine.**
| **MEMBER ZAMUDIO: When I am looking at the verbiage in that paragraph, as opposed to how it's written in like the rule, should we then say consistent with the CNP's advanced formal education, training, and experience? Just that way we are putting the word "advanced" in front of formal education which is what -- what it is across the program.** | **MS. DI PASQUALE: Trash the... Thank you.**
| **MEMBER SIEVERS: Yeah, I think that's good. This is Sherri.** | **CHAIRWOMAN KEELS: That's fine. Okay. And then one more ask was that the statement in smaller print that references the Consensus Model as connected to the available CNP certifications, we respectfully request that the statement be deleted. So these are, I guess, under the asterisk, right? Where you are calling out that the acute and the primary care certifications are distinctly separate, that seems to be pretty important to understand that the program prepares an individual to practice both acute and primary care in pediatrics or adult gerontology, the primary and acute national certifications must be obtained.**

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Oh, are they asking just to strike Consensus Model 2008?

MS. EMRICH: No. This is citing that portion. I think they are wanting the whole thing removed.

CHAIRWOMAN KEELS: Oh.

MS. DiPASQUALE: This is Anita. I just wanted to say I believe -- pull this up. I believe that paragraph, and I think that's Lisa is saying, is actually if you go to the Consensus Model, the page that has sort of the summary triangle.

CHAIRWOMAN KEELS: At the bottom.

MS. DiPASQUALE: I think that language was pulled almost -- I don't know that's a direct quote, but it might even be a direct quote anyway; isn't that right, Lisa?

MS. EMRICH: Yes.

MS. DiPASQUALE: Yeah. So I think that's why -- I think citing APRN Consensus Model 2008 is saying -- kind of citing that this is in that Consensus Model, and it also reflects --

CHAIRWOMAN KEELS: It's the reference.

MS. DiPASQUALE: Yes.

MEMBER ZAMUDIO: Is it in that law in 4723? I'm sorry. I didn't look it up.

MS. DiPASQUALE: 43(C) is the one that goes through each that says your -- your national -- that your scope is consistent with your national certification, your advanced formal education, training, and clinical experience, so .43(C) is one that has the four sections, one for each role.

MEMBER ZAMUDIO: It looks like we are quoting it there though. It looks like we are quoting law that you have to have both.

MEMBER GRAHAM: I don't think the Consensus Model is in law. I think what the law is you have to practice according to your specialty.

MS. EMRICH: To your national certification.

MEMBER GRAHAM: Right, right.

MEMBER SIEVERS: This is Sherri. Do we think that the purpose of this statement was just to clarify so people know that there is a pediatric primary acute and ped -- or pediatric nurse practitioner acute and pediatric nurse practitioner primary and the same with the adult gerontology? Because, I mean, there's two totally separate certifications.

MEMBER BOLTON: You know what I commonly find is that people will say I'm an adult care NP, and they totally forget the acute care and primary care, so I think sometimes it's very confusing and even -- I have even had newly graduating NPs not know the difference, and I have had to ask them are you acute care or are you primary care. So I think this is just a way to clarify that information. It's very confusing for people, and it's probably because it starts out with adult gerontology.

CHAIRWOMAN KEELS: I would agree with that. And again, not only is this information going to be used by APRNs but also employers or, you know, the public that have questions. I think it's important to understand those are two distinct separate exams, and you have to have, you know, the right one. So I would -- I would lean towards keeping that in there.

Pete, you have your hand up and then Angie.

MEMBER DiPIAZZA: Yeah. Erin, I was going to say exactly what you just said, that as I read this, I think what this says is you could have had your formal education in both, but if you want to practice both acute and primary, you have to have certification. You can't just become certified in acute and say, well, I've been trained in both, so I can do both.

CHAIRWOMAN KEELS: Okay. That's Pete. Angie?

MEMBER GAGER: Sorry. I was on mute. My hand was actually up for the more resulting but we also resolved that but I agree with you and Pete. This does need to stay in there to clarify this.

CHAIRWOMAN KEELS: Okay. So it feels like everybody is okay with -- most people are okay with keeping it in there.

Margaret.

MEMBER GRAHAM: I think that this is a document that's referring to our rules and law, and I don't think we have the Consensus Model in rules and law, so I think that can be confusing. I think we also state that we look at clinical practice and law. That's what the statute says and so I -- I think that it's really, really important that as educators we teach our students that they are primary care, or they are acute care, and we match their clinical experience to their certification that they will be sitting for. And now, we as educators can help our students decide which is the very best one; but, quite frankly, we do have some adult nurse practitioners who have been working in the acute care

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I was next. I'm kind of torn because with working with pediatrics I do get that there's a little bit of a confusion, and so I think it's helpful.

And to your point, Dr. Graham, I think this document is also used by -- is going to be used by other people, and so it helps to clarify. And I think students are for the most part aware at this point, but other folks and employers might have questions.

But instead of -- could we just tweak the language just a bit to where like after it says both primary and acute national certifications must be obtained and that language in this document somewhere else that just says like -- that references just the law, and we could take out the Consensus Model as the reference but like according to the training, education, blah, blah, blah, just to say that again instead of saying -- and maintain for authorized practice in both acute and primary because that kind of gets down the path again? Do you see what I am saying? Like just kind of -- I can look for language in here that we have already used.

CHAIRWOMAN KEELS: Okay. Thanks, Sherri. Michelle, do you have your -- oh, Anita has got her hand up and then Pam and I will go back around.

MS. DiPASQUALE: Yes. Thanks. So I just want to clarify, I guess just make two points. It seems like the objection is to literally the phrase "APRN Consensus Model 2008" and that can be discussed but .43(C) is law passed by the legislature. And when you read .43(C), which we just, you know, repeat over and over and over, a nurse authorized to practice as a CNP, I am going to skip over, in collaboration, da, da, da, consistent -- may provide service consistent with the nurse's education and certification.

I mean, it's just -- it's law. You can only -- the scope is defined in law, and it must be consistent with the national certification that one has obtained and maintains. It's not -- it is true that -- I'm sorry, I don't remember the Board meeting, but at some point in the past, the Board affirmed its intent to approach role and population foci in a manner consistent with the Consensus Model. That's my recollection. Correct me if I'm wrong about that. I don't remember exactly which Board meeting.

So I guess maybe if it were a strictly legal document, what I might do if it were -- you
know, if it were strictly a legal document, is cite
Section .43(C), and then put a comma or a semicolon
see also, a see also, here is something else that's
relevant, although not controlling. I think that's
what you are getting at here.
And I did pull up that -- the triangle
from the Consensus Model and that sentence really
is -- the sentence that we have here really is
borrowed from the second half if -- I know some of
you are picturing that model, the second half of the
footnote in that model. It's very, very similar
to -- I guess I am trying to say, you know, this --
this language is just kind of a truth that's
expressed in .43(C) whether you include that
reference to the Consensus Model or not. So just
want to add that.
CHAIRWOMAN KEELS: Anita, I think what
you were saying -- what you just said is great. The
piece of that, just that put that there and then, you
know, I'm -- I'm leaning towards not saying anything
about the Consensus Model because we don't want
to get misconstrued that's where they go for
their source of truth. And if we just reflect that
little sentence you just said, according to blah,
blah, blah, like summarize 4723.43 in a -- in a
sentence and take out "Consensus Model" because that
has to be the source of truth for folks.
And then if they go to (C) also and they
go to the Consensus Model and they start to think
that's something they should be following when the
message should be, yes, we know that that document is
out there, but if you have questions, you go to the
law and rule.
MS. DI PASQUALE: But what I am saying is
the sentence as it exists is fully supported by the
.43(C).
MEMBER SIEVERS: Can we then take out
"Consensus Model"?
MS. DI PASQUALE: Well, I leave that to
all of you.
CHAIRWOMAN KEELS: Pam had her hand up.
MEMBER BOLTON: So I am looking at page
11, and in page 11 we have NAPNAP's position
statement on age parameters for pediatric nurse
practitioner practice, so I think that what we've
done here is we have pulled a number of documents
which help support why as -- as a Board or an
Advisory Committee we have -- we are suggesting that
these things come into play, so I -- I so appreciate
that this has many of the ORCs in here and that's
very important, but I -- but I -- based on that, I
don't think that we're saying that it's just the ORCs
that we are basing that on.
And I would also say that, you know, as a
Board of Nursing, we are -- we are implementing some
of the components of the Consensus Model. So I don't
think it's adverse to reference that just because I
think does add clarity to this and just in the
article that you shared with us, which I'm grateful
that you did, there's a statement at the bottom of
that two-page article that says many non-F&P programs
are having trouble recruiting students into their
program. This may be partially driven by the fact
that there are many NP students entering F&P programs
because they've perceived they will be more versatile
and marketable.
And, you know, I have the highest respect
for Ohio State, worked there, loved the university.
I would probably be in that Ph.D. program if it
wasn't an on campus program. So I so appreciate
where you are, Margaret, and I think you all do an
excellent job of providing an education.
I also know that I worked -- I worked for
Georgetown and teach there, and I have students who
are outside the acute care program who come in to
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<td>and I certainly hope that someday we are all following all the components of it. And I like the summary of it at the end because honestly before I joined this team I didn't even know much about it, so I am glad we do reference the consent as an FAQ. I just don't think it belongs in this particular section of it because this is -- if you remember, this is the title &quot;currently available national certification exams.&quot; So if you want to reference .43(C), that's fine but if somebody were to just look at this part of the document and they went to the Consensus Model, they are going to think they have full scope practice. I mean, we aren't following it completely, so I don't think it's a good place to reference it when you are talking about certifications. If we do like the know your role kind of statement right there, we could -- we could reference the ORC, not the Consensus Model, but then we have the thing at the end, right, about like so what is the Consensus Modeling and why are we all talking about it now? I thought there was an FAQ later in here, right? That would be, I think, appropriate so that people know what it is and what we are working towards but definitely not in this area because the way it reads right now is the Consensus Model and then the semicolon and the law, and it makes it look like that's law. So that's just my thought. CHAIRWOMAN KEELS: Okay. Thanks, Michelle. Margaret, is that an old hand or new hand? MEMBER GRAHAM: It's an old hand, but I'll state. I thought my hand was down so let me see how I put it down. Oh, I see. Okay. I agree completely with Michelle, I think to put in the law because I think it's -- we want people to follow the law, and so to put in 4723.43(C) there would be the best thing to quote versus to quote the Consensus Model because we want people to follow that, and the Consensus Model is discussed later. CHAIRWOMAN KEELS: Would it be a compromise to put the language from .43(C) there and say meaning that in order to practice adult primary care, you must be certified in primary care; and in order to practice in adult acute care, you must be certified in adult acute care? That's kind of what we are trying to clarify there, right? Sherri, your hand went up first. MEMBER SIEVERS: But I think what I am hearing Anita say this current statement reflects 4723.43. I think what I hear the group saying is just leave that as the sole reference for this part right here, that the Consensus Model doesn't really add anything here nor is it something we should be following as a source of truth. It is mentioned later. I appreciate Pam's comments. I think that it's important to have it as part of this document. But I just did a quick scan of the whole first part before you get to the FAQs, and I don't think we reference any of those other documents in that portion of it. So I think I would -- I would like to propose to leave it as is and just take out the Consensus Model reference. CHAIRWOMAN KEELS: Is that considered plagiarism if we do, or do we have to reference it because we lifted it off of there, off of the Consensus Model document? MEMBER SIEVERS: Oh, that was never a question. CHAIRWOMAN KEELS: Was the verbiage general enough that we don't have to reference the Consensus Model? MS. DiPASQUALE: This is Anita. If I could address that. No, I don't think it's -- it's not -- it's a paraphrasing, so I don't think there's an issue. CHAIRWOMAN KEELS: Oh, okay. MS. DiPASQUALE: And in terms of restating .43, if you go to the top of page 5, that whole paragraph is the language. CHAIRWOMAN KEELS: Okay. MS. DiPASQUALE: &quot;Provide services for acute illnesses, and evaluate and promote patient,&quot; that is .43(C). CHAIRWOMAN KEELS: Okay. So what I am hearing is we will just strike the words &quot;APRN Consensus Model 2008.&quot; MEMBER ZAMUDIO: This is Michelle. CHAIRWOMAN KEELS: Yes, Michelle. MEMBER ZAMUDIO: So when I am reading it, it does single it out, it says in order to practice both acute and primary, in those two areas. Do we want to make it more just thinking from midwife perspective? Do we want that to be more general and say if a program prepares you in more than one, why does -- why are we singling out those two? It should really apply even to the women's healthcare. It should apply to everyone. So can it be more broad and say,</td>
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<td>could address that. No, I don't think it's -- it's not -- it's a paraphrasing, so I don't think there's an issue. CHAIRWOMAN KEELS: Oh, okay. MS. DiPASQUALE: And in terms of restating .43, if you go to the top of page 5, that whole paragraph is the language. CHAIRWOMAN KEELS: Okay. MS. DiPASQUALE: &quot;Provide services for acute illnesses, and evaluate and promote patient,&quot; that is .43(C). CHAIRWOMAN KEELS: Okay. So what I am hearing is we will just strike the words &quot;APRN Consensus Model 2008.&quot; MEMBER ZAMUDIO: This is Michelle. CHAIRWOMAN KEELS: Yes, Michelle. MEMBER ZAMUDIO: So when I am reading it, it does single it out, it says in order to practice both acute and primary, in those two areas. Do we want to make it more just thinking from midwife perspective? Do we want that to be more general and say if a program prepares you in more than one, why does -- why are we singling out those two? It should really apply even to the women's healthcare. It should apply to everyone. So can it be more broad and say,</td>
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you know, these are distinct, separate exams for the population specific to the particular certification? If your program prepares you in more than one, then both certifications must be obtained so that it's not applying to just acute and primary care; it's applying to all of them.

MEMBER SIEVERS: But I think this is under the paragraph that's talking about certification CNPs, and I think these two particular certifications are confusing.

CHAIRWOMAN KEELS: Yeah.

MEMBER SIEVERS: This is under the paragraph for examinations for CNPs.

MEMBER ZAMUDIO: Oh, yeah. There is asterisks there, that's true.

CHAIRWOMAN KEELS: Angie, is that a new hand or old hand?

MEMBER GAGER: That's still an old hand.

I need to figure out how to put my hand down.

CHAIRWOMAN KEELS: I want to make sure I am not skipping over.

MEMBER GAGER: I'm so sorry.

CHAIRWOMAN KEELS: I think that we all agree then to strike the word "APRN Consensus Model 2008" and leave it as it stands; is that what I'm hearing? Thumbs up from Sherri. Michelle shakes her head yes. Can't see Pete or Angie. Margaret thumbs up. Okay. All right. Anything else on page 5 to discuss?

Okay. We are going to flip the page and go to 6. Anything on page 6? I always feel like I learn something new when I read these things too.

MEMBER ZAMUDIO: Yeah.

CHAIRWOMAN KEELS: Anything on page 6?

Okay. Moving on to page 7, any notes to yourself on page 7?

Okay. Going on to page 8. And now we come into the FAQs, much of which I think are the same as the last time, and then a couple new ones at the end.


MEMBER ZAMUDIO: Erin, I'm sorry. I had my hand up for page 8.

CHAIRWOMAN KEELS: Oh, sorry, back to page 8.

MEMBER ZAMUDIO: So the -- let's see, under the "SCA FAQs," the third question down, is there a limit, when it starts off, the answer says there is no limit and so that kind of is suggesting the answer, but actually the first part of it, it's more important. I think it says there is a limit on how many just with relationship to prescribing. I'm wondering if we should start that part first so they don't begin reading the answer and not see later that there is, in fact, a limit on how many -- for the prescribing components how many it could be. So maybe leading with that sentence.

MEMBER BOLTON: Or should those questions be separated?

MEMBER ZAMUDIO: I like them together. I like the way it was put out there. I like the question, and it's a common question too.

MS. DiPASQUALE: So just move the lead to the lead position.

MEMBER ZAMUDIO: Yes.

CHAIRWOMAN KEELS: Yeah, to make the prohibition more obvious so that you don't skip over it. Okay.

MS. DiPASQUALE: So start there is a limit on the number of APRNs with whom da, da, da.

CHAIRWOMAN KEELS: Correct.

MEMBER ZAMUDIO: Yes.

CHAIRWOMAN KEELS: Thank you. Good point.

MEMBER SIEVERS: Maybe -- sorry. This is Sherri. Maybe just highlight prescribing component just to make that stand out.

MEMBER ZAMUDIO: Uh-huh.

MS. DiPASQUALE: Okay.

CHAIRWOMAN KEELS: Put it in bold like the word is.

MS. DiPASQUALE: Okay. Got it. Thank you.

CHAIRWOMAN KEELS: Moving to page 9.

Page 10.

Page 11.

All right. Page 12.

Page 13.

All right. Page 15.

MEMBER ZAMUDIO: I have one comment on page 15.

CHAIRWOMAN KEELS: Yes.

MEMBER ZAMUDIO: Under "Pronouncing Death," and I realize these are ORC that we are quoting, et cetera, do we want to address nurse midwives in that, particularly if they are delivering a stillborn baby or pronouncing death? Let's say
MEMBER ZAMUDIO: Okay. That seems like a big limitation to me.

MS. EMRICH: Correct. And it goes to circumstances of when death occurs.

MEMBER ZAMUDIO: Okay.

MS. EMRICH: So it's not all circumstances of when death occurs.

MEMBER ZAMUDIO: Okay.

CHAIRWOMAN KEELS: Yeah. The bullet points down here, folks that are in specific facilities, under hospice care, so in that instance during a resuscitation, et cetera? I don't know if that's even possible because it might speak to scope of practice, but I don't know if we would address it with adding the immediate newborn care.

I work in a hospital, but not all nurse midwives do. They might be at home when they are delivering a baby, so I don't know if we need to put a blurb in there to help the midwives that work in birth centers, et cetera, because it does say nurse practitioners can pronounce death, but I don't know if that means globally an APRN.

MEMBER ZAMUDIO: Okay. That seems like a big limitation to me.

MS. EMRICH: Well, it's -- it's -- and it's specific to deaths that occur in very, very specific circumstances too.

MEMBER ZAMUDIO: Okay.

MS. EMRICH: So it's not all circumstances of when death occurs.

MEMBER ZAMUDIO: Okay.

CHAIRWOMAN KEELS: Yeah. The bullet points down here, folks that are in specific facilities, under hospice care, so in that instance during a resuscitation at a home birth, a nurse midwife would not be able to pronounce death.

MS. EMRICH: Correct.

CHAIRWOMAN KEELS: You would need to call --

MEMBER ZAMUDIO: Only a CNS or CNP can do that. I think that's probably oversight.

CHAIRWOMAN KEELS: Well, I don't believe a CNS or CNP. No. 1, it's outside the scope of our practice. Well, I mean --

MEMBER ZAMUDIO: It says -- 4723.36 says it addresses determination of death by a CNP or CNS.

MS. EMRICH: Uh-huh.

MEMBER ZAMUDIO: So I read through all that and clicked on the link and I looked at it and as far as like the individual's respiratory and circulatory functions are not being sustained, et cetera, et cetera, and then it does also allow for a registered nurse to do that. So at the very bottom of the page it said the registered nurse is providing or supervising the individual's care, that was only through Hospice.

So I didn't know if there was anything you guys are aware of, if we are allowed to as a registered nurse for that declaration, can we do that as a nurse midwife?

MS. EMRICH: So the registered nurse's determination is only if they are supervising the patient's care through a hospice program. So in short that patient would be expected to have, for example, a do not resuscitate order. There's no provision in this particular section of the statute for a nurse midwife --

MEMBER ZAMUDIO: Okay.

MS. EMRICH: -- to determine --

MEMBER ZAMUDIO: I just wanted to clarify because it's, of course, important.


MEMBER BOLTON: Also you can only do that if you are in a nursing home, residential care facility, not in a hospital, not in a -- you know, in an ER or freestanding ER or anything like that or if you are in a house -- unless you are in a hospice situation; is that -- am I reading that correctly? I guess I am asking for clarification.

MS. EMRICH: Correct.

MEMBER BOLTON: So essentially we cannot do it except as very specific circumstances.

MS. EMRICH: Correct. And it goes to prior to this statute, remember that it was all about...
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<tr>
<td>1. if that's appropriate for the situation so. And</td>
<td>1. minimal. They are either typos, adding the</td>
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<td>2. then, of course, in the -- in particular</td>
<td>abbreviation NPA earlier, changing the -- you know,</td>
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<td>3. circumstances for the APRN, specifically the CNP or</td>
<td>4. adopting the OAAPN recommendations, and changing the</td>
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<td>4. CNS, they can go in and, you know, declare that that</td>
<td>5. order of the sentence on the number of physicians the</td>
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<td>5. patient is deceased and then they still have to</td>
<td>6. APRN may collaborate with when prescribing.</td>
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<td>6. notify the attending physician who will be signing</td>
<td>7. MEMBER ZAMUDIO: Adding the word</td>
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<td>7. the death certificate --</td>
<td>8. &quot;advanced&quot; and adding the word &quot;training.&quot;</td>
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<td>8. MEMBER ZAMUDIO: Okay. Thank you, Lisa.</td>
<td>9. CHAIRWOMAN KEELS: Oh, yes, under</td>
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<td>10. MEMBER ZAMUDIO: Thanks.</td>
<td>11. MEMBER ZAMUDIO: Amazed we got through</td>
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<td>11. CHAIRWOMAN KEELS: Okay. Anything else</td>
<td>12. this because having come on this Board and then left</td>
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<td>12. on page 15?</td>
<td>13. and come back, I mean, this is a great document.</td>
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<td>13. And then page 16, any comments?</td>
<td>14. Working on this, it's great.</td>
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<td>14. Yes, Michelle.</td>
<td>15. CHAIRWOMAN KEELS: Thank you, Lisa.</td>
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<td>15. MEMBER ZAMUDIO: Before we move on, I</td>
<td>16. MS. EMRICH: Just to clarify you said</td>
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<td>16. know you asked about page 16. I didn't see any</td>
<td>17. adopting OAAPN's recommendations. We're not removing</td>
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<td>17. response. I just wanted to clarify on page 1 we</td>
<td>18. the verbiage that's under --</td>
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<td>18. decided to not make any changes, correct?</td>
<td>19. CHAIRWOMAN KEELS: Right.</td>
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<td>20. MEMBER ZAMUDIO: Yeah. Licensure, we</td>
<td>21. just -- we're not removing it. We're just -- you're</td>
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<td>21. were talking about deleting the sentence, and without</td>
<td>22. removing the reference to the &quot;Consensus Model&quot;; is</td>
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<td>22. knowing all the players and et cetera, I don't see a</td>
<td>23. that correct?</td>
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<td>23. reason to change it as it exists right now.</td>
<td>24. CHAIRWOMAN KEELS: Correct.</td>
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<td>24. CHAIRWOMAN KEELS: I'm sorry, Michelle.</td>
<td>25. MS. EMRICH: Okay. Just wanted to make</td>
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<tr>
<td>1. MEMBER ZAMUDIO: Yeah. Under &quot;APRN</td>
<td>1. CHAIRWOMAN KEELS: Sorry about that.</td>
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<td>2. Licensure,&quot; it was that interrelated field comment.</td>
<td>2. MS. EMRICH: No, no. That's fine. I</td>
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<td>3. CHAIRWOMAN KEELS: Oh, oh.</td>
<td>3. just wanted to...</td>
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<td>4. MEMBER ZAMUDIO: Yeah, I asked that we</td>
<td>4. CHAIRWOMAN KEELS: So then can we feel</td>
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<td>5. leave that in since it's already there. There's no</td>
<td>5. comfortable -- do we feel comfortable with making</td>
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<td>6. advantage to taking it out. We don't know all the</td>
<td>6. those changes and then sending it on for the legal</td>
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<td>7. players, et cetera. I don't want to make a rash</td>
<td>7. review? Because that will take some time. And I</td>
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<td>8. decision on that.</td>
<td>8. believe it has to go to the full Board as well, or</td>
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<td>9. MS. EMRICH: Yeah. And to be clear, my</td>
<td>9. does it come back to this group before it goes to the</td>
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<td>10. question was about is there need for a statutory</td>
<td>10. full Board?</td>
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<td>11. change itself, you know, because this would be -- it</td>
<td>11. MS. EMRICH: I'll check with Betsy, with</td>
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<td>12. would start with this group, the Committee being</td>
<td>12. our Executive Director, and I'll see how that might</td>
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<td>13. obviously the experts in APRN education and practice,</td>
<td>13. be and with the Board's president. We'll check and</td>
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<td>14. that to know whether that phrase &quot;interrelated field&quot;</td>
<td>14. discuss how that needs to go.</td>
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<td>15. is still relevant or not.</td>
<td>15. CHAIRWOMAN KEELS: Okay.</td>
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<td>16. CHAIRWOMAN KEELS: And I believe</td>
<td>16. MS. EMRICH: And then I'll know more. I</td>
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<td>17. everybody agreed until there is more information</td>
<td>17. can be in touch. Well, we'll probably talk about it</td>
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<td>18. around the midwife topic that we would wait.</td>
<td>18. this week, Erin.</td>
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<td>20. understood.</td>
<td>20. Yeah, because I remembered that we need to make sure</td>
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<td>21. MEMBER ZAMUDIO: Okay. Thank you.</td>
<td>21. that this is congruent with all current statute and</td>
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<td>22. CHAIRWOMAN KEELS: So no comments for</td>
<td>22. rule and does not enact anything new, just with the</td>
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<td>23. page 16 is what I'm hearing. So we actually made it</td>
<td>23. current.</td>
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<td>24. through the document in record time. Thank you. And</td>
<td>24. MS. EMRICH: Yeah. We cannot enact new</td>
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<td>25. the -- the changes that we're going to require are</td>
<td>25. rules with -- with a paper so.</td>
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So then next on our agenda are to pick time -- dates for next year meetings, 2021. My gosh. And do we have suggestions? We meet three times a year.

MS. EMRICH: Usually. You are required to meet, I think, two, but three is historically what is done.

CHAIRWOMAN KEELS: Is the Committee in favor of scheduling three meetings for 2021? Okay. And do we have suggested dates and times? Sorry, Lisa, I didn't even think about it.

MS. EMRICH: No. We could keep -- do they work well being like the Monday of a Board meeting week?

CHAIRWOMAN KEELS: It can be really hectic for those on the Board but.

MS. EMRICH: Yes. We can stay in non-Board meeting months too.

CHAIRWOMAN KEELS: I like having it, you know, before the Board meeting so it's fresh, and we can report on it to the Board. Maybe not two days before the Board meeting just since I know you all are very busy getting materials together for the Board meeting, and I have a lot to review.

MS. DiPASQUALE: I have the Board meeting dates up if we need them.

CHAIRWOMAN KEELS: Perhaps the week before.

MS. EMRICH: Well, let me pull up some possible dates.

CHAIRWOMAN KEELS: Perhaps the week before.

MS. DiPASQUALE: I have the Board meeting dates up if we need them.

MS. EMRICH: Go ahead, Anita.

MS. DiPASQUALE: So March is the 17th-18th. April is the retreat, so I don't know how you want to factor that into your thoughts. That's April 14th-15th. May is 19th-20th, July 21st-22nd, September 22nd-23rd, and November 17th-18th which is very similar to this week. So they are typically mid, you know, second or third week. So, Erin, are you saying you would like to have a week in between is ideal?

MS. EMRICH: Or the week before?

CHAIRWOMAN KEELS: Yeah. For me personally that would be great.

MS. EMRICH: So March the 8th is a Monday, or March the 9th is obviously Tuesday. Those might be good days.

CHAIRWOMAN KEELS: March is fine for me.
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<td>MS. DiPASQUALE: Monday, the 12th.</td>
<td>have not read the full -- I read it a while back, but</td>
<td>have not read the full -- I read it a while back, but</td>
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<td>CHAIRWOMAN KEELS: Okay. And then</td>
<td>are you talking about whether or not it's being</td>
<td>are you talking about whether or not it's being</td>
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<td>November.</td>
<td>rolled out or not or what have you?</td>
<td>rolled out or not or what have you?</td>
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<td>MS. DiPASQUALE: So that's the 17th-18th</td>
<td>MS. EMRICH: More the -- from the CRNA</td>
<td>MS. EMRICH: More the -- from the CRNA</td>
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<td>for the Board meeting.</td>
<td>perspective we were all interested in your take on</td>
<td>perspective we were all interested in your take on</td>
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<td>MEMBER GRAHAM: I can easily get someone</td>
<td>the application with respect to, you know, the timing</td>
<td>the application with respect to, you know, the timing</td>
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<td>else to cover me on the 17th if Mondays are better</td>
<td>of writing orders, the clinical support functions,</td>
<td>of writing orders, the clinical support functions,</td>
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<td>for you all so.</td>
<td>and, you know, having the orders already there and</td>
<td>and, you know, having the orders already there and</td>
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<td>MEMBER ZAMUDIO: If we are doing the week</td>
<td>existing, but you are also directing nurses to</td>
<td>existing, but you are also directing nurses to</td>
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<td>before, Monday is a holiday, so we could do the 12th</td>
<td>administer certain I.V.s and medication.</td>
<td>administer certain I.V.s and medication.</td>
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<td>which is a Tuesday. Did you say the Board was the</td>
<td>MEMBER GARRETT: Yeah. So I received</td>
<td>MEMBER GARRETT: Yeah. So I received</td>
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<td>18th?</td>
<td>some inquiries from around especially in the</td>
<td>some inquiries from around especially in the</td>
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<td>CHAIRWOMAN KEELS: Not September,</td>
<td>OhioHealth System because I work for OhioHealth and</td>
<td>OhioHealth System because I work for OhioHealth and</td>
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<td>November.</td>
<td>people are -- you know, some hospitals are not going</td>
<td>people are -- you know, some hospitals are not going</td>
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<td>MS. EMRICH: 8th or 9th.</td>
<td>to implement and some are going to implement it based</td>
<td>to implement and some are going to implement it based</td>
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<td>CHAIRWOMAN KEELS: Either the 8th or the</td>
<td>on local control which is the intent of the bill all</td>
<td>on local control which is the intent of the bill all</td>
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<td>9th.</td>
<td>along.</td>
<td>along.</td>
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<td>MEMBER ZAMUDIO: Okay.</td>
<td>MS. EMRICH: Correct, policy.</td>
<td>MS. EMRICH: Correct, policy.</td>
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<td>CHAIRWOMAN KEELS: And it's -- either one</td>
<td>MEMBER GARRETT: The problem is everybody</td>
<td>MEMBER GARRETT: The problem is everybody</td>
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<td>is fine for me.</td>
<td>is really looking for somebody else to be the first</td>
<td>is really looking for somebody else to be the first</td>
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<td>MEMBER ZAMUDIO: I am okay on the</td>
<td>to do it. And so, you know, I've had a couple</td>
<td>to do it. And so, you know, I've had a couple</td>
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<td>Tuesday.</td>
<td>hospitals call me, well, could we use whatever you</td>
<td>hospitals call me, well, could we use whatever you</td>
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<td>MEMBER GRAHAM: I'm okay either one.</td>
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<td>That's a long time out. I can get coverage.</td>
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<td>CHAIRWOMAN KEELS: Okay. The 9th then?</td>
<td>do you know anybody else? Like no. So I call some</td>
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MEMBER GARRETT: The hospitals that I talk to basically going to the CRNAs and say -- again, the CRNAs contacting me saying, hey, we want to implement this at the hospital, but the hospital is leaning on us to come up with the guidelines. And then they say we're -- a lot of CRNAs are good clinicians and practice people, but they are not the best at writing policy and guidelines.

So, you know, they reach out to somebody like me, and I say, well, you know, I don't know of anybody that's done it yet. So again, that is kind of where it's at. The administrators don't know where. And a couple of them I suggested -- I said just, you know, tailor it to your other APRN language but just put in the -- put in the -- go to the law and where it says perioperative area kind of define for your area what perioperative area is, so, you know, and use the -- use the bill as your guideline, right, for that.

MS. EMRICH: Right.

MEMBER GARRETT: Make sure you stay within it. Don't go outside of it. Make sure you stay within it. You'll be fine. I have not heard back because, like I said, COVID took the -- took the -- took away resources and meetings and things like that. So again, if anybody else has anything out there, that's my experience with it so far. I see Tom Dilling on here or somebody else.

MR. DILLING: Yeah, I did. I clicked that on. Sorry, Sherri. But, yeah, I just wanted to reiterate what Brian was saying. I think that the time that we are in right now with COVID makes it very hard to communicate the same way, you know, across distances, and here we are a bill that became law in March is more of an emergency bill.

And I think what happened the other day, just to give you a brief, you know, background, last month I went to an ONA virtual meeting with some leadership from different groups, and so as I want to do, I'm a pretty open guy, and I tell people what we're doing, so I said, hey, we have an APRN Advisory Committee meeting coming up. We are talking about, you know, a number of different things. One of the things we want to talk about is the CRNA, you know, bill, make people aware of it, and we've gotten a couple of questions recently. And, you know, we will be able to talk about those at the time which are the ones that we talked about with Cameron, you know, and

Well, the next day we got a number of inquiries about that statement, I guess, and wanting to know what these questions were and who is asking them and, you know, so forth. So, you know, we're telling people, we'll tell you again too, boy, Lisa and Anita are about the easiest people at the Board to get ahold of and, you know, you send them an e-mail and you get a response back and they are the ones that are dealing with it on a day-to-day basis. I'm pretty easy to get ahold of.

But, you know, I just want to reiterate that I think all we were doing was tracking back and wanting to utilize this forum, the APRN Advisory Committee, as a way to say here is what we've heard. What have you heard? How are things going? Let's -- let's keep on the same page as best we can and I think for the most part that has occurred.

It was just a little rough here for a moment or two just because we don't communicate quite as easily. You can't -- the Pharmacy Board heard from the DEA. The DEA wasn't even aware of this law change. They are the feds, but you would have thought that they would have been a little bit more aware and a little bit more ahead at this time, but

we're catching up. I think we're getting, you know, good answers. We seem to be on the same page. I don't want to throw it all on Brian and say what do you know, Brian.

We'll circle back with the Association and make sure that we are on the same page, and again, this Momentum article and the stuff that Lisa and Anita publish, I think, will be helpful. No one has -- has questioned the accuracy, and I think it's a pretty broad view.

Thanks. I just needed to kind of set a background for that, I thought.

CHAIRWOMAN KEELS: Thanks, Tom.

Sherri, your hand is up.

MEMBER SIEVERS: I do. I just have a question. Well, I have two questions actually. So 197, I have the Momentum, we get some paper copies at our office so that's really nice. It says the Pharmacy Board.

Well, the next day we got a number of inquiries about that statement, I guess, and wanting to know what these questions were and who is asking them and, you know, so forth. So, you know, we're telling people, we'll tell you again too, boy, Lisa and Anita are about the easiest people at the Board to get ahold of and, you know, you send them an e-mail and you get a response back and they are the ones that are dealing with it on a day-to-day basis. I'm pretty easy to get ahold of.

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CHAIRWOMAN KEELS: Thanks, Tom.

Sherri, your hand is up.

MEMBER SIEVERS: I do. I just have a question. Well, I have two questions actually. So 197, I have the Momentum, we get some paper copies at our office so that's really nice. It says the facility's required to adopt written policy. Has there been any issues with that? Because I heard rumors about facilities just kind of saying we're not taking a stand. We are not going to do anything. And my understanding is they have to address it somewhere. So has that been an issue?

And then I don't know if I should have
asked Cameron this, or anybody on this call knows, for the DEA to use the institutional number, it says institution or there's another word like facility or location. Does anybody know, does that cover the same-day surgery centers where a lot of our CRNAs work or facilities? It's an institution, but it's not like a hospital system. It might be like a freestanding surgery center.

MR. DILLING: Yeah. I think we can get with Cameron to clarify some of those questions. It's not that very recent guidance that he -- just came across his desk today, and we will work and make haste to get that out in a readable format and try to answer a question or two from that.

Again, quite frankly, as the CRNA bill moved through, I didn't hear too much discussion directly with us. Nobody ever brought up the DEA. Now that I look back at it, I kind of go duh, but, you know, it just wasn't that big an item. And I think Cameron, I don't know, he served to call me that -- that CRNAs are a known commodity. They are not nationally. Most everybody works this way or beyond this already, so again, I don't think we are going to be walking a tight rope here. I think it's just more or less the institution, the facility,

MR. DILLING: But hospitals work under a credentialing system. They have some oversight for their reimbursement. Look, if they aren't credentialing or privileging people to write orders, anything with it, and they really don't have that option, right? They have to do something, either say yes or no in some sort of policy. I know we are looking at ours to try to figure out what language needs to be inserted there.

Maybe Brian can chime in.

MEMBER GARRETT: A couple of the institutions where I'm at, Grant, OhioHealth where they don't, they already have CRNAs can't do it, so they are just not changing it to they can. Now, it's a good question if they didn't state it explicit either way, then, yeah, you are right. But I know our language already had it as they can't do that, so it didn't need to be changed. But that's a very good question.

MEMBER DILLING: But hospitals work under a credentialing system. They have some oversight for their reimbursement. Look, if they aren't credentialing or privileging people to write orders in this way, then it's not being done. And it's just that way. If they do, if they want to do it, they

going to have to look at what they are all doing and fit their policies, write them down, you know, and fit them within everybody's law. They dealt with it before. They have dealt with it here.

There are certain facilities if it's not broke, I am not going to fix it. I am not going to move on right at the moment. And then there is some smaller places, I believe, that really need this ability to maneuver this way with their personnel and feel strongly like, hey, we are going to hit it and hit the ground running here.

And I think we'll see in the next six months some growth certain places, and then other places it's just it will take a little bit to train in that practice.

MEMBER SIEVERS: Have you heard of any institutions not wanting to do policies? Because it -- I mean, it looks like they have to establish standards and procedures to be followed. So they may not have mentioned it before because it wasn't something that they could legally do, so you wouldn't have to call out like a negative, but if an institution chooses not to enact this, would that need to be in a policy where it says they may not because somebody could just say, oh, well, we can do

this, and the policy doesn't say we can't.

So I didn't know if you were hearing anything about that because if -- just to someone's comment about institutions kind of not wanting to do anything with it, and they really don't have that option, right? They have to do something, either say yes or no in some sort of policy. I know we are looking at ours to try to figure out what language needs to be inserted there.
(Thereupon, at 1:27 p.m., the meeting was adjourned.)

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, November 16, 2020, and carefully compared with my original stenographic notes.

Karen Sue Gibson, Registered Merit Reporter.

(KSG-6989)