BEFORE THE OHIO BOARD OF NURSING

ADVISORY COMMITTEE ON ADVANCED PRACTICE
REGISTERED 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
Brian Garrett, APRN-CRNA, Committee Member
Margaret Graham, APRN-CNP, Committee Member
Angela Gager, APRN-CNP, 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,
November 16, 2020.

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.

Page 5

Are there any other Committee Members that I have failed to recognize? We're missing Michelle Zamudio. Anyone else?

Okay. Lisa, would you like to introduce yourself.

MS. EMRICH: Oh, sure. I'm Lisa Emrich, Program Manager for Education, Practice, and Licensure.

CHAIRWOMAN KEELS: Anita, would you like to introduce yourself.

MS. DiPASQUALE: Yes. Anita DiPasquale, Board staff. Thank you.

CHAIRWOMAN KEELS: Thank you.

Chantelle.

MS. SUNDERMAN: Hi. Chantelle Sunderman, Board staff.

CHAIRWOMAN KEELS: Chantelle. And is Tom still on the phone?

MR. DILLING: Yes, I'm here. Tom Dilling, Board staff.

CHAIRWOMAN KEELS: And then Angie -- no. Is it -- Karen Gibson will be our court reporter. I think I have everybody.

So, Committee Members, we will try to virtually raise our hands or at least speak your name

Page 6

clearly so that you can be called upon to speak and then be sure to speak slowly and clearly so the court reporter can record the conversation accurately.

Are there any other introductions or announcements?

Okay. Great. First on our agenda is some discussion on House Bill 197 in relation to CRNAs in practice and DEA certificate. And, Lisa, were you going to lead that conversation?

MS. EMRICH: I can. I just want to recognize we have invited Cameron from the Board of Pharmacy to be on this meeting to address the CRNA DEA question. I know someone just joined us. Is that you, Cameron?

MR. McNAMEE: No, Lisa. I've been here. I'm here.

MS. EMRICH: Are you here? Okay, Cameron.

CHAIRWOMAN KEELS: So sorry.

MEMBER ZAMUDIO: Hi, Lisa. It was Michelle Zamudio. I'm sorry. The Teams -- Microsoft Teams wouldn't let me in, so I'll just use the audio version for now. I am working on the audiovisuals here.

MS. EMRICH: All right. Very good. Very

Page 7

good.

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.

Page 8

MR. McNAMEE: Sure, yeah. Thanks for having us on the call today. We did reach out to DEA and subsequently this morning received a letter back from their policy unit regarding the CRNA midlevel registration.

Interestingly enough, the DEA interpretation of it kind of falls into two pots. One, they have recognized the ability of the CRNA to fall under the institutional DEA registration as many other practitioners do in a hospital setting, but they do also state that the midlevel does have the opportunity to obtain a midlevel practitioner if they so choose.

So we'll be sharing this guidance out shortly once we're able to sort of process it. But, yeah, so essentially there are two options available in those -- in those spaces for -- for the CRNAs in order for them to order controlled substances in a hospital setting.

MS. EMRICH: Okay. Thank you. And I think Sherri.

CHAIRWOMAN KEELS: Sherri, you have a question?

MEMBER SIEVERS: Yes. Do you have -- this is Sherri Sievers. I'm one of the Committee

Page 9

Members, nurse practitioner. Do you know how quickly the system will be updated? Because I believe that in Ohio currently there is not an option for the CRNAs to even register like that. There wasn't an option for their kind of title. Will that be included in your information?

MR. McNAMEE: Yes. So that's part of the -- that's part of the additional fact finding we are going to do with DEA. So they don't update their systems until they're approached by an individual state and provided with that level of, you know, here is what the law now allows, here is who qualifies.

So the next step of this is circling back with DEA Detroit that we've been working with, because they handle all the registrations, and making sure that they've got that process established. We had a similar process for when the pharmacist consult agreements came into -- came into play. They -- they did also qualify for midlevel, but we had to establish a process with DEA to get that moving.

So we'll circle back and talk about next steps should CRNAs wish to obtain midlevels, but again, they are -- they are more than welcome and able to use that institutional credential as well.

MEMBER SIEVERS: Thank you.

Page 10

MS. EMRICH: Okay. Any other questions or just questions to Cameron?

MEMBER DiPIAZZA: Cameron, what's the anticipated time frame?

MR. McNAMEE: You know, it all kind of -- it's beholden to DEA and what they sort of -- how quickly they are able to move in terms of allowing CRNAs to obtain midlevels. But again, you know, in terms of their current practice, the institutional is still available to them and so that's sort of probably what most CRNAs will seek to utilize because, again, you know, we were a little -- DEA was a little sort of going back and forth as to whether or not, since they can't technically prescribe to someone, you know, leaving the facility, they were concerned about whether or not that -- that holds true. But they have a very -- we'll share the letter, but they have a very sort of, you know, cut and dry, if they are able to do this, this, and this, then they do qualify as midlevels.

So, you know, it will be up to the CRNAs in the hospital to decide what's the best course of action. From the Board's perspective, it makes sense to just use the institutional, but again, that is an option that DEA said is available for them. So we'll

Page 11

work on that and get some additional details. And but, again, in terms of time frame, there's nothing stopping CRNAs from practicing under that registration now, but if they want to become midlevels, that would be -- that's another discussion that again we'll have with DEA registration on.

MS. EMRICH: Okay.

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.

MS. EMRICH: 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.

MS. EMRICH: Effective in December

Page 12

pharmacists will be able to enter consult agreements with APRNs which, you know, they've been entering with physicians for a few years now, and so now APRNs are included. And that additional information was provided to you in your materials as well.

Again, Cameron is on the meeting, and if you have any particular questions for the Pharmacy Board related to this, I'm sure this would be a good time to ask as well.

MEMBER DiPIAZZA: I do have a quick question, this is Pete, regarding the consult agreement. So in looking at the memo, I just want to make sure I understand. It just has to be an agreement with the collaborating physician that the APRN can enter into the consultative agreement, or is it the physician also has to have a consultive agreement with the pharmacist?

MS. DiPASQUALE: This is Anita. I do not know the answer to that question offhand, but I can tell you that we do anticipate rules will be proposed by the Board of Nursing and, you know, that process is very public. They'll be published. You can comment on them. That was not my understanding but really everything I know is in this memorandum so I don't want to overstate. Your question is can the

Page 13

APRN only have an agreement with a pharmacist with whom the collaborating physician also has --

MEMBER DiPIAZZA: Correct.

MS. DiPASQUALE: -- an agreement? I do not know, but we can find out.

MEMBER DiPIAZZA: Thank you.

MEMBER GRAHAM: This is Margaret. I certainly hope that is not the case. In primary care that would be a challenge. I think it would be a challenge in the acute care arena as well, but in primary care we don't necessarily have physicians on-site practicing. We have the standard care arrangement, but we have -- we work with pharmacists, and I think to expect there to be that arrangement would be prohibitive for the good collegial relationships that I think nurses and pharmacists can have in this treatment regime.

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

MEMBER DiPIAZZA: Absolutely agree,

Page 14

Dr. Graham.

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

Page 15

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

Page 16

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

Page 17

broadly if you are working in a wide institutional facility where there's credentialing. It could be done very locally, so for say 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.

Page 18

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

Page 19

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 can 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

Page 20

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

Page 21

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

Page 22

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

Page 23

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

Page 24

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

Page 25

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?

MS. EMRICH: Get to that. Correct. The -- first the CNSs, they can be pediatric or adult as far as age ranges, but it's -- their -- their

Page 26

scope is across the continuum of health, so from 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

Page 27

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

Page 28

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 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 that aren't necessarily first adult or first family

Page 29

or acute care. And I think that, you know, we may see more of that in the future. So I think it's again based on the person's national certification versus a population.

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

Page 30

Michelle. I feel like we have jumped ahead about issues we are going to talk about later, and I notice there's several different -- I think there's four things I think in the statements. I am not sure if we should go one at a time and address each of the recommendations because we are kind of jumping back and forth on Ms. Singleton's note between, you know, 1, 2, 3, and 4.

That said, I think -- I think labeling it as population foci currently available certificate exam, that's going to be too confusing. I think we should take out population foci because that's not how it's listed on our certification exam. People can read about the Consensus Model later in the document which I thought was -- was so well done, but if we are labeling it, right now it says the currently available population foci certification exam. That's too much.

It may not be labeled as a population foci to that person who is looking at this, right, but their national guidelines, that's not what it's called. It's a certification exam, so I think it's clear if we say their currently available certification exam and that would be my input for Nos. 1 and 2. My recommendation is that we go

Page 31

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.

Page 32

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,

Page 33

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 midwifes, and we also interestingly

Page 34

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 if'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

Page 35

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

Page 36

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.

Page 37

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

Page 38

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

Page 39

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

Page 40

basically of continuing this?

And again, silence has been deafening to date. Mostly I've heard back from organizations and individuals who are not happy with the license, not happy with delays attending to it. And again, I think this will be a point of emphasis in some bill, some legislation, you know, during lame duck.

I'm sorry. Does somebody have their hand up and have a comment there or question on that? Okay. I'm sorry.

CHAIRWOMAN KEELS: Michelle, your hand is up. I think it's from the -- from your last question.

MR. DILLING: Okay. Yes, Michelle.

MEMBER ZAMUDIO: Erin is correct. I still had it up from the last time. Sorry, Tom.

MR. DILLING: No, no, no. I'm confused. I'm sorry, because the legislation is confusing. And the other part of this too is that certainly we have this idea or this -- these policies that have been put in place along with pretty broad rules for our schools to have clinical practice and clinical education for the nursing students, but it certainly has impacted that clinical education.

And so now I guess I've heard -- the one

Page 41

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,

Page 42

but the people that put in all the time and effort helping transition through the CPG, and the CPG is a vehicle to, 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

Page 43

staff. They are attempting to get us numbers and answers to some of our questions that may make us feel, you know, more supportive. You know, right now, we are an interested party. We have questions. People haven't answered the questions.

At the same time nobody at the Board has ever said we are against this as a concept, you know, and as a way to -- you know, as a way to change it and so forth. Again, some of these questions should be simpler to answer than they have been and near caused you to scratch your head a little bit. I think we will have a hearing or two here. I don't see it passing in the lame duck but just because we haven't really had that many discussions and I haven't seen back any of the answers to any of the questions over the last couple of months but next -- next session that's going to be right up top, right up front, I think. We are going to have some bills being heard with respect to the compacts so keep your eyes open with respect to that.

As far as the APRN is concerned, I'll just mention briefly that there are different questions with an APRN compact, and I think it's a little bit more difficult by the nature of it that there's so many different scopes of practice out

Page 44

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, eliminating 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 I was 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

Page 49

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 midwifes and certified professional midwifes, the CMs and CPMs. It's been an ongoing issue in our state because obviously the legislation addresses certified nurse midwifes.

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,

Page 50

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: Yes. 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

Page 51

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

Page 52

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

Page 53

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.

MEMBER ZAMUDIO: Okay. Thanks, Tom.

MR. DILLING: Sure.

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 think that -- you know, I don't see how you stop that, you know, from happening. The PAs are always going to be able to do that, and to some extent it

Page 54

impacts the APRN's ability to move forward without understanding that nuance of it, that it all -- a lot of people are being carried forward here and that tends to make, I think, people who are maybe traditionally opposed to it to take a step backward and say, okay, I need to get a bigger -- you know, big picture here.

But in the end it's not necessarily the PAs; it's not necessarily the APRNs. The employers are a huge reimbursement, huge factor in all this, right? You know, and people are asking in the employment setting, hey, why can't my PA, you know, 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 done it this way, or it hasn't been.

This transaction is happening, and again, I'll be surprised if it -- if it doesn't happen maybe in the next General Assembly. I don't know that it's going to happen here at the end but, you know, look at how these battle -- scope battles are fought. You give to one group, and then the other group wants something, so again, it's hard for me to think that the PAs or the APRNs are going alone here. They may

Page 55

in terms of it's 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

Page 56

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

Page 57

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.

Page 58

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.

Page 59

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

Page 60

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

Page 61

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.

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.

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?

MEMBER ZAMUDIO: Right. I will get that

Page 62

detail soon.

CHAIRWOMAN KEELS: Thanks, Michelle. We'll come back to that.

Okay. Any others questions for Tom?

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?

CHAIRWOMAN KEELS: You're on mute, Anita.

MS. DiPASQUALE: Let's see there. Okay. 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.

Page 63

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.

MS. DiPASQUALE: All right. So it's HB 492 if you want to Google it and see what the provisions are.

MR. DILLING: Thank you.

CHAIRWOMAN KEELS: Thanks, Anita.

MS. DiPASQUALE: Sure.

CHAIRWOMAN KEELS: Okay. Any other comments, questions, or concerns for Tom?

All right. Thanks so much, Tom. We appreciate you.

MR. DILLING: Thank you.

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?

MS. EMRICH: Okay. Sure.

Page 64

CHAIRWOMAN KEELS: Lisa, do you want to give us?

MS. EMRICH: 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.

Okay. So just wanted to, you know, remind everyone of that for those that may be impacted by LPN licensure.

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.

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

Page 65

that date.
CHAIRWOMAN KEELS: And if they have taken their NCLEX and did not pass, then they are no longer permitted to practice.
MS. EMRICH: Yes, they are. We don't -- we do not currently have authority to invalidate or inactivate an HB 197 license.
CHAIRWOMAN KEELS: Okay.
MS. EMRICH: If they were issued the license and then subsequently failed the NCLEX, they do have opportunity to attempt the NCLEX again or for as many times as they can between now and March 1, but we do not have statutory authority to inactivate the license before the expiration date.
CHAIRWOMAN KEELS: They just have to get it passed by then.
MS. EMRICH: Yes.
CHAIRWOMAN KEELS: Okay. Then it's invalidated. Okay. Good to know.
MS. EMRICH: Just as an FYI.
CHAIRWOMAN KEELS: Thank you.
MS. EMRICH: Thank you. We have -- we've had to do a lot of looking at dates and there's a number of moving parts with the HB 197 licenses so that's been something we've had to do. There have

Page 66

been close -- a little over 45,000 LPNs who have renewed, and every year we expect there may be about 7 or 8 thousand who choose not to renew just due to they've either gone to another state and are licensed, or they have chosen not to maintain their license, so we are close to getting close to that number now.
Okay. As usual, we have included a sample of -- or summary of APRN practice questions we've received, and this time Anita included the responses to those as well as understanding you all have found that helpful so.
CHAIRWOMAN KEELS: Yes. Thank you. A few new topics this time so that was -- that was interesting to me.
MS. EMRICH: And then we did include two articles of interest that we -- it's more for informational and of interest. As they come along, we will continue to provide you with articles that cross our desks that may be of interest to the APRN Committee.
CHAIRWOMAN KEELS: Thanks, Lisa. Does anyone have any comments or questions?
Okay. So I recommend that we take a break here until, what, about 10 after noon? That

Page 67

gives us half an hour? Is that okay with everyone?
MEMBER ZAMUDIO: Erin, it's Michelle. Just super fast note, you guys, I did get some clarification because there is a document on the American College of Nurse-Midwife site about certified midwives if you guys are interested in looking at it. It's like what is the CM? What's the pathway?
And to address Dr. Graham, it's actually through a college of allied health sciences, not through a nursing college, so they have the exact same core competencies that they have to meet clinically, et cetera, and then they sit for the same exam. They are recognized in Delaware, Hawaii, Maine, New Jersey, New York, and Rhode Island, so several other states are trying to do that, and I think Ohio will be one of those soon.
So I just wanted to give that background information. CM has that undergraduate degree in a different area, and then the Master's in the midwifery through the allied health, so they are identical practices but without the word nurse in there. So if -- if we're all okay with that, just letting the information on the site stand as is would be appreciated.

Page 68

MS. EMRICH: To be -- if my understanding then is that if an individual is a registered nurse and they obtain a Master's Degree through an allied health program of an institution and get a Master's or Doctoral Degree, then they can take the certified nurse midwife exam and could be licensed as a certified nurse midwife.
MEMBER ZAMUDIO: Their Master's Degree would need to be a nurse midwifery, I believe, but I don't know the answer to that clearly. I just know leaving -- I don't see an advantage to striking that out.
MS. EMRICH: I think my --
MEMBER ZAMUDIO: Right now in Ohio, we don't have a program available for them through allied health but not to say it couldn't happen.
MS. EMRICH: Okay. I just want to make sure, I'm -- if that is left in as being in a related field, those persons, I'm thinking, and we would discuss -- can discuss at the Board, but those persons could indeed become certified nurse midwives.
MEMBER ZAMUDIO: There would be that pathway if that program existed in Ohio.
CHAIRWOMAN KEELS: Pete, you have a question?

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.)

Monday Afternoon Session,
November 16, 2020.

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.

MEMBER BOLTON: Hey, Erin, it's just a small issue. Under -- it has "NPA" in the second -- or the third sentence in parentheses, but it doesn't have NPA after -- in the first sentence where it says "Nurse Practice Act." And I just think that just for clarification it would be helpful.

CHAIRWOMAN KEELS: Great. Thanks, Pam. Something I -- oh, Michelle.

MEMBER ZAMUDIO: Oh, mine was actually the same as Pam's and then, and this is silly, but the third paragraph it says "The first part is a summary of APRPN," just striking one of the Ps, just a typo. I just thought I would mention it.

MS. EMRICH: Just as an FYI, once the Committee is good with this, we are going to go through it. We have detected some typos. It's going to have to be reviewed by legal as well before it's actually published just to make sure that everything is -- is good with current law and rule as well so. But thank you. I appreciate it because we'll fix these now.

CHAIRWOMAN KEELS: Okay. Thanks. Okay. Moving down to the part of "APRN Licensure," any comments?

Any comments on page 2?

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.

Page 73

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?
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 OAAPN comment is made as well.
MS. EMRICH: Erin, if I may, just

Page 74

speaking to under the currently available exempts 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.

Page 75

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

Page 76

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

Page 77

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?

MS. EMRICH: I will defer to Angie being the educator or.

CHAIRWOMAN KEELS: Or Margaret.

MEMBER GAGER: 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.

CHAIRWOMAN KEELS: Okay.

MEMBER SIEVERS: 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.

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.

Page 78

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" --

MEMBER SIEVERS: Yeah, I agree. I was going to ask. That's the next point. I just don't know what that means.

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.

MEMBER ZAMUDIO: So along those lines --

MS. EMRICH: You have your formal education and everything and then you go and you take your exam and you become nationally certified.

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

Page 79

board for the APRN. I don't know if it matters but. It would change what type of formal education putting the word "advanced" in front of it.

MS. EMRICH: Advanced formal?

MEMBER ZAMUDIO: Yeah, which is, I think, how it is written for everybody.

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 SIEVERS: Yeah, I think that's good. This is Sherri.

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. DiPASQUALE: This is Anita. In all four headings remove "population foci," add the word "national" before "certification."

CHAIRWOMAN KEELS: Yes.

Page 80

MS. DiPASQUALE: Just to keep it, okay.

CHAIRWOMAN KEELS: Just to keep that clean.

MS. DiPASQUALE: And then no consensus yet on whether "resulting" is in or out in paragraph 1 on page 5.

CHAIRWOMAN KEELS: It feels like "resulting" doesn't have to be there because you're -- have to have the national certification.

MS. EMRICH: Okay.

CHAIRWOMAN KEELS: So that's fine.

MS. DiPASQUALE: Trash the... Thank you.

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 gero, the primary and acute national certifications must be obtained.

Page 81

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.

Page 82

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,

Page 83

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

Page 84

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

Page 85

arena for 20 or 30 years because there wasn't an acute care specialty at that point, and I'm not prepared to tell them, especially during a time of COVID, that they cannot practice there when they -- their clinical practice has -- I would let them take care of me.

So I think it's kind -- to me it's similar to when we initially recognized advanced practice nurses in the state who were not educated at the Master's levels but they went through accredited programs. They just didn't receive a Master's. And then we moved to the Master's Degree, and now we have great programs across the state and across the country in acute and primary pediatrics, acute and primary adult, and I think we need to go forward making sure that our students are educated.

And I think the point that Pam made sometimes they don't know is unconscionable, and they have to know because they have to do their clinical where they were. But I also think that we have to be very, very careful when we have experts in the clinical arena who are actually adult nurse practitioners who are working in an acute care setting, and I don't think that we want to close the door on them, at least I don't. I -- not during the

Page 86

time that we are in such need.

So I think I understand the point of this, and I understand moving forward that as educators and as professionals, we have got to make sure that our students and our new graduates understand the difference and understand, yes, you chose the primary care area and that's where you need to be working and you chose the acute care, but I think we have some real experts in the state who are possibly adult nurse practitioners who are working in the acute care arena and I -- we don't have the Consensus Model in our law and rule. We do have practice, and so I think I feel like that I understand wanting new people to understand their role.

And I agree with Pam on that, if they don't understand it when they graduate, that's a problem. But I also think we have to be careful about what we're doing to the practice of nursing right now and in the future when we are in the pandemic, and I think we have got to figure out how to work that delicate balance.

CHAIRWOMAN KEELS: I think Sherri's hand was up next. There's some old hands up too.

MEMBER SIEVERS: Yeah. I am not sure if

Page 87

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 then is there 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

Page 88

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

Page 89

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 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 people 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

Page 90

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. DiPASQUALE: 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. DiPASQUALE: 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 as 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

Page 91

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 it 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

Page 92

evidence-based practice, and they're telling me that they're in acute care, and they want to work in an ICU. So, I mean, even though there are, you know -- there's -- I guess what I am saying to that, there still is a lot of confusion around that. And I -- and I feel like, you know, do we really want to take NAPNAP out.

I don't know anything about neonatal but I -- I know that's a highly reputable organization. And I think that although I see ORC everywhere, all over this document, and I agree with that, I think we should be open to utilizing some of those key position statements or white documents that support the practice.

CHAIRWOMAN KEELS: Thanks, Pam.

Let me go back up to the top of the screen, my screen. Angie, do you have a comment?

MEMBER GAGER: No. That must be an old hand. I'm sorry.

CHAIRWOMAN KEELS: No worries.

Michelle, old hand or new hand?

MEMBER ZAMUDIO: That's a new hand, a continued hand. Sorry. So, you know, I did look through this. I like that we do bring up the Consensus Model because we all did talk about that,

Page 93

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 "currently available national certification exams."

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

Page 94

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

Page 95

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

Page 96

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: "Provide services for acute illnesses, and evaluate and promote patient," that is .43(C).

CHAIRWOMAN KEELS: Okay. So what I am hearing is we will just strike the words "APRN Consensus Model 2008."

MEMBER ZAMUDIO: This is Michelle.

CHAIRWOMAN KEELS: Yes, Michelle.

MEMBER ZAMUDIO: So when I am reading it, it does single 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,

Page 97

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: No worries.

Okay. I think that we all agree then to strike the word "APRN Consensus Model 2008" and leave

Page 98

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. Very good.

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.

Okay. Page 9.

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

Page 99

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

Page 100

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.

14.

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

Page 101

during a resuscitation, et cetera? I don't know if that's even possible because it might speak to scope of practice, but I didn'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.

MS. EMRICH: No. The statute -- the statute is specific to CNPs and CNSs.

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

Page 102

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

Page 103

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.

MS. EMRICH: Understand. Understand.

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

Page 104

a nurse would be reporting, has to report to, for example, the physician that a patient has expired and the -- this does not prohibit -- this doesn't waive the nurse's obligation to attend to any complication that occurs meaning the nurse walks in and finds the patient in cardiopulmonary arrest. There is every expectation that in the absence of a do not resuscitate order, that nurse is going to resus -- attempt to resuscitate the patient, okay?

The nurse had to actually call the attending or the physician or someone who has the ability to certify or declare death that the patient was without vital signs, et cetera. That was actually a Medical Board rule that said a physician could accept information from a nurse before the physician declares the death.

Okay. This statute came, and it really requires the same thing. It requires notification of the -- of the physician. It just gives some time before, meaning if -- if there is an expected death say at 2 o'clock in the morning, the nurse can wait until the next morning or later to call the physician. They can go ahead and call the -- you know, the funeral home or start that process and can wait until later to call the physician if that's --

Page 105

if that's appropriate for the situation so. And then, of course, in the -- in particular circumstances for the APRN, specifically the CNP or CNS, they can go in and, you know, declare that that patient is deceased and then they still have to notify the attending physician who will be signing the death certificate --

MEMBER ZAMUDIO: Okay. Thank you, Lisa.

MS. EMRICH: -- in that amount of time.

MEMBER ZAMUDIO: Thanks.

CHAIRWOMAN KEELS: Okay. Anything else on page 15?

And then page 16, any comments?

Yes, Michelle.

MEMBER ZAMUDIO: Before we move on, I know you asked about page 16. I didn't see any response. I just wanted to clarify on page 1 we decided to not make any changes, correct?

CHAIRWOMAN KEELS: On page 1?

MEMBER ZAMUDIO: Yeah. Licensure, we were talking about deleting the sentence, and without knowing all the players and et cetera, I don't see a reason to change it as it exists right now.

CHAIRWOMAN KEELS: I'm sorry, Michelle. I'm lost. On page 1 what?

Page 106

MEMBER ZAMUDIO: Yeah. Under "APRN Licensure," it was that interrelated field comment.

CHAIRWOMAN KEELS: Oh, oh.

MEMBER ZAMUDIO: Yeah, I asked that we leave that in since it's already there. There's no advantage to taking it out. We don't know all the players, et cetera. I don't want to make a rash decision on that.

MS. EMRICH: Yeah. And to be clear, my question was about is there need for a statutory change itself, you know, because this would be -- it would start with this group, the Committee being obviously the experts in APRN education and practice, that to know whether that phrase "interrelated field" is still relevant or not.

CHAIRWOMAN KEELS: And I believe everybody agreed until there is more information around the midwife topic that we would wait.

MS. EMRICH: And that's what I understood.

MEMBER ZAMUDIO: Okay. Thank you.

CHAIRWOMAN KEELS: So no comments for page 16 is what I'm hearing. So we actually made it through the document in record time. Thank you. And the -- the changes that we're going to require are

Page 107

minimal. They are either typos, adding the abbreviation NPA earlier, changing the -- you know, adopting the OAAPN recommendations, and changing the order of the sentence on the number of physicians the APRN may collaborate with when prescribing.

MEMBER ZAMUDIO: Adding the word "advanced" and adding the word "training."

CHAIRWOMAN KEELS: Oh, yes, under "Advanced," yes. Thank you.

MEMBER ZAMUDIO: Amazed we got through this because having come on this Board and then left and come back, I mean, this is a great document. Working on this, it's great.

CHAIRWOMAN KEELS: Thank you, Lisa.

MS. EMRICH: Just to clarify you said adopting OAAPN's recommendations. We're not removing the verbiage that's under --

CHAIRWOMAN KEELS: Right.

MS. EMRICH: We're just -- yeah. So I just -- we're not removing it. We're just -- you're removing the reference to the "Consensus Model"; is that correct?

CHAIRWOMAN KEELS: Correct.

MS. EMRICH: Okay. Just wanted to make sure.

Page 108

CHAIRWOMAN KEELS: Sorry about that.

MS. EMRICH: No, no. That's fine. I just wanted to...

CHAIRWOMAN KEELS: So then can we feel comfortable -- do we feel comfortable with making those changes and then sending it on for the legal review? Because that will take some time. And I believe it has to go to the full Board as well, or does it come back to this group before it goes to the full Board?

MS. EMRICH: I'll check with Betsy, with our Executive Director, and I'll see how that might be and with the Board's president. We'll check and discuss how that needs to go.

CHAIRWOMAN KEELS: Okay.

MS. EMRICH: And then I'll know more. I can be in touch. Well, we'll probably talk about it this week, Erin.

CHAIRWOMAN KEELS: Yes, yes. Thank you. Yeah, because I remembered that we need to make sure that this is congruent with all current statute and rule and does not enact anything new, just with the current.

MS. EMRICH: Yeah. We cannot enact new rules with -- with a paper so.

Page 109

CHAIRWOMAN KEELS: Yeah. Okay. Great. Thanks for everyone's assistance on that. That's awesome.

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

Page 110

are very busy getting materials together for the Board meeting, and I have a lot to review.

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.

Page 111

How about everybody else? That's a Monday.

MEMBER ZAMUDIO: What day? The 8th?

CHAIRWOMAN KEELS: Yeah, Monday, March 8. Shaking heads.

MEMBER GRAHAM: Tuesday is a little better for me, but I can. Just teach lots of classes on Mondays.

CHAIRWOMAN KEELS: Tuesday is fine with me as well.

MS. EMRICH: Brian has his hand up.

CHAIRWOMAN KEELS: Oh, he does. Well, hi, Brian.

MEMBER GARRETT: I have been here for the last hour. I'm just listening. You covered that document very fast. No, I was just raising my hand I was okay with all three.

CHAIRWOMAN KEELS: Monday or Tuesday? Is Tuesday okay if Monday is busy for Margaret?

MEMBER GARRETT: Monday is better. Either one I will make it work.

MEMBER GRAHAM: I can make Monday work.

MEMBER BOLTON: Let's do Tuesday because --

CHAIRWOMAN KEELS: Tuesday is fine with me. Let's do Tuesday.

Page 112

MS. EMRICH: Tuesday the 9th.

CHAIRWOMAN KEELS: All right. March 9.

MEMBER GRAHAM: Thank you.

CHAIRWOMAN KEELS: Thank you. And we did July last year. Was July okay with everyone?

MEMBER BOLTON: Yes.

MS. DiPASQUALE: So the Board meeting in July is the 21st-22nd.

MS. EMRICH: So Monday would be the 12th or Tuesday the 13th.

CHAIRWOMAN KEELS: Again, either one is fine for me.

MEMBER ZAMUDIO: Are you okay if we flip it back for one of those? Tuesdays are kind of hard, but I also -- I probably think, Dr. Graham, you are more important than me.

MEMBER GRAHAM: No, I'm not. No, I'm not. I think I can get someone else to cover for me, so Mondays are fine for me in July.

MEMBER ZAMUDIO: If we could split one, otherwise, I can make it work.

CHAIRWOMAN KEELS: Monday, the 13th?

MS. DiPASQUALE: Monday, the 12th?

CHAIRWOMAN KEELS: Yeah, Monday, the 12th.

Page 113

MS. DiPASQUALE: Monday, the 12th.
CHAIRWOMAN KEELS: Okay. And then November.
MS. DiPASQUALE: So that's the 17th-18th for the Board meeting.
MEMBER GRAHAM: I can easily get someone else to cover me on the 17th if Mondays are better for you all so.
MEMBER ZAMUDIO: If we are doing the week before, Monday is a holiday, so we could do the 12th which is a Tuesday. Did you say the Board was the 18th?
CHAIRWOMAN KEELS: Not September, November.
MS. EMRICH: 8th or 9th.
CHAIRWOMAN KEELS: Either the 8th or the 9th.
MEMBER ZAMUDIO: Okay.
CHAIRWOMAN KEELS: And it's -- either one is fine for me.
MEMBER ZAMUDIO: I am okay on the Tuesday.
MEMBER GRAHAM: I'm okay either one. That's a long time out. I can get coverage.
CHAIRWOMAN KEELS: Okay. The 9th then?

Page 114

MS. EMRICH: Tuesday, the 9th. Okay.
CHAIRWOMAN KEELS: Tuesday, the 9th.
MEMBER GRAHAM: So Tuesday, March the 9th; July, Monday, the 12th; and Tuesday, November 9. Those are the three days?
CHAIRWOMAN KEELS: Yes.
MEMBER GRAHAM: Okay.
MEMBER ZAMUDIO: Okay. Could we say it one more time? I was trying to put it in the calendar.
CHAIRWOMAN KEELS: March 9.
MEMBER ZAMUDIO: Okay.
CHAIRWOMAN KEELS: July 12.
MEMBER ZAMUDIO: Okay.
CHAIRWOMAN KEELS: And November 9.
MEMBER ZAMUDIO: Got it. Thank you.
CHAIRWOMAN KEELS: Thank you. Okay. Anything else? Any other comments, questions, concerns?
MS. EMRICH: Erin?
CHAIRWOMAN KEELS: Yes.
MS. EMRICH: Is Brian available to speak to just general CRNA practice with implementation of HB 197?
MEMBER GARRETT: Yeah, I can. Yeah, so I

Page 115

have not read the full -- I read it a while back, but are you talking about whether or not it's being rolled out or not or what have you?
MS. EMRICH: More the -- from the CRNA perspective we were all interested in your take on the application with respect to, you know, the timing of writing orders, the clinical support functions, and, you know, having the orders already there and existing, but you are also directing nurses to administer certain I.V.s and medication.
MEMBER GARRETT: Yeah. So I received some inquiries from around especially in the OhioHealth System because I work for OhioHealth and people are -- you know, some hospitals are not going to implement and some are going to implement it based on local control which is the intent of the bill all along.
MS. EMRICH: Correct, policy.
MEMBER GARRETT: The problem is everybody is really looking for somebody else to be the first to do it. And so, you know, I've had a couple hospitals call me, well, could we use whatever you have down here? I said, well, I work at Grant. It's not going to be instituted any time soon. And then do you know anybody else? Like no. So I call some

Page 116

other people. What are you guys going to use for guidelines? Well, they are -- everybody is waiting on everybody for like the first pass, right? And then everybody will probably fall in line with that. But that's locally in Columbus.
There are lots of people excited to do it because I think it's going to help with workflow and especially with COVID. But again, I've had four or five inquiries, and everybody is kind of waiting to see what everybody else does, so it's slow to implement.
And then I think COVID probably didn't help with that because we, of course, were interrupted in the spring with COVID. You know, we were out -- everybody was out of the OR for -- I know ORs and -- students were out of the OR for two or three months and they were getting back into it and I heard one place maybe do like an emergent, I don't want to call emergency order but like emergency implementation, but I haven't seen any of the guidelines around it, things like that. So does that help answer? Like everything else COVID interrupted so.
MS. EMRICH: Well, it helps us to understand where hospitals and all are with it so.

Page 117

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

Page 118

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.

CHAIRWOMAN KEELS: Tom, do you have your hand up?

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

Page 119

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.

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

Page 120

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 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

Page 121

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. He's got 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,

Page 122

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

Page 123

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.

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.

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 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

Page 124

are going to have to write that policy and position as stated in the law. But there's some places that are, you know, firmly rooted in prior practice and I imagine they got other things that they are worried about right now and there is nothing that I understand, we can clarify this, but there's nothing that I understand that says, hey, if you are not going to do it, then you need some type of policy enacted on that. You know, it's quite the opposite.

CHAIRWOMAN KEELS: Thanks. Thanks, everyone.

Anything else, Brian?

MEMBER GARRETT: No. That's it. I sent Ms. Sunderman an e-mail so, just to follow up.

MS. SUNDERMAN: Very good.

CHAIRWOMAN KEELS: Any topics for discussion at our next meeting that we should be sure to include other than the standing agenda items?

Okay. If you think of something, let us know.

All right. Well, with that we are adjourned. Thanks so much for all your time and effort and support. Really appreciate that and hope you guys have a great rest of your day and happy holidays early. Stay safe. Stay well.

(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.

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Karen Sue Gibson, Registered Merit Reporter.

(KSG-6989)
