BEFORE THE OHIO BOARD OF NURSING

Meeting of the Advisory Committee on Advanced Practice Registered Nursing

PROCEEDINGS
conducted via Microsoft Teams videoconference, called at 10:05 a.m. on Tuesday, March 9, 2021.

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the July -- of the prior meeting have been
distributed for review.
Committee Members, as I call your name,
please introduce yourself, along with your APRN title
and your role on this Committee.
First, I see Angela.
MEMBER GAGER: Good morning. I'm Angela
Gager. I am a Family Nurse Practitioner, and I am
representing nursing faculty.
CHAIRWOMAN KEELS: Thanks, Angela.
We have, Carolyn. Carolyn, you are our
transcriptionist for today.
THE COURT REPORTER: I am. Good morning.
CHAIRWOMAN KEELS: Okay. Thank you.
Anita.
MS. DIPASQUALE: I needed to unmutemyself. Yes. Anita DiPasquale, Board staff. Thank
you.
CHAIRWOMAN KEELS: Lisa.
MS. EMRICH: Hi. Lisa Emrich, Board
staff. Good to see you all.
CHAIRWOMAN KEELS: Margaret.
MEMBER GRAHAM: Margaret Graham, Family
Nurse Practitioner, and I represent advanced practice
education.

MEMBER ZAMUDIO: Hi. Michelle Zamudio.
I work at the Christ Hospital, and I work for the
University of Cincinnati College of Medicine. I am
on the Committee to represent nurse midwives because
I am a CNM. I forgot to start with that. Sorry.
It's good to see everybody.
CHAIRWOMAN KEELS: Thanks, Michelle.

Pam.
MEMBER BOLTON: Good morning, everyone.
Pam Bolton; Cincinnati, Ohio. I am a Critical Care
Clinical Nurse Specialist and Acute Care NP,
representing the employer.
CHAIRWOMAN KEELS: Pete.
MEMBER DIPIAZZA: Hi. Good morning.
This is Pete DiPiazza. I am an FNP, and I represent
primary care.
CHAIRWOMAN KEELS: Sherri.
MEMBER SIEVERS: Sherri Sievers, FNP,
representing practice.
CHAIRWOMAN KEELS: Chantelle.
MS. SUNDERMAN: Good morning. Chantelle
Sunderman, Board staff.
CHAIRWOMAN KEELS: Tom.
MR. DILLING: Good morning. Tom Dilling,
Board staff.
CHAIRWOMAN KEELS: Thank you.
And I believe I represented -- or, I
introduced myself before. My name is Erin Keels. I
am a Certified Nurse Practitioner from Columbus,
Ohio, representing -- and I'm the Board member to the
Committee. Did I get everybody?
MS. EMRICH: Yes.
CHAIRWOMAN KEELS: Okay. Great.
And so then, Committee Members, please
raise your virtual hand to speak, and I will do my
best to call on you in the proper manner and time.
Are there any other introductions or
announcements?
Okay. So then, moving forward, we will
start with our first order of business which is
titled "APRN's and Consult Agreements: Draft Rules."
Lisa, was Holly going to join us?
MS. EMRICH: No. She submitted the
Memorandum, which I think is fairly self-explanatory.
She wanted to provide the Committee with the draft
rules. I know everyone has been interested in the
consult agreements with the new statute being passed.
Although you don't have to wait for the rules to
implement the statute, but the rules obviously lay
down some additional framework for that, so.
CHAIRWOMAN KEELS: Okay.
MS. EMRICH: Give you time to, you know,
review, comment, and then those -- we will progress
through the rulemaking process for those.
CHAIRWOMAN KEELS: Thanks, Lisa.
Did anyone have any questions or comments
about the draft rules?
Holly wrote in her memo that the time --
the proposed time frame was to -- is to submit to the
Governor's Office in August of 2021, to file those in
October 2021, they will be subject to hearing in
November of 2021, and should become effective in
February of 2022.
I believe we will review these at the
upcoming board meeting as well. And so, I suppose if
anybody has any questions, concerns, or
recommendations, they should send those to Holly. Is
that correct, Lisa?
MS. EMRICH: Correct. You can do so
individually and you may also review and make
comments as a committee if all is in agreement with
the comments.
CHAIRWOMAN KEELS: I reviewed them, and I
believe that they are congruent with the current
Pharmacy Board rules. I know that in our

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organization we are trying to implement this as it stands through the Pharmacy Board rules.

MEMBER ZAMUDIO: Lisa.

CHAIRWOMAN KEELS: Hi, Michelle.

MEMBER ZAMUDIO: Hi. So if we're going to talk about it as a committee, I just had a few things I wanted to mention.

I pulled up 4729.39, like, the original ORC, about the consult agreements. Just a couple comments.

On page 2 of the draft, which I think is 3 of the handout, on 8-12 under (k), I think. Is it (k)? Maybe it's underneath that. It talks about the quality assurance criteria and it says that the training and experience criteria for the managing pharmacists may include, et cetera.

We won't need to verify their training, right? I mean, we can't really verify a pharmacist's training no more than we do when we write a prescription.

The law states that they have to -- the ORC says each pharmacist must have the training for that particular diagnosis, but it doesn't say that we need to verify their training.

CHAIRWOMAN KEELS: Yeah. I -- I believe there's a paragraph in there that kind of sends that back to the institutional credentialing process.

MEMBER ZAMUDIO: Yeah, it did mention -- it did mention that it could be through -- it said it may include privileging or credentialing, board certification.

So we're back to, do we have to verify their board certification? I don't know -- it's already in the ORC. I don't know that that needs to be in here.

MS. EMRICH: I'm just trying to -- MEMBER ZAMUDIO: It says, "The agreement shall include" -- I'm sorry. Under -- so we're on 8-12, and on page 3, it looks like we're under (B)(l).

CHAIRWOMAN KEELS: While Lisa is looking, Tom, I see that your hand is up.

MEMBER ZAMUDIO: Yeah. It says -- it says that the criteria may include privileging, credentialing, board certification, continuing education, and other training requirements. The agreement shall -- our agreement -- shall include a process to verify their training.

Again, that's putting the onus back on us to -- in our consult agreement to verify that. I mean, past them being a pharmacist, how are we going to verify that?

MR. DILLING: Yeah. If I may? I think that, again, this is one of the reasons we have an Advisory Committee and you review this.

You know, I think that those are good questions. I have not been involved in that drafting process but it is a process that is mandated by statute to be kind of collaborative between medical, pharmacy, and us. And medical and pharmacy have gone before us.

I do not believe that -- and of course the PAs are a part of this as well. This is not unique language, you know, to us. And I think we need to go back and kind of firm up what we understand those -- that language to mean.

I'll play lawyer here on both sides. It seems like, you know, we're verifying and so forth, put an onus on you, and is that really -- is that reflective of the statute and is that reflective of the real world? I would throw back at you, yes, it is.

As your attorney, which I'm not, I would advise you that you best know something about the people that you are going to be practicing with. If you are sharing the care of someone, that you have some basic knowledge of who that is you're training with.

And as Erin pointed out, if you are in an institutional setting, then you have someone whose job it is to check those things off and you feel a little bit more comfortable.

If you're more independent or on your own and you have a, you know, more individual agreement, then I think the onus or the burden becomes a little greater on you as the practitioner or as one of the collaborative practitioners here working on a consult agreement that you have pretty much an understanding of who you're entering into that agreement with, who you're practicing with and, you know, what their specialty and training is.

So I think that that's what the statute rules are trying to nudge you towards. But your questions, I think, are valid and -- they are certainly valid but even more so to understand how far do you have to go, what do you mean by "verification," and -- and what's needed there. And yeah, I think that we need to go back and report back to you on that.

CHAIRWOMAN KEELS: Uh-huh.
MS. EMRICH: Right.
CHAIRWOMAN KEELS: Sherri, you have your hand up?
MEMBER SIEVERS: I do.
I guess I'm -- so this applies to institutions and how? Can anybody, that can understand it a little better than me, give an example, because, you know, we have rounding teams, and I'm sure you do too, Erin.
CHAIRWOMAN KEELS: Uh-huh.
MEMBER SIEVERS: So how does this apply to an institution and what is a situation where you would need -- if it applies, how -- who would we need to have that with because we obviously collaborate with all the pharmacists in the institution, in some way or another, depending on what teams they're on or what their capacity is. So do you understand it for institution application?
CHAIRWOMAN KEELS: Sherri, are you asking me directly?
MEMBER SIEVERS: Well, anyone that has a little bit more understanding of it than I have for the institutions.
CHAIRWOMAN KEELS: I know at Nationwide Children's, in my organization, we are working through this process. We haven't implemented it fully. We're still working on the credentialing process right now.
But one of the opportunities is in diabetic management through the hospital, throughout the entire hospital, because those patients can be found in all different spaces outside of endocrinology. And in partnering with APRNs, there will be like an APRN consultant working with a pharmacist to then manage the diabetes plan on the inpatient side, so that's the objective. I don't know the details because it's still pretty new to us.
Margaret, have you worked in your capacity with this at all yet?
MEMBER GRAHAM: We have had a clinical pharmacist at our Total Health and Wellness federally-qualified health center since we started it, so we have been working very closely with clinical pharmacists.
And, you know, I think -- I don't know if it was Michelle -- I mean, what Tom said applies to us because all of our providers have to go through credentialing at the medical center so, you know, we know that our pharmacist meets the criteria.
And I do understand that this will be a bigger challenge for people who are in solo practice or much smaller practices to be able to meet that, but, you know, our experience with clinical pharmacists has been tremendous. I mean, they have been a tremendous addition to our team so I'm really delighted to see this rule, you know, go into place.
And I think for us, at our Total Health and Wellness Center, you know, this isn't a challenge but I think it can be for some in primary care who aren't -- who don't go through the very rigorous credentialing practice that health centers require, medical centers require.
MEMBER SIEVERS: Yeah, I'm not as worried about the verification as I am what this really means. Like, do we have to have an agreement with every pharmacist that we've been, you know, talking to over the years? Because, to Erin's point, those people that she has on that endocrine team have been partnering to come up with a patient plan and so now is it any time you talk to a pharmacist you have to have this agreement?
I'm trying to think about how this is going to have to be operationalized at the institution but what I'm hearing is we don't quite know yet and so maybe -- but that might be important to spell out as we put guidelines and rules forward to make sure that it's clear what has to be in place for what types of relationships and situations.
Because we are a multidisciplinary team when we round. Everybody is there. The pharmacist is on rounds and gives input about the patient plan of care. And so, do all the APRNs have to be in agreement, then, to consider those comments as part of rounds on their particular patient or, you know, it's really -- it's confusing to me about how this is going to -- but it sounds like we might not totally understand it ourselves yet.
CHAIRWOMAN KEELS: And, Sherri, I see what you're saying as a part of the interdisciplinary team member. Right now currently, in current state, we round as team members. We really value the input of our pharmacy team and they're providing recommendations for us to either accept or not accept.
I feel like this is that next step up where there is more of a formal relationship where they might still round with us, but then perhaps they are actually writing the orders and ordering the, you know, any lab testing and then making adjustments collaboratively but independently. So I see -- I do
see it as a little bit different.
And I've been thinking about it for our
service line, like, how are we going to
operationalize this and to what extent will we
operationalize it, because one of the concerns is all
these people writing orders now, right? And so we're
going to just have to be really thoughtful on how we
integrate this into our practice, and maybe it will
be in certain spaces or certain disease states, but
I'm not sure.
I mean, to Margaret's points, our
pharmacy team is so integral to the care of patients,
and they are very, very expert in their knowledge and
depth and breadth of pharmacology and
pharmacokinetics and pharmacodynamics. I'm pleased
that they are able to have this scope, but, yeah,
we're just going to have to work together to figure
out how this will look.
Michelle.
MEMBER ZAMUDIO: I mean, I agree with all
of those comments. And we are fortunate, as well, to
have clinical pharmacists in our office, as well as
at the hospital when we do rounds.
But when I approached this and I began
reading about what consult agreements are, I mean,
they're for up to two years. So it's not just while
the patient is in the hospital. The pharmacist will
be ordering lab tests, managing medications, changing
doses, etcetera. They can't make a diagnosis but
they can certainly manage the plan.
The rules, as I read them, were so
cumbersome that I thought no one can ever do this for
every single patient for every single drug.
So my concern in that particular
statement under (l) it was your consult
agreement -- so this is your agreement, right -- must
include a process to verify the pharmacists meet the
criteria.
Now, one of the criteria, when you go
back to the ORC, states that each pharmacist must
have training and experience related to that
particular diagnoses for which the drug therapy
you're ordering. That means you as the provider,
according to this, will need to verify that that
pharmacist has actually managed diabetes, etcetera.
You have to verify their training with diabetes. You
have to verify their experience with diabetes.
I think that last line, where it says
"The agreement shall include a process," that needs
to be stricken. No one can really do this for every
pharmacist who either are employed by the institution
if people work in institutions or if there's been a
robust -- I mean if you were, to Michelle's point,
the person who is out working in a rural area, if
they've done a really good search and the pharmacist
that's been hired is qualified and licensed and has
proper credentials for education, it seems like
that's done at the time and the point of hire. And
then, you know, to think that you have to do this
with every pharmacist on every disease state, I agree
that that's -- that will be way too cumbersome.
MEMBER ZAMUDIO: And it includes every
agreement. Every consult agreement that you send to
them has to have that process redone according to
(B)(l).
So I understand the idea because of
viewing this for patient safety. When I first
learned about consult agreements, I was very
hesitant. I mean, when you put that in the context
of safety, having another member that's remote,
that may not have access -- it says in here that they
should have access to the chart. But not everybody
is on electronic medical records. So every time they
see that patient, do we have to fax them a copy of
the chart? Do we have to -- so there's a lot in here
single diagnosis and medication that they give to a
patient.
So I'm trying to think about that primary
care provider out in, you know, a more rural area,
and some of these things won't be possible so they
won't have this benefit.
I don't think that agreement needs to --
that our consult agreement -- it's not that you
wouldn't verify. Obviously you would. And we have a
good relationship even with our community pharmacists
that I am able to call with questions, but I'm not
going to verify their training. And this rule states
that you must put in every single consult agreement a
way that you're going to verify the pharmacist's
training and experience.
MEMBER GRAHAM: I--
CHAIRWOMAN KEELS: Yes, Margaret.
MEMBER GRAHAM: Thanks. I was going to
raise my hand. Thanks, Erin.
The thing I wonder is, is this in
reverse? Are the pharmacists going to have to verify
the training of all of the providers that they're
working with? I mean, it does seem to be, as
Michelle said, it's very, very cumbersome. I mean, I
think if we -- I think if they're a licensed
that I feel like is additional to what's in the ORC
that's going to make it very difficult for us to ever
do a consult agreement.
I think the agreement should not have to
include a process every time to verify that they know
about the disease, that they've had training and
education -- or, experience with that disease and
with that drug. And it does say "the particular
diagnosis."
So you have to verify every consult
agreement, unless that last part of (B)(1) is
stricken where it says that your consult agreement
shall include a process to verify that they meet the
specified criteria.

CHAIRWOMAN KEELS: Okay. Tom has his
hand up again, and then Pete.
MR. DILLING: Yes.
So, look, these consult agreements date
back several years. And when I was with the Medical
Board and they were just starting up with these, the
best example that was given was Coumadin, okay? And
you entered into a consult agreement with
the pharmacist because the pharmacist really was the one
who is managing the levels that were going up and
down after the tests and so forth. The physician,
who is caring for that person, had seen the patient
initially, they were under that person's care, they
were familiar with that, wrote up a set of orders,
depended upon that, but that order could fluctuate
between certain types of dosages depending upon how
the person is reacting to the drug and how the person
is reacting to their recovery and -- and -- and the
treatment.

So in the evolution of health care, the
pharmacist practicing to the top of their license
said this is what we do, this is how we manage it, we
will work in a collaborative sense with you. But to
gain that scope of practice, to gain that
collaborative nature, that required some adjustment
to the statutes and, you know, an enlargement of that
scope in law, thus was created the consult agreement.
Now we have moved forward to a point
where the legislature wanted to add both the APRN and
the Physician Assistant to these type of agreements.
We are not talking -- I just want to make
sure everybody understands, you know, the people are
listening too, we are not talking about the
day-to-day prescribing practices of the APRN or a PA,
where they have to go back and have an agreement, you
know, and follow up on that.
We're talking about special situations
where you have gone to the point of collaborative
practice with that pharmacist where that pharmacist
is going to maybe up the dosage or down the dosage
dependent upon your understanding and your agreement
as types of practitioners.
There are other entities involved here
too. Not only the pharmacy itself who employs the
pharmacist, but the institution where this is
occurring. And then you get into Margaret's good
comments and your own about, you know, how practice
occurs in those different areas and how you have
support there.

But, statutorily, and through our rules
here at the Board and the ones that were created here
with the other boards, you are still tied to
collaborative practice and a written standard care
arrangement with a physician or physicians, okay? So
those people are party to all the things that you're
doing as well. Maybe not on a day-to-day basis but
you are tied together by law, okay?

And so the statute is not really creating
anything new that affects this practice. You are
being added to the course of this practice where we
are today.

If you don't like the fact that you have
to go and have an understanding individually with who
you are having that extra level of care with, with
that pharmacist, well, then don't do it, because
right now we are at a point where we're dealing with
institutional care and you're dealing with primary
care, you know, out somewhere where you probably have
a relationship with one or two pharmacists. But if
you're going to raise to the level of this consult
agreement, they want you to understand and have that
as part of the agreement.

And this is regulated by the Pharmacy
Board and the pharmacists and so forth. So if it was
swinging too far burdensome and so forth, the first
person you would hear from is the pharmacist and the
Pharmacy Board, okay?

We're fortunate in a lot of ways in that
the Medical Board and the Pharmacy Board fought
through the same type of issues we're talking about
here today in the past couple of years, you know, and
it resulted in the rule and the practice as it is
today. We are kind of assimilating ourselves, so to
speak, within that practice. And we are, as you are
all saying, going back into our institutions, to our
collaborative practices, and figuring out how can I
use this practice, how can we all provide better care through that.

And at the start of anything, it's going to be more rule-heavy, rule-oriented, maybe more formalistic than it will be in a few years when APRNs have independent practice and so do pharmacists in certain areas and everybody else and collaboration becomes just second nature.

But, until that happens, the legislature is saying here's the broad-based parameters; medical, pharmacy, nursing, you have a better idea of the regulation within there; this is how we want you to start off; move on, move forward.

So I'm sorry that's a long way of going about it, but we are -- we are building upon several years of practice and practice with other people. And I think that it would be beneficial, after listening this, to provide, you know, at a certain level whether it be in some type of written document, FAQs or whatever, to kind of give an understanding of that type of background but without all the blah, blah, blah from Tom. Maybe make it a little more concise and that would be helpful to everybody who is reading it.

MEMBER ZAMUDIO: Tom --

MR. DILLING: That would be today's comments.

MEMBER ZAMUDIO: -- I did go back and read everything and I'm pretty aware of the progress that it's made because I went back and I noticed all the different versions that were done. So I went to the ORC, the medical rules, and our rules, and that particular statement isn't anywhere in the ORC. So to do it at the beginning, I feel like, is an opportunity to get this right.

I understand that it's progress and that people have the option to not do it, but I don't want them to not do it because it's too cumbersome. This is a requirement. We're talking very specifically about one line. The agreement, the consult agreement, shall include your process to verify the managing pharmacists meet all specified criteria.

That's not required in the ORC.

So I understand the history and I think it's a very positive thing, but I kind of feel like instead of just, "Oh, we'll make progress," let's do it right when we're doing it the first time.

MR. DILLING: I appreciate those comments, sure, but I want you to understand that this is not the Nursing Board dreaming up that language.

MEMBER ZAMUDIO: Oh, sure.

MR. DILLING: This is really coming from prior rules through the Medical and Pharmacy Board, and us coming in and being required by statute -- being required by statute to have rules that all look the same and build upon that past.

If I go back and come back to you in the future and say, "Hey, I was all wrong, they didn't have any of this language over in Medical and Pharmacy," I'll be shocked. I'll be really surprised.

And I think, again, what I was saying was maybe we need to do a little bit better of a transition to explain, you know, what steps have gotten us to this language today.

But unless Lisa or Anita, you want to contradict me, this is not language that we sat around in a room and said, "Hey, these APRNs need another level of, you know, supervision."

MEMBER DIPIAZZA: So --

CHAIRWOMAN KEELS: Yeah. I think -- I know Pete had his hand up, and then Margaret.

Go ahead, Pete.

MEMBER DIPIAZZA: Yeah. You know, I just wanted to say, I mean, I'm listening to the conversation and one thing I guess I -- I may be making this too simplistic but I don't think the consultive agreement is meant -- when we talk about multiple diseases, I don't think it's meant to address every disease state of the patient.

Like, Tom, you brought up the Coumadin clinics. I see this as being viable for maybe better management of diabetes. But I think it's very specific disease states and we shouldn't confuse it with every disease out there we want our pharmacists to manage. Does that make sense? Because I think when we start to think about that, it becomes very overwhelming.

CHAIRWOMAN KEELS: Right. Exactly. Margaret, you had your hand up?

MEMBER GRAHAM: Yes.

I think -- I hear what Tom is saying, but I do think the first thing we should do is look to see if there is potential for striking that particular -- that one area because I think we want to think two things.

We want the care that's provided to be the very safest, and I think adding the pharmacist to the team helps with that safety. I think it adds
another layer of safety. So those of us who have had
the opportunity to practice with clinical pharmacists
have had really, really positive experiences, and I
think patient outcomes are, although better, you
know, and have that expert of the team there.
And so I don't want it to be so
burdensome that people think, "Oh, I would love to
have a pharmacist practice with me, but I can't go
through the, you know, requirements in rule."
And so I guess for that I just would
request that we look at that one statement and see if
that -- if there is a possibility to strike that so
that people won't misinterpret, or that people will
feel they can move forward, because I do think the
practice with the team is a real positive.
CHAIRWOMAN KEELS: Thanks, Margaret.
So what I am hearing is, number one, can
we strike that sentence about the process to verify.
Is that what I'm hearing? Because we're concerned
that that creates a burden and folks may feel that is
so burdensome that they wouldn't move forward. Or,
can there be more language added that clarifies that
further, exactly what means, that's in
statute or in the FAQs that we have with examples.
Would that be something we would be able to do if we

of the comments about how valid and great this is. I
do think if it's not in the ORC and it does state
it's for every single diagnosis and every single
drug, then let's make it as user friendly as we can
for the nurse practitioner while maintaining safety.
They do have --
MEMBER DIPIAZZA: Except you wouldn't
necessarily need to use a pharmacist for every
disease state though. So you choose what value is
most important to me having the pharmacist involved
in the patient's care and you select those disease
states. It doesn't have to be every disease state,
nor do I think we would want it to be every disease
state.
MEMBER ZAMUDIO: Well, it might not be
for you, but there might be nurse practitioners who
manage other disease states.
So it does state that they have to have
the education, training, and experience related to a
particular diagnosis. So you may not manage
bio-identical hormone therapy, but a nurse midwife
would.
So what I'm trying to do is also think
about all the nurse practitioners having to verify
that a pharmacist has training as well as clinical

can't strike it?
MEMBER ZAMUDIO: Lisa.
CHAIRWOMAN KEELS: Yeah, Michelle.
MEMBER ZAMUDIO: Just to -- first, to
address Pete.
Pete, if you look through the entire
statute, it actually does state that it will be all
disease states. You must verify, it says, training
and expertise of the pharmacist -- this is verbiage
from the ORC -- related to the particular diagnosis
for which your drug therapy is being ordered.
So when I looked at this and went back
through it, I tried to do it very globally because
it's such a great idea. So I'm not addressing so
much the idea of doing the consults; they're so
important. I'm addressing how this will be
translated for nurse practitioners, for our practice.
So it does state it.
When you look at the consult agreements,
you guys, these are going to be lengthy, but I think
it's doable in a institution where you have the
support of, like, risk management or someone to draft
that for you, but if you're the community person I
think that would be a challenge.
So I'm certainly not disagreeing with any

experience with that diagnosis. And to say, "Well,
just don't do it if it's too hard," doesn't make
sense to me. I think we should do it right the first
time.
CHAIRWOMAN KEELS: Margaret, is that a
new hand up?
MEMBER GRAHAM: Yes, it is, because I now
know how to take it down.
I -- I agree with Michelle. And I think
we should look at our history.
And Tom was there when we had our first
meeting way back when we got -- when we had the pilot
project and APRNs started prescribing in Ohio, and I
think that was 1993, so it was a long time ago. We
had to have a set of, I'll call them, "protocols,"
for lack of a better word, for every diagnosis.
That's the way that we did that. And it was
unwieldy.
And we had those who were -- and they
were divided by adult, family, pediatrics, women's
health, geri. And those of us who are family had to
have a book for all of those and, I mean, it was
an unwieldy thing to do. Fortunately, we moved away
from that after about two years, but I do think we
should learn from our mistakes. And that was, I
think, a mistake to look at every diagnosis. It
was -- it made it -- I mean, it really made it almost
impossible to practice.
And so I feel like that if we can make
this much more general so that it can apply, it will
be easier to implement. And again, I think the
people, you know, the providers, who are working with
this, will benefit, and the people in the state will
benefit.

CHAIRWOMAN KEELS: Thank you.

I did see some language in the draft
rules about the pharmacist working within their scope
of practice and it feels like that general term sort
of encompasses, I think, what we're trying to get at.
Tom, is that a new hand?
Oh. You're muted.
MR. DILLING: Yes, it is. Thank you.
Look, I don't disagree with Michelle and
Margaret from a perspective of questioning and asking
and saying, hey, can we make this less formalistic,
less burdensome on the providers.
I'll stand by my point of -- and I don't
think necessarily things in terms of the
 evolutionary stages of anything, including scopes of
practice.

The CPG was burdensome and cumbersome,
but the fact that everyone worked through that and
that it changed from years to years over that period
of time led to changes in statute and a greater scope
of practice for the APRNs. If you disagree with
that, that's fine, but I'll tell you my 33 years
tells me it just did. It certainly was something
that was used by proponents to increase as, "Hey,
look, we went through this process. It's safe. Now
we can go to a smaller leap and get rid of the CPG,"
which we recently did, and we'll report on later.
Here, if you're going to remove that
language about the verification and so forth, and
taking in mind that people have preceded you and
utilize this language and you have others involved
here, I think you would have a better chance of
making inroads there if you explained, through
another sentence, perhaps, how you are going to
replace that system.
Staff here will take your comments to
heart and certainly work on that, but anything that
you could do to help get us there and bridge that
gap, we can come up with language and we can report
back to those different groups.
Just temper your enthusiasm for the

Board's ability to break through there, because we
have to go through JCARR, Common Sense Initiative,
and so forth. And based upon where the APRN is
today, and how last year's bill went and so forth, I
don't think you're going to be able to crack that to
the degree perhaps that you would want to.
But again, if we can move forward, let's
take a shot at it. People need to hear, you know,
what you have to say. I was just trying to, again,
give some historical background and temper enthusiasm
to some degree. Thanks.

CHAIRWOMAN KEELS: Michelle.
MEMBER ZAMUDIO: Just a quick response.
So, Tom, I'm not saying that we shouldn't verify. Please don't misunderstand. That's in the
ORC. But what's not in the ORC is that it has to be in
every single consult agreement. So I'm talking
about just the piece of paper and our individual
agreements.
If they're meeting the other rules, and
you can mention that, it's mentioned in here several
times what the ORC states to do, but I'm saying in
every consult agreement it's not necessary.
Globally, all of these things are theoretical and
should be done. And we're not changing anything.

We're following the ORC. It states in here that
you -- it states specifically the pharmacist should
have training and experience related to the
particular diagnosis for which the drug therapy is to
be prescribed. So that's great. And there's
actually mechanisms in there where it states the
Board of Pharmacy should do that.
What I'm saying is every single consult
agreement individually doesn't need to have that
process revisited on every single piece of paper. So
I'm more thinking process, not ideology.

MR. DILLING: Okay. Let's analogize that
to the written standard care arrangement which you
are entering into with someone who is -- has the same
or similar practice specialty as you do and -- and
has that. How do we jump that hurdle on each and
every written standard care arrangement that you
enter into? And then how do we transfer that to our
argument that we remove that in each and every
consult agreement?
MEMBER ZAMUDIO: Should I answer?
CHAIRWOMAN KEELS: Sure. Go ahead.
MEMBER ZAMUDIO: So I'm stating that in
each consult agreement that you don't have to do
that. You can have that somewhere else in your
standard care arrangement. You can have it anywhere you want. It does state in the ORC that they have to have that experience. What it doesn't state is that we have to verify every pharmacist's training and that it has to be in every single document.

So the way the verbiage is here, the problem is where it states "the agreement shall include a process." So every time you do an agreement, you have to write your process down again, instead of just having a process.

The ORC states, and I wrote it down, I researched it, looked at it, that the pharmacist does need to have training and experience. Okay. That's like the pharmacist, they have to verify that I know how to manage hormones or whatever. No. Of course not. We are under our own standards of care that we need to do those things. But for every prescription I write, I don't have to verify that.

So I'm saying every consult just for that one portion, that's adding to the ORC, not taking away from it. That statement is actually adding another layer to what's already in the rule -- I mean, in the statute. Sorry.

So in this rule, to remove that the process itself has to be embedded in every single document, that's what I'm saying.

MR. DILLING: Okay. I guess I'm seeing it a little different than you are there and -- but I understand what your concern is, and maybe we need to go back and clarify that concern. I'm not sure that we aren't closer than we may appear here and are just articulating it in different ways. Yeah, it would -- we'd have to go back and we need to, again, articulate it a different way so that we all get on the same page. But I do understand what -- where you are coming from globally, I guess, yeah.

CHAIRWOMAN KEELS: Sherri. Did you have --

MEMBER SIEVERS: I had one question. So I understand you saying this has been in place with the physicians. Could we look at what their rule says and what they've been doing, and model it after that? Because, you know, we always try to not set up something that's more restrictive than what we have already in place. And if that's been working, could we model it after that? Do the physicians even have a rule that says what has to be in there, or is the onus on the pharmacist?

Because I'm hearing, and as we work through this for the institutions, I'm really seeing that our institution would have to decide is this something that they're going to allow the pharmacist to do because it's really giving them more bandwidth to do different things with orders and things.

And so it really is -- I mean, it is on us, if we're collaborating with them, to have some understanding that they're at least licensed.

And like Erin said, I like the "within their scope of practice," but it's really on them if they're going to be managing these Coumadin orders or whatever we apply this to.

And I'd like to see — maybe if somebody could look at that at lunch and share what the rule is for physicians so we could take a look at that and see what the language is there.

MR. DILLING: Absolutely. Understand, everybody — everybody is all in here. You know, the pharmacist, the physician, the APRN, the PA, they all have either explicit requirements or implicit requirements based upon, you know, liability and so forth.

So we can go back. There are rules. We can let you see those and that should help. It should help.

CHAIRWOMAN KEELS: Thanks, Tom.
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1  responsibility for that.
2  And so whatever we're putting in there,
3  that really could be done. Don't set people up for
4  failure if they can't reasonably verify an experience
5  or an education.
6  I mean, you know, we have to -- through
7  our medical staff, as you all know, they do frontline
8  verification. It's not even the pharmacist showing
9  us their degree or their credentials. The
10  credentialing committee goes right to the school to
11  get a verified degree and so, you know, if you're not
12  in an institution that does that, what is that
13  responsibility on that provider to have to do a true
14  verification of credentials, education, training.
15  So it has to be something that could be
16  reasonably done and not have the responsibility on
17  us. And I don't want to speak for Michelle, but I
18  think that's what she's trying to say. Not setting
19  us up for failure and to have it worded such that
20  there is responsibility of the pharmacist to have the
21  knowledge and education that they're agreeing to.
22  So, yeah, that would be helpful, Erin, if
23  we can look at the rules. I don't think this is
24  something we're going to solve today, but just really
25  having the tools that we need to go back to our, you

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1  know, folks, to make reasonable recommendations would
2  be helpful.
3  MEMBER ZAMUDIO: Uh-huh.
4  CHAIRWOMAN KEELS: Okay. Great. Good
5  discussion.
6  Any further comments or questions before
7  we leave this topic?
8  MEMBER ZAMUDIO: So -- a quick one.
9  CHAIRWOMAN KEELS: Yes, Michelle, go
10  ahead.
11  MEMBER ZAMUDIO: So, yeah, I just want to
12  be very clear at the end that I'm not saying that
13  that shouldn't happen that you verify. I'm just
14  saying it shouldn't be in every single individual
15  consult agreement.
16  So think about this: You're writing a
17  prescription to the pharmacy, what if that pharmacist
18  has left employment? So now you have a consult
19  agreement with a pharmacist, you've verified them,
20  but they go work for another company in two months.
21  You start over to verify that pharmacist.
22  So I think just having the process in
23  place globally, but not in every single individual
24  written agreement for every medication.
25  And then I just had a few more things on

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1  -- sorry, you guys, you know my details.
2  It says that we have to provide all
3  managing pharmacists with access to our patients'
4  medical records.
5  So I think if we could think of a process
6  there to include maybe for the people who aren't on
7  electronic medical records, that may be helpful. I
8  don't know that everybody will have it. Maybe that
9  will just need to exclude everybody who is not on EMR
10  from having the consult agreements. But that was one
11  difficulty. That's under (D)(a).
12  And then it's probably a typo on page 4
13  of the printed -- when you printed it off on page 4.
14  Paragraph (i) ends with the words "and or" and
15  there's nothing there.
16  Under (E), "Review of consult
17  agreements," it states, "Upon the request of the
18  board, the practitioner shall immediately provide a
19  copy of the consult agreement," et cetera. Which I
20  completely agree with, but the word "immediately,
21  I'm not sure that needs to be in there because I
22  don't know how we're going to define that if you're
23  off call or on vacation or -- you know?
24  So we definitely should provide them with
25  a copy, just like we would our SCA. I think it

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1  should be in line with that as well. So we would
2  provide a copy, but I don't know about that word
3  "immediately." I don't want to be in trouble if I'm
4  on vacation and I can't get back here.
5  CHAIRWOMAN KEELS: Thanks, Michelle.
6  I saw Lisa's hand. And then Tom, I don't
7  know if that's a new hand or not. Old hand.
8  MS. EMRICH: Thanks.
9  My only comment is just to when -- when
10  an agreement states you'll have -- you describe the
11  process for verifying. The process could be the same
12  in every consult agreement that you have.
13  For example, I'm thinking, you know, our
14  process for verifying is that the pharmacist will
15  provide a copy of their current credentialing, or CV, or
16  so forth.
17  I'm just -- I just don't want -- it's --
18  you're discussing the process for the verification.
19  So I just don't want to get so deep into the weeds
20  or, you know, that -- that it's -- it's about
21  the process. I just wanted to leave it at that.
22  Which could be standardized language in each consult
23  agreement that you might develop or have.
24  CHAIRWOMAN KEELS: Okay. Thank you.
25  Are these new hands up, Tom and Michelle,
I'm sure we'll revisit it here in the coming session.
I am told, and perhaps Sherri or others
can comment on, I've been told that the Ohio
Association of Advanced Practice Nurses has -- is no
longer being represented by the lobbying group that
had been representing them for the past several years
and they are in search of another lobbying group. So
that will probably affect when and how and what is in
the follow-up to the Standard Care Arrangement Bill
from last session.

In terms of this session, I will have --
tomorrow it will be posted, and we can send a copy to
you of my March Legislative Report, and items of
interest on that report, of course, are our budget,
which, I believe, we maybe put our testimony in there
for the budget authorization. That seems to be going
well.

The -- I am reporting on another bill
from last session, House Bill 442. It started off as
a Public Accountant Bill but the Medical Board got a
number of different items attached to it. There were
changes to the PA law that allowed the Medical Board
to recognize any accrediting organization for PA
education programs. They did some work to reduce
hours in massage therapy. I believe massage is part
of the RN's scope of practice, but the Medical Board
has authority to license massage therapists. You are
excepted out of those requirements.

They also licensed oriental medicine
practitioners. And those oriental medicine licenses
will be converted to acupuncture licenses, I guess,
to more focus on the acupuncture nature of things
rather than perhaps some alternative medicine that
was added into the overall oriental medicine
practitioner license.

Cosmetic therapy, too, was eliminated
from the Medical Board and moved to some general
regulatory authority by the Cosmetology and Barber
Board when cosmetic therapy is practiced in a salon.
Those may be of interest to you. I'm
just reporting it to you as I was not aware of those
previously.

The other bills were House Bill 6, which
is the extension of the RN and LPN temporary nursing
licenses during the COVID period. That expired on
March 1st, those licenses, but there's a proposal
that that be extended to July 1st. That passed the
House. It has not been heard yet over in the Senate.
Obviously there's going to be a little gap period
here if that bill passes.
But I think that the proponents, the main proponent of this law, are really after a certain group of large healthcare institutions that are tied to large healthcare programs that assimilate the best of those students into their own health systems and would like that to continue on, at least through this spring's grads, so that life can be a little bit easier during these unique circumstances with COVID, and certainly the fears that perhaps we will spike up again. Hopefully that doesn't occur, the spike, but we shall see.

Senate Bill 3 is the Nurse License Compact Bill. This is not applied to APRNs, per se. It applies to RNs, and you are RNs. But, quite frankly, the compact itself, at least, has gone through a couple iterations, most recently the new e-license -- or, the new nurse license compact. And we're up to in the thirties now of states who have adopted that compact. And in Ohio there are many proponents who would like to join that compact.

So that bill was heard over in the Senate. It has passed the Senate already, as it did last year. It has not yet been referred to a House Committee. No. I'm sorry. It just recently was, at the beginning of the last week, referred to the House Health Committee, but it hasn't been heard over there.

So there's several professions, PT, occupational therapy, psychology, there are other -- and medical, I guess, that have bills out there for compacts. They're all a little bit. There are similarities, but there are differences in the different compacts.

That is the licensing bill du jour. Last session, it was military special licensing. This year is the year of the compacts.

So I think we will probably come to some type of resolution to that over the course of this General Assembly. Maybe sooner than later. But I would say that bill has legs. And we will continue to be an interested party to that bill, the ONA is an interested party to that bill and, as I say, there are numerous employers and other healthcare organizations who are supportive of the bill, which would allow greater mobility to travel nurses and telepractice. Chiefly and border practice as well. So those are -- the proponent testimony has been focused on that.

I will add that the reason that the APRN compact is not a part of this is that you would have to have more of an independent scope of practice akin to the majority of other states in order to be a member of the compact, and we would not qualify as a member at this point in time.

Certainly interesting to me, it should be to everyone else, that one of the driving arguments for the nurse license compact now is that there are a growing number of members and the majority of other states have accepted the nurse license compact. Why not Ohio? It can't be wrong if so many other states have jumped on board and they are going through this process.

So I guess I would put the same question out there towards scope of practice for APRNs. If the majority of other states have scopes of practice for APRNs that are acceptable, you know, around the country and not unique, why not Ohio? And if why not Ohio, why not the APRN compact? It would make life easier for both practitioners and employers to the same degree.

This is, you know, what are we, 15- to 20,000s APRNs in the state of Ohio? If I were driving the argument as a proponent to changes in scope and wanting to have a compact, I think I would be making those arguments.

I'm an interested party for the Board. I just throw that out to you as the APRN Advisory Committee. Do what you may with that information.

Our concerns right now -- while there are public safety concerns we have, and the autonomy, and being governed by a group that is not state regulated per se, it's under a contract, those are concerns from a -- legal and safety concerns but we really have concerns about what the cost is going to be and how it's going to be implemented through our e-license system. And we keep asking those questions, you know, within the state and we have yet to hear answers. So when those occur, I'll report back. But I think that will go a greater way towards moving dialogue even further with respect to the compact.

Finally, for Michelle, doula services.

House Bill 142 has just been introduced and that would create a path for doulas to become professionally certified and would create a Doula Advisory Board within the Board of Nursing, is the proposal, under a four-year pilot program.

As part of that, there would also be a four-year pilot through Medicaid for reimbursement for the doulas as well as a four-year pilot through
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<th>1</th>
<th>the Department of Corrections for nursing services through the prison system.</th>
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<td>2</td>
<td>Ohio is reported to have the worst -- one of the worst infant mortality rates in the country.</td>
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<td>3</td>
<td>We rank 42nd out of 50 states with that rate with the CDC data from 2018. And outcomes for black newborns are even worse. 2019 data shows that black infants die at nearly three times the rate of white infants.</td>
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<td>In Ohio, about 5 white babies die per 1,000 live births compared to over 14 black newborns per 1,000 live births who die.</td>
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<td>So, you know, it is -- it's an issue. It's an issue that needs to be addressed here in Ohio. I think that we will see some type of advisory board or reimbursement here in the next session to try to bolster the studies that show that these doula services do help and do contribute to better statistics. But whether or not it's the Nursing Board or, say, the Department of Health who has regulatory authority over some of these maternal areas and has special sections and people who are devoted to, you know, these type of issues and can focus their support of those, I think that where the points of discussion will lie with respect to this bill.</td>
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| 1 | bill. It's not going to be in terms of having a pilot for reimbursement and so forth. I think those are no-brainers. It's just finding the right home. Certainly the nursing board is supportive, you know, of this program and the bill otherwise. Are we supportive of them coming to the Nursing Board? I think we're an interested party at this point in time. The Board wanted to see where the legislation was going on this, but we did have previous discussions about, you know, wanting to find the right niche, the right home for them and certainly, you know, open that up for further questions or discussions, but it certainly seems like the Department of Health has a little greater of a tie-in, you know, to that. And you, I think, Michelle, brought up, at the last meeting, the fact that during the pandemic there were hospitals that were not allowing the doula to come in and attend that birth and that was problematic, but, again, that was more on the employer end. I did go back and find persons over in the legislature and so forth who were interested in that area and I passed on that information. I'm sorry if I wasn't able to bust loose anything here in that. |

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| 1 | Ohio greater than what we have, but, you know, again, we were -- we were listening, we are supportive here, and we did make our attempt. I'll open the floor to questions, but that pretty much is an overview where legislation stands at this point in time, except for one final thing because I know Erin will ask me about the Advanced Practice Respiratory Care Therapists which I can't yet find the bill, this session, for that, but it was House Bill 803 last session. So that 803, that's a big number. That came on right at the end of the year. But the only program that's going, as far as I know, is over at OSU. And I kind of thought that the first grads were coming down this spring, so you would think that there would be some impetus towards -- |
| 2 | CHAIRWOMAN KEELS: Uh-huh. |
| 3 | MR. DILLING: -- having some introduction in hearings here. Again, I'm getting old. I've been around for a while. It wouldn't necessarily surprise me if, in a 2,500-page budget bill, some language popped up. Call me crazy, but that's always a possibility. But yeah, as of now, I haven't found it, |

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| 1 | but I'm still -- I'm still looking. I'm catching up on my legislation. We're all in on licensure at the moment, right? Right, Lisa? |
| 2 | MS. EMRICH: Uh-huh. Yes. |
| 3 | MR. DILLING: Licensure, yes. |
| 4 | So that's it. |
| 5 | CHAIRWOMAN KEELS: Thanks, Tom. Michelle, is that your hand up? |
| 6 | MEMBER ZAMUDIO: Yes. |
| 7 | Tom, thank you for your support for doulas. They're closely tied with midwives as you know. And so there's actually been recent studies showing that midwifery care had a positive impact on lowering that infant mortality rate. So we're very supportive. And I definitely appreciate the support. And I just want to mention, because I think this came from you, Tom, the budget testimony from the Board of Nursing. My goodness. Folks, that is eye-opening. So I read this and the entire time I thought, "Can we put this on the website?" Because the fact that you got almost 34,000 license applications and, at the same time, 8,000 complaints, a fourth of which were actually from, like, a criminal-investigation standpoint, and you did that with seven FTEs. And most of us never realize that. |
And I certainly did not realize the funding was only
from fees.

So I want to point out to everybody who
may be online and listening -- and I'm not on the
Board of Nursing, to be clear, everybody, but I want
to say this though -- those fees haven't increased
for 17 years and that is your budget. So just a
shout out to the Board, there, for being able to do
that.

As a leader, I know a basic question I've
always asked people is, do you have the tools you
need to do your job? And it certainly would seem
like that's a stretch here.

So I guess my question is, was the
purpose of this testimony, given by the Director, to
seek general funds for the Board? Which all of us
probably assumed that you already had.

MR. DILLING: Yeah, if I -- if I may.
Thank you, Michelle.
Actually, the Chair of the House Health
Committee was on the subcommittee and did remark
about the fees, and how long it was. We felt that
the Board's requests were -- he called them
respectful and made some nice comments about, you
know, how much work that we were doing.

I think that, you know, we're in a
difficult budget time and the Governor asked a lot of
agencies to, you know, hit certain markers, you know,
from a budgetary perspective. Even if -- this is
kind of politics too, but even if you're generating
those funds through licensure fees solely, it is
about the picture that it creates and everybody
tightening their belt.

The numbers that we put forth in the
budget testimony are the same numbers that we put
forth in House Bill 6. And, you know, to be quite
frank, certainly the pandemic didn't help us in terms
of -- you have to understand how much of the
licensure process occurs outside the Board and we're
reliant on, you know, other entities, like BCI and
FBI and Pearson VUE, who have their own issues with
the pandemic.

But House Bill 197 was a bill back in
March that was created with good intentions, and
hopefully provided some, you know, help when it was
most needed there in the spring. To what degree, I
don't know if anybody has ever really measured that,
or at least certainly no one has testified to those
measurements.

But, from our perspective, what we were
showing was in -- in Ohio's haste, they
probably could have created other avenues there
and -- and really put an extra burden here, but that
burden is expiring. Whether it's created again, for
a brief, narrow time period, we'll get through it.
But once that's gone, then Lisa and the good people
from licensure and so forth will be able to get back
to normal timelines which should be good enough to
meet people's expectations.

It just really was focused on this huge
influx and getting thousands of applicants who came
from Florida. And many of them, I guess, came up to
Ohio and were practicing in nursing homes where they
really needed, you know, some help there.

Why 500 people would apply from Hawaii,
not too sure. Turns out that, of the Hawaiians who
applied, the majority -- the vast majority of those
had failed their NCLEX.

So there were a lot of these other
undercurrents that were going on at the same time.
Unfortunately, the Board, until the beginning of this
year, wasn't able to extract the data from our
licensure and NCLEX failures. It's just not kept
that way nationally. People only care about people
who pass. So they don't keep that data for the
boards themselves through NCSBN.

But Betsy kept on them. There's a great
person there that works on the testing side at NCSBN,
and he went an extra mile, pulled in this data, and
that's something that came out in the House Bill 6
testimony.

And I think it was reflected, too, in the
budget testimony where I got to say horrendous
statistics on the number of people who either had
failed that exam and continued to practice, and/or
just didn't take the exam out of fear of failing or
failing again, you know, when they had that license.
Those loopholes were there. Those have been closed
in the House on this House Bill 6, but that doesn't
-- it doesn't close the extra work, you know, towards
that.

But if we were to do it over again, I
think Ohio would do it, you know, a little bit
differently. And again, quite frankly, all the
people who were proponents for this, really hadn't
seen those statistics. And again, quite frankly,
some of the proponents remain, who have seen the
statistics, but, you know, everybody -- you know,
politics is geared this way. And society, I'm sorry
to say, to some degree during this pandemic is, you
know, laser focused on how to get the job done. You know, you can't really be thinking about all these other, you know, aspects of it and you put forth your take for your provider organization and then it goes into the mix and we have testimony and we come out with the best, you know, law possible and, you know, that's kind of where we're at.

Sorry for the long story, but you hit upon that it is critical testimony. It is eye-opening. It will be in the Momentum in the Executive Director's Column and so you can point people to that. Certainly take this back and spread it among your associations and inform people.

I can't, on a day-to-day basis, as much as I would like to, respond to these individual persons who call in and say, "What are you doing. Board? You know, I put in my license application last week and I still haven't heard anything, you know, about it."

And again, bless them, they want to help, they want to help in the pandemic, they want to help by getting to work, and we want -- we want the same thing. It's just not possible to meet quite the same timelines that are being pushed forward, especially during these times.

CHAIRWOMAN KEELS: Sherri, you had your hand up?

MEMBER SIEVERS: Yes. I'll be real quick.

Just a "thank you" to Tom and his work for sunsetting the CPG. It's been a long time coming. And I think it's also to the Board and the Board staff who supported the evolution of that process and our prescribing. And just thank you to everyone.

And just a quick question about it. So your report was from January. Did the Governor sign it, and does it have an effective date, and does it mean no more meetings for this year?

MS. EMRICH: I don't know where Tom went.

MEMBER SIEVERS: Oh. I think we lost him.

I did pull it up. It looks like it says effective 4/12 or something. So I'm hoping he signed it and I think we're probably good, right?

MS. EMRICH: Yeah, yeah, exactly. You know, we had prospectively scheduled the required two meetings for the last half of the year. So yeah, you're right. You're prompting some recall on my part now. That was effective April, so we're good to go.

No more meetings. Exactly.


Thank you all. It's good news.

MS. EMRICH: Yeah. Thank you. It's been good working with you on the committee, Sherri --

MEMBER SIEVERS: Oh. Thank you.

MS. EMRICH: -- and all. So it's been good.

MEMBER SIEVERS: Thanks.

CHAIRWOMAN KEELS: Thanks, Sherri.

Did Tom come back in?

MS. EMRICH: He just came back in, I believe. Yes, he's there.

CHAIRWOMAN KEELS: Hey, Tom. And you might be --

MR. DILLING: I'm sorry.

MS. EMRICH: Yeah, he's on.

CHAIRWOMAN KEELS: You disappeared all of a sudden.

MR. DILLING: Yeah, no. That's the --

I'm a lawyer. I'm not really good with technology.

I should know not to click red, right?

CHAIRWOMAN KEELS: Don't click red.

MR. DILLING: Never click red.

CHAIRWOMAN KEELS: Yeah. That's a panic button.

MR. DILLING: That's exactly it.

CHAIRWOMAN KEELS: You were right on the money. I did want to know about the APRT legislation for scope of practice because we do have students coming out of Ohio State that are going to be graduating soon and are looking for jobs, but they have no title and they also don't have a national certification yet.

Last year there was discussion from the PA organization about introducing legislation to expand scope in certain areas especially around sedation. Did that -- did that get reintroduced? I don't think it went anywhere.

MR. DILLING: No, not to my knowledge, it hasn't. It was -- you know, it was part of something last, you know, session and it died off.

Look, the PAs are smart, just as the APRNs are, but the PAs have been allowing the APRNs to go forward first, and then they come right in and say, "Hey, we're the same, we're the same. Let's do it for us too."

However, they have that longstanding language, you know, on the anesthesia. And the anesthesiologists -- and so, you know, 177 didn't go...
anywhere. The PAs aren't going to sweep in. I think the physicians realize now that it's not 20 years ago and you can't just say I pledge my allegiance to, you know, whomever, and let me do something. You know, it's -- it's different.

So I think that we'll see APRNs, we'll see PA legislation in the next bimarium here, the next -- this General Assembly, but I think they'll be a tagalong again.

And if -- if the PAs want to go specifically after that, the anesthesia language, which would certainly be an approach, then it's going to be a dogfight just like the CRNA legislation was, but that got through.

So, you know, again, you have a lot of different providers who are educated in different ways to do the same thing. At a certain point there's a logic gap there, you know. I get that there's lots of ways to get from point A to point B and that's part of the answer, but when you get into the legislative arena with lots of different interested parties, proponents and opponents, that's just an avenue for confusion and it tends to hold things up, right, until something else, you know, busts it loose.

CHAIRWOMAN KEELS: Thanks.

And then I thought, correct me if I'm wrong, I thought I heard you say, related to House Bill 142 with the doulas, that their home, their professional home, could be the Board of Nursing or could be the Department of Health. Is that what you said?

MR. DILLING: Yeah.

So at the end of last session there were two bills. There was one in the House and there was one in the Senate. And I think the House people were leaning towards us at the end. They were going from board to board. The Social Workers Board was picked at one point in time or at least there were discussions of that. And everybody tried to distinguish themselves.

And, you know, I'm such a happy, pleasant guy. "Hey, let's put them with the Nursing Board," you know, when I talk to them. But, no, it was more like I think there is this affinity, as Michelle said, with CNMs, and the professionalism of the Nursing Board that draws them, you know, this way. I did talk with people and the sponsor, last year, about community health workers, and the doulas kind of fit within that niche, because the community health workers were -- are kind of an ubiquitous group, right, and there's all kinds of different practices and names and so forth for them.

But I think the doulas are really looking to carve out their own niche and I think they want to avoid the "community health worker" umbrella. They want to, you know, do this on their own. And there are some very forward-thinking people, you know, in these groups but there are a couple different groups, right, and that plays into this advisory-group nature of it.

Again, they put them under the Board, to begin with, in this House Bill. Whereas, the Senate was more, I think, going towards the Department of Health. We're in a pandemic. Do you generate much discussion over at the Department of Health unless you say the word "COVID"? Probably not right now. I mean, you know, I can cry about licensure here. They've got so much stuff going on that perhaps that is something that's tugging at, you know, further discussion in that area.

But, again, I just throw out that the previous discussions and the discussions I had with them have to point out that there are these programs at the Department of Health that just seem to link more closely to, you know, the work of the doula and the care provided by a number of different groups and, again, I think that that's going to be the focus of any legislation is those discussions.

CHAIRWOMAN KEELS: Okay. Thank you.

MR. DILLING: Sure.

CHAIRWOMAN KEELS: Any other questions or comments for Tom around legislation?

MEMBER SIEVERS: No. In fact, he might not have heard my "thank you" because he popped off.

Tom, I was saying thank you for all your work for the sunsetting. I know that was a little bit of a lift for you, but we appreciate it. Thank you.

MR. DILLING: Yeah. Very easy. You guys were such a good group that I think that they did such good work over the years that that's kind of a happy ending, right?

MEMBER SIEVERS: Absolutely. Yeah.

MR. DILLING: That's the way it should go.

CHAIRWOMAN KEELS: So sort of dovetailing on that discussion. I thought there was language in that bill that if any new drugs or if there were any questions or concerns about drugs, they would come to
MR. DILLING: Yeah. I'm not sure exactly what the statute says right now, but that's a common path for us. You know, any time we do rules, we seek out comments as we're drafting them. And just like the stuff we brought to you today on consult agreements, which was actually specified in statute, but the same way for any drug.

I just don't see it happening. You know, I really don't. But if it did for some reason, yeah, I -- we would be remiss in not coming to you. It's just a part of the process now. A good part, you know.

CHAIRWOMAN KEELS: Yeah. I was wondering what that might look like. It doesn't seem like much came before the CPG in the last couple of years -- correct me if I'm wrong, Sherri -- that it wouldn't be like a regular agenda item for this committee at all. It would be maybe comments received or something that was brought to us.

MEMBER SIEVERS: Right. It would be something very unusual. Yeah, yeah.

CHAIRWOMAN KEELS: Okay.

MEMBER SIEVERS: Maybe as the medical marijuana or some of those things progress, it might be an issue around that, but typically no, not an issue.

CHAIRWOMAN KEELS: Okay. Great. I just wanted to confirm that. Thank you.

Okay. Well, next up on our agenda is lunch, so we will break until right about 12:15. Does that sound okay with everyone?

Lisa, do you need something? You are muted.

MS. EMRICH: Thank you.

We found the original, it looks like, Medical Board Consult Agreement draft. So we sent that out to everyone so you can take a look at that. It looks like they -- it's -- it is as I recall. They inserted "APRN" in each place. So you can take a look at that. It was the original version. I believe there may be another version at the Medical Board's meeting coming up. We'll look for that too. But this will show you how it originated.

MEMBER SIEVERS: Thank you.

CHAIRWOMAN KEELS: All right.

MR. DILLING: And Lisa, I will send to you now the Pharmacy Board rules, which they also have for their consult, so that you can see where they're coming from. And they have a very nice FAQ explanatory document. That may help you too. So I'll -- I'll send that over to you right now.

MS. EMRICH: So, Tom, include Chantelle on that, and she can send it out to the mass e-mail for the Committee, so.

MR. DILLING: Will do.

MS. EMRICH: Thank you so much for that.

MR. DILLING: You're welcome.

CHAIRWOMAN KEELS: Okay. Thank you. All right. See everybody at 12:15.

(At 11:39 a.m. a lunch recess was taken until 12:15 p.m.)

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Tuesday Afternoon Session,
March 9, 2021.

CHAIRWOMAN KEELS: Welcome back from lunch, everyone, to the Advisory Committee on Advanced Practice Registered Nursing.

Thank you to Tom and Anita and Chantelle for sending out the additional documentation.

Do we want to just pick up where we left off and go back to the pharmacist consult agreements, see if there's any further dialogue or discussion to give to the Board staff before we move on?

(No response.)

CHAIRWOMAN KEELS: Not at this time?

Okay. All right.

Next up on the agenda is "APRN Licensure and Practice." The document was finalized and published for your reading pleasure. It was sent to you as a paper document -- well, electronically, and it is posted on the Board. And I was really happy to see that we were able to refer some of the questions that the Board receives back to those FAQs, and hopefully people will find a lot of value in that.

So thanks again to Lisa and her team for making that happen. That was a lot of heavy lifting and a lot of
work to accomplish that.

Does anyone have any questions, concerns, or comments related to the document?

(No response.)

CHAIRWOMAN KEELS: Okay. I'm going to take that as a "No."

Oh. Michelle. Yes, ma'am.

You're muted.

MEMBER ZAMUDIO: Sorry.

Only one. There was one comment. There were a few little changes that I thought were great that added clarity to the document that we approved in October.

The only thing I had requested was on page 7, at the very top, the second little dot, says "APRNs are prohibited from prescribing any drug or device to perform or induce an abortion, or to otherwise perform or induce an abortion."

I'm not sure about the second part of that, but I had asked that we include, just as an addition for clarity, the definition, the legal definition of "abortion" because there's the legal definition, the medical definition, and then the lay terminology.

So I thought including, I think it's in the OAC, but it's 2919.11 is clear and wouldn't place prohibitory language on specifically nurse midwives with prescribing a Paragard intrauterine device or Cytotec for labor induction.

So I didn't know, since it's referencing abortion, if we could just put that legal definition in there.

CHAIRWOMAN KEELS: I defer to Lisa. I believe the document is sort of a living document that we can make additions and tweaks to.

Yes, Anita.

MS. DIPASQUALE: I was just going to say, Michelle, are you suggesting we put a "See," just a reference, so that people can find that?

MEMBER ZAMUDIO: I kind of looked at it from a legal perspective when an employer might perhaps be looking at this or a pharmacy person or even a provider. I think writing out the definition, because it's not very long.

It actually states that a provider shall not prescribe any drug or device to perform or knowingly induce an abortion, and then it goes on to say an abortion is the purposeful termination of a human pregnancy with an intent other than to produce a live birth or to remove a dead fetus or embryo. So that allows for miscarriage and for labor induction, Paragard insertions, et cetera.

So I would -- I would like the verbiage in there. It's very short but it's very clear, I think, so no one could read into that hot-button word of what we're talking about.

MS. EMRICH: Anita and Michelle, both, and Erin, I wonder if we refer to anything, maybe perhaps it should be the formal Attorney General Opinion that they provided to the Nursing Board regarding administering a medication for purposes of inducing an abortion.

MEMBER ZAMUDIO: We could. It's also in statute, so, I mean, we could also just reference that. I like the idea of that though. That's another good thing to include.

MS. EMRICH: Since it was provided specifically at the Board's request. I don't know if that's something we would do. We can certainly look at it.

MEMBER ZAMUDIO: Okay. Yeah. I think add just at least the legal -- we mention the word "abortion." If we could put the legal definition of what we're prohibiting in there, I just think it would add clarity.
MEMBER ZAMUDIO: One other point. Do you think, perhaps, that we should -- I loved Erin's idea of doing an FAQ about that consult agreement. To maybe add an FAQ about that, that would be, I think, very helpful to everyone just because it's kind of new. Maybe after we get our ducks in a row, etcetera, we could add an FAQ about that and then maybe the standard care arrangement waiver that exists through May. I mean, it's temporary, but I don't know if we should add that.

MS. EMRICH: I --
CHAIRWOMAN KEELS: Go ahead, Lisa.

MS. EMRICH: No, no, no, I'm just -- the wheels are turning as I -- so we already -- we have information and communications out about the consult agreement. I mean, Momentum articles are coming out and so forth.

MEMBER ZAMUDIO: Awesome.

MS. EMRICH: But I would probably wait until the rules and everything are more firm up before we change the actual document that we have. That would be my -- from a staff recommendation.

Now, the temporary -- the waiver for the standard care arrangements, that's -- it is temporary. We have that documentation on our website, as well, just as general information. I mean, since it is temporary, I don't know if we would put that into the permanent document --

MEMBER ZAMUDIO: Yeah.

MS. EMRICH: -- which is what this is.

MEMBER ZAMUDIO: That makes sense. I was just doing it for like retrospection if somebody were to look at it and say, "Hey, you know, your standard care arrangement wasn't updated during this time," historically that would --

MS. EMRICH: Right.

MEMBER ZAMUDIO: -- put it there. But you're right, it's a temporary thing.

Okay. You know, I went through it line by line. Can I add one more thing?

At the bottom, let's see, the next-to-last page where it talks about the consensus model, which we all agreed to put in here. The very last line says that our approach to the role and the population foci is consistent with the Board's approach and will continue to be followed.

Should we -- I looked back over our minutes. Should we add a line that says "recognizing that not all elements of the Consensus Model are present in Ohio statute and rule"? Because if people read the Consensus Model, it's full prescriptive -- I mean, it's full practice authority. So I think maybe a little line that says, you know, we are recognizing that all elements are not followed. Just throwing that out there for discussion.

CHAIRWOMAN KEELS: I think that we tried to indicate that, Michelle, through the words that "the ARN Consensus Model approach as to role and population foci." So carving that piece out of the overall Consensus Model, understanding that the rest of it we haven't achieved yet.

MEMBER ZAMUDIO: I knew that, because I knew that's what it was implying just because of where we started and how far we've all come. Thank you. But it doesn't say it explicitly. And I thought, you know, I always try to think about it as not one of us doing it. So the average person who just got their license, clicking on that. Would they know.

So I didn't know if we needed to be clear about that for now that, yes, we support this, and we all agreed, as a Committee, about this, but we recognize that not all elements are addressed in the Consensus -- all elements don't get addressed in the Consensus Model. They're not all present in Ohio rule and -- law and rule.

CHAIRWOMAN KEELS: Margaret, you have a hand up?

MEMBER GRAHAM: Yes.

I agree with Michelle. I think if you come from one of the many states that they have full practice authority and you read this and you don't read the law or the rules carefully, you may interpret this to be that we do have full practice authority. I mean, we know that we don't and we know that we have to have the standard care arrangement, but I do think it would help with clarification until we can get our standard care arrangement removed.

CHAIRWOMAN KEELS: Any other comments?

Anita, is that an old hand or a new hand?

Okay. Lisa.

MS. EMRICH: So although the document discusses the need for a standard care arrangement, it's not --

CHAIRWOMAN KEELS: Perhaps there can be a single sentence that -- something to the effect that Ohio has not achieved all elements of the Consensus Model, with a link to it.

MS. EMRICH: Or it's met three out of the
<table>
<thead>
<tr>
<th>Page 81</th>
<th>Page 83</th>
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<tr>
<td>1 four elements or, yeah, all but so-and-so elements.</td>
<td>1 got extended to July the 1st. So they've had a long renewal period due to both HB 197 and then House Bill 404.</td>
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<td>2 We -- yeah, we could do -- we could do that. I just...</td>
<td>2 There is -- currently APRN and RN renewals are planned as usual so that the renewal period will begin July the 1st. Late fees will start on September the 16th. And then the end of renewal or the last day to renew will be October the 31st of 2021.</td>
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<tr>
<td>3 CHAIRWOMAN KEELS: Okay. Sounds good.</td>
<td>3 We have implemented some enhancements for e-license for APRNs and that is to -- remember, for APRNs, you have to renew your RN, first, before you'll be permitted to renew your APRN.</td>
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<td>4 Anything else?</td>
<td>4 There's been some -- again, maybe persons new to Ohio and all, they thought that if they renewed their RN, that was all they needed to do and it came up to the last moment and they were renewing their APRN, realizing.</td>
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<td>5 (No response.)</td>
<td>5 So what we've done is we've worked with DAS to -- for some enhancements so that if the APRN has renewed their RN -- well, each licensee will get a notification that you have to renew your RN and APRN, okay? After they renew their RN, the APRNs will continue to get e-mail reminders that still have not renewed your APRN. So we're hoping that...</td>
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<td>6 CHAIRWOMAN KEELS: No? Okay. Thank you very much.</td>
<td>6 The second paragraph under the answer says that a CRNA may act in the capacity of an RN, and as an RN, and may administer drugs pursuant to an order from an authorized provider who is acting within their scope of practice. In parentheses it lists: physician, PA, or APRN-CNP. Can we eliminate</td>
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<td>7 Next up is General Information and Updates, which I believe is Lisa.</td>
<td>7 that will help to remind persons of the dual -- it's really a dual license that has to be renewed.</td>
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<td>8 MEMBER ZAMUDIO: Oh.</td>
<td>8 CHAIRWOMAN KEELS: And Lisa, that's because the system, itself, could not just link automatically and take you into your APRN license renewal, right?</td>
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<td>9 CHAIRWOMAN KEELS: Yes, Michelle.</td>
<td>9 MS. EMRICH: Right.</td>
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<td>10 MEMBER ZAMUDIO: I'm so sorry. There was one other.</td>
<td>10 CHAIRWOMAN KEELS: You have to complete one and then go back in and redo it for your APRN.</td>
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<td>11 When I printed the document off, on page 12, it was the question about the CRNA</td>
<td>11 MS. EMRICH: Correct. Correct. It's not -- you can do that, but it -- because it's a parent-child dependency it will not recognize your ability to renew your APRN until your RN is renewed, and so yes, it is two different pages so you do have to go back in.</td>
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<td>12 authorized to administer drugs for like the treatment-resistant depression, which is a great question and example.</td>
<td>12 CHAIRWOMAN KEELS: And we couldn't insert a question at the end, &quot;Are you an APRN?&quot; and if you click &quot;Yes,&quot; it would take you back to the start for the APRN. I think you explored that and weren't able -- the system wasn't able to do that.</td>
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<td>13</td>
<td>13 MS. EMRICH: Yeah. And we can continue to look at ways to enhance that ability, but for right now it's getting the reminders out is what we're going to need to do.</td>
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<td>14 The second paragraph under the answer says that a CRNA may act in the capacity of an RN, and as an RN, and may administer drugs pursuant to an order from an authorized provider who is acting within their scope of practice. In parentheses it lists: physician, PA, or APRN-CNP. Can we eliminate...</td>
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<td>15 that will help to remind persons of the dual -- it's really a dual license that has to be renewed.</td>
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<td>16 the CNP? Because other types of APRNs may be prescribing that, and I didn’t want to limit it to only the CNP.</td>
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<td>17 CHAIRWOMAN KEELS: Anita.</td>
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<td>18 MS. DIPASQUALE: It may be better to add the CNS, rather than -- I mean, the whole point was sometimes we get a question from a CRNA, saying, you know, can I open a ketamine clinic for breakthrough depression and it's -- like, that's not actually -- you would still need an order, which is what this point was addressing. So wouldn't it be better to add CNM and CNS, rather than delete the CNP?</td>
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<td>19 MEMBER ZAMUDIO: Yeah, I agree.</td>
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<td>20 CHAIRWOMAN KEELS: That would probably make it more clear.</td>
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<td>21 MEMBER ZAMUDIO: Yeah.</td>
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<td>23 MS. EMRICH: So RN and APRN renewal preparations. Renewal will begin on July 1st of this year.</td>
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<td>24 So, you know, in the past renewal periods, especially for LPNs and certain temporary permits to reciprocity applicants, DT's, DTIs, medication aides, NCHW, their renewal period actually...</td>
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helpful.

MS. EMRICH: We're hoping that will help.

CHAIRWOMAN KEELS: Thank you.

MEMBER SIEVERS: I have a question. Was there any changes to -- just remind me and maybe the folks listening. So the requirements for CE starts this time, right? It's the --

MS. EMRICH: When you renew your license, you have to verify that you have obtained your 24 hours of CE as an APRN, correct. Last renewal it was a waiver because it was your first renewal after receiving your new APRN license.

MEMBER SIEVERS: Okay. I was just making sure, due to COVID, there was nothing -- because I know a lot of folks didn't get to travel for conferences and stuff, but there was nothing in that -- in that extension. So folks will be required to have all that.

MS. EMRICH: Correct.

MEMBER SIEVERS: Okay.

MS. EMRICH: Yes.

MEMBER SIEVERS: Thank you.

MS. EMRICH: Yes. And you have until October 31st to obtain that. And it's 24 hours of CE.

MEMBER SIEVERS: Plus nursing. So it's 48, and 12 has to be pharmacology.

MS. EMRICH: Correct.

MEMBER SIEVERS: Okay.

MS. EMRICH: For everyone except for CRNAs, so yes.

MEMBER SIEVERS: Right. Okay. Thanks.

CHAIRWOMAN KEELS: Michelle.

You're muted.

MEMBER ZAMUDIO: Sorry.

Related to what you were just discussing, I get that question all the time about how many hours, which ones apply for nursing, how many of the others. Would that be a good FAQ?

MS. EMRICH: We have -- we have dedicated CE documents on the website. One is explicitly for APRNs and it's all about CE.

MEMBER ZAMUDIO: Right. I don't -- I guess because it changed, we get a lot of -- a lot of conversation about that.

MS. EMRICH: Uh-huh. Yes.

MEMBER ZAMUDIO: Thank you.

CHAIRWOMAN KEELS: Okay.

Anita, is that an old hand? Okay.

Next up was the 'Sample/Summary of APRN

Questions" that the Board received for your perusal.

Does anyone have any comments or concerns? Like I said before, I was glad that we could refer some of this back to the FAQs.

MS. DIPASQUALE: This is Anita speaking.

Yes, I have been able to refer people back to the FAQs that everybody has worked on so hard, and so that's been helpful.

CHAIRWOMAN KEELS: Great.

Is that you, Anita?

MS. DIPASQUALE: Yes. Erin, I would add in terms of Question 1, I just wanted to note that the people who approached me with that question, there was some additional correspondence back and forth and it turned out that they were really -- the section that they were really wondering about was not (m), it was (g), subsection (g), community mental health services provider, as defined in Section 5122 ORC.

And so I looked that up and it -- the definition in 5122 ORC, which is not one of the laws and rules we enforce, it's the Mental Health and Addiction Services Office that enforces that. But, anyway, the definition is a community mental health entity that is certified by the Director of Mental Health and Addiction Services under Section 5119. So I just wanted to kind of give a little follow-up information there.

I kind of focused on the "privately owned" and so I went straight to part -- subpart (m). But there is a part in .481 that is more specific and applicable to community health and so that was what was relevant to the two people who separately wrote in. It was kind of a funny coincidence. I got lots of questions about that all of a sudden. So I don't know if that will be a trend or kind of a little bit of a one-off, but I just wanted to provide that bit of additional information.

CHAIRWOMAN KEELS: Thank you.

Give people a minute to take a look through there.

Still have questions about women's health, scope of practice, I see. Hopefully this will help out.

I wonder what it's like to work in a medical spa. It sounds like it might be really nice.


Anything else about that?

Yes, Michelle.

You're muted.

Armstrong & Okey, Inc., Columbus, Ohio (614) 224-9481
MEMBER ZAMUDIO: Sorry. I'm getting my virtual hand and my real hand mixed up. On the question about the women's health nurse practitioner, can they manage male patients. Do we want to add some verbiage for transgender people who are biologically male but identify as female? I think it's just, when I read the question, I kept going, "Oh, are we going to go there? What are we going to do with this answer?"

And I think maybe looking to the national standards for the women's health nurse practitioners and nurse midwives and maybe saying are we addressing that. It is part of the conversation and I feel like it does a lot in this answer to define, like, woman and pediatrics and children.

I don't -- I just thought I would bring this up. I think it will be important to a lot of people.

CHAIRWOMAN KEELS: So, Michelle, you're asking for something in greater detail than what's listed here, which refers back to the -- to the certification exam?

MEMBER ZAMUDIO: Yes. Because our answer goes there, right? Our answer talks about the management of male patients in the context of sexual and reproductive health. And I believe that was meant to address treatment of STIs and then maybe sperm counts for fertility awareness. But because it states that, do we need to have a position or a statement about "For these patients, refer to your -- your, you know, national guidelines," et cetera?

CHAIRWOMAN KEELS: You want to specifically call out transgender individuals?

MEMBER ZAMUDIO: Well, we're calling out the words, yeah, female and male. And it says, you know, the word "woman" is in parentheses. And it says what the Candidate Guide does and doesn't address. So if it doesn't address transgender care in the Candidate Guide, at least we could state that. Because we get questions about it a lot in our -- in our facility there's a specialty area for transgender patients.

So I don't know if we want to maybe give some extra guidance there or just wait and do a separate question. I just wanted to throw that out for discussion.

CHAIRWOMAN KEELS: Margaret.

MEMBER GRAHAM: Michelle, I wondered if you know what the women's health certification or midwifery, I mean, do those certifying bodies address this yet? Because that's kind of one of our guidelines. And I think it's a great question and I think it's something, as you say, we will be seeing more and more of that and so I think it needs to be certainly in our curriculum and we need to be able to care for our transgender patients, but I didn't know if there was a statement yet from the national certifying bodies.

MEMBER ZAMUDIO: I know the nurse midwives are working on that on a national level, definitely we have on a state level, but I don't know if they've actually ingrained those in the standards of care or standards of what we call our standards of care when we graduate in those core competencies for the women's health nurse practitioner. I would have to look that up to see if that's in there.

But, you know, in a women's health office you could definitely see a biologic male who is -- or a biologic female who is transgendered to male, is the more common scenario, that perhaps is having side effects of the hormone therapy and those side effects relate only to the female genital tract, which we wouldn't say that to them, "their female genital tract," but to the vagina specifically.

So I don't know if we -- I'm -- I'm just throwing this out there because I thought, you know, maybe we need to mention that because we're mentioning -- we're mentioning those candidate guidelines for the women's health care practitioner, so maybe we need to investigate whether or not they address transgender care and then we could insert a statement like that.

CHAIRWOMAN KEELS: It feels like we would -- before we would put anything out there, we would need to make sure that the national certifying bodies have a position on it, right?

MEMBER ZAMUDIO: Definitely.

CHAIRWOMAN KEELS: But I do agree, I feel like it deserves its own question pulled out separately for both biological male, biological female, and then what the scope of practice is with those individuals. But perhaps Lisa and her team could do a little investigation. I gave her -- I voluntered her for something, didn't I?

MS. EMRICH: It's all good.

MEMBER ZAMUDIO: Sorry, Anita.

MS. EMRICH: We can check. And obviously, as you discussed, we would wait for the national certifying entity to make a determination first, and then we would, you know, add that, but
we'll see if they have made that determination.

MEMBER ZAMUDIO: Okay. Thank you.

CHAIRWOMAN KEELS: Great. Anything else?

My gosh, is that my computer?

Okay. Well, then I guess we are going to set dates for the rest of the year.

MS. EMRICH: No. They've -- they've been set. They're July 12th --

CHAIRWOMAN KEELS: I'm glad you remember when they are.

MS. EMRICH: They're on your agenda. The remaining 2021 meetings, the next one is July the 12th, and then on November the 9th.

MEMBER SIEVERS: So Lisa, I have a question. This is Sherri. Many of us, I think, have our term up; is that correct? And do you have any instructions about what that will look like, the applications, and what -- because we could possibly not be here on the 12th, correct? I think a lot of us have our terms ending.

MS. EMRICH: Yeah. Let me pull those up.

MEMBER SIEVERS: Okay.

MS. EMRICH: So the Board is convening a committee for your APRN Advisory Committee appointments. It will select the committee in March.

It will convene in May. So those -- we will send out applications -- have applications available just like your initial ones.

And I'll let you know who is up. Okay. I'm just going to go down through the whole committee so that each one of you will know when your term is up.

So Pete is -- is -- his term expires in May of 2022.

Sherri, your term expires in May of this year. You're eligible to apply for a second term.

Michelle, your term expires in July of 2022.

Brian Garrett, who was not able to join us today, his term expires in May of 2021.

Margaret, your term expires in May of 2022.

Angela, your term expires in May of this year.

And then Pam's appointment expires in May of this year.

So we will have those applications available probably at the end of this month, first of April, and then they will go to the May board meeting, all applications received, and then the committee will make appointments during its meeting.

MEMBER SIEVERS: Okay. Thank you.

MS. EMRICH: Uh-huh.

CHAIRWOMAN KEELS: Thanks for bringing that up, Sherri.

Yes, Michelle.

MEMBER ZAMUDIO: This is a question for Lisa. So just to revisit this one more time. So I took over a spot that was, I guess, vacant. So would I be eligible to reapply after my July '22, since I did a portion of that vacated spot?

MS. EMRICH: I believe so.

MEMBER ZAMUDIO: Okay.

MS. EMRICH: I believe so. We can doublecheck, but I think we had discussed it.

MEMBER ZAMUDIO: We did.

MS. EMRICH: I believe that was the case.

MEMBER ZAMUDIO: Okay. Thank you.

MS. EMRICH: Uh-huh.

CHAIRWOMAN KEELS: Okay. Anything else?

Comments? Questions? Concerns? Recommendations?

Something you'd like to talk about at the next meeting?

I hope you all will reapply. I hope to see you all again in July.

Okay. Well, with that, it was a great meeting. Thanks so much for all of your engagement and your thoughts and recommendations and dialogue.

I appreciate it. Everybody have a great spring.

MEMBER SIEVERS: Were we --

CHAIRWOMAN KEELS: Stay well.

MEMBER SIEVERS: Were we going to circle back to that other topic about the rule, or were we just going to send out the physician rule? I can't remember where we landed.

CHAIRWOMAN KEELS: Oh. Sorry. Maybe you weren't on. So at the beginning, when we got back from lunch, I asked if anybody had any comments or concerns or had --

MEMBER SIEVERS: Oh, okay.

CHAIRWOMAN KEELS: -- they reviewed it.

MEMBER SIEVERS: All right. No worries.

CHAIRWOMAN KEELS: But -- so I --

guess, going forward, we've made the recommendation that we'd either like to remove that language or make it more clear so that -- so we can avoid burden. And I can -- Lisa and I can certainly take that to the board meeting next week.

MEMBER SIEVERS: Okay. Perfect.

CHAIRWOMAN KEELS: Because I'm assuming,
I don't think I've seen the agenda yet, that we will
discuss it there as well.

MEMBER SIEVERS: Okay. Thanks.

CHAIRWOMAN KEELS: Okay.

Are any hands new hands?

Yes, Anita.

MS. DIPASQUALE: Erin, I just wanted to
point out that the memo that was sent around was
taken from the Medical Board's website today. That's
their current marked-up version.

So the rule was adopted effective
October 2020. And then what you have, that memo that
you have is marked up so it shows some deletions, it
shows some additions to add PAs in. And just to let
you know, I went and looked to see if that language
from our (I) is in there, and it is.

CHAIRWOMAN KEELS: Yeah.

MS. DIPASQUALE: So it came from the
existing Medical Board rule that was -- that became
effective initially in October of 2020. So you can
find that, I think it's around page 23ish of the memo
from the Med Board website.

CHAIRWOMAN KEELS: Thanks, Anita.

MS. DIPASQUALE: Uh-huh.

CHAIRWOMAN KEELS: Any final thoughts?

(NO response.)

CHAIRWOMAN KEELS: No? Okay. Then we
will adjourn. Thank you everyone. Have a great day.

(Thereupon, the meeting concluded at
12:51 p.m.)

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CERTIFICATE

I do hereby certify that the foregoing is a
true and correct transcript of the proceedings taken
by me in this matter on Tuesday, March 9, 2021, and
carefully compared with my original stenographic
notes.

Carolyn M. Burke, Registered
Professional Reporter, and
Notary Public in and for the
State of Ohio.

My commission expires July 17, 2023.

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