BEFORE THE OHIO BOARD OF NURSING

... ADVISORY COMMITTEE ON ADVANCED PRACTICE REGISTERED NURSING ...

MEETING

before the Advisory Committee on Advanced Practice Registered Nursing, at the Ohio Board of Nursing, 17 South High Street, Suite 660, Columbus, Ohio, called at 10:00 a.m. on Tuesday, November 9, 2021.

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Tuesday Morning Session,
November 9, 2021.

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MS. EMRICH: Good morning, everyone, and welcome to the November 9th meeting of the Board of Nursing's Advisory Group on Advanced Practice Registered Nursing. My name is Lisa Emrich. I'm a Program Manager for the Board.

In the absence of a designated Chair at this particular meeting, Erin's tenure as a Committee Member came to an end, I will be facilitating the meeting only to the point of electing -- or this Committee electing a new Chair, so I'm convening it at this time.

I do have just a couple of announcements before we begin that. And even before the announcements, since we do have new members and all, I think it would be a good idea if we went around the table and introduced ourselves, and there's one -- there's one that's not here yet and hopefully she will arrive in time. She might be having some parking issues or something.

So, again, my name is Lisa Emrich, I'm Program Manager for Practice and Education for the Board and Staff of this Committee. And going to my left.

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MS. DI PASQUALE: I'm Anita DiPasquale, Board Staff.

MS. EMRICH: And to my right.

MS. WARREN: Chantelle Warren, Board Staff.

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MEMBER CONTRERA: I'm Peggy Contrera.

I'm a CRNA from Cleveland Clinic.

MEMBER GRAHAM: I'm Margaret Graham. I am a Family Nurse Practitioner and I'm from Ohio State.

MEMBER TYSON: My name's Lee Tyson. I'm a Psychiatric Nurse Practitioner and the founder and owner of Lee Side Wellness, outpatient psychiatric practice in the Mason, Ohio area, and I'm the Program of the -- the Director of the Psychiatric Nurse Practitioner Program at the UC College of Nursing, so it's good to be here.

MEMBER ZAMUDIO: I'm Michelle Zamudio. I work for the University of Cincinnati at Christ Hospital in Cincinnati, Ohio, and I'm here to represent the nursing midwives.

CHAIRPERSON SIEVERS: Sherri Sievers.

I'm a Family Nurse Practitioner at Cincinnati Children's and I'm representing practice.

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MEMBER DiPiazza: I'm Pete DiPiazza. I am representing primary care. I'm an FNP. I work with Mount Carmel Medical Group as the Director for Clinical Practice and Performance, and I have my own practice, Healthy Alliance.

BOARD MEMBER KEELS: I'm Erin Keels. I'm a Nurse Practitioner at Nationwide Children's Hospital, the Past Chair of the Advisory Committee, and a member of the Board, so -- and I am here as an observer.

MS. EMRICH: Yeah, Erin and I were talking, she's -- she is a member of the Board of Nursing, so she is here in that capacity, and we appreciate that. And also just from a staff member, appreciate your chairmanship these past several years.

BOARD MEMBER KEELS: It was fun. Got some stuff done, so it was great.

MS. EMRICH: I have one other announcement to make before we get to the election of your new Chair. I want to let you know that there's been a change in administration with the Board of Nursing. Betsy Houchen, who had been our Executive Director for several years, and she -- after 30 plus years of service to our great State of Ohio, she retired.

And Charity Robl is our Interim Executive Director. She began her work here on October the 1st. She comes to us from the Department of Commerce in an exchange agreement with that agency. So we're happy to welcome her here, and she will be obviously at the November Board meeting next week.

We do have a court reporter who is transcribing the meeting proceedings. We do ask that when you begin to speak, if you would raise your hand and identify yourself by name, that would be helpful for her and to speak up when you -- when you speak. And -- welcome.

MEMBER BRAZEE: So sorry. Geographically challenged.

MS. EMRICH: You are good. We are just doing introductions. Would you like to introduce yourself and give us a little background.

MEMBER BRAZEE: Sure, sure. I'm Kimberly Brazee. I am a nurse practitioner in critical care and I represent employer.

MS. EMRICH: Thank you so much. Okay.

So next up on the agenda is the Advisory Committee Chair. We have -- What we should do first is hear nominations and hear if persons are willing to accept that nomination. And then when it comes to the vote, we can do an open vote poll or we can do a paper vote poll, whichever would be -- whichever you would prefer. So we are now open for nominations.

MEMBER ZAMUDIO: Can I ask just a point of clarification?

MS. EMRICH: Yes.

MEMBER ZAMUDIO: What if we want to nominate someone but we don't know if they want it?

MS. EMRICH: It would be up to that person to accept it or not.

BOARD MEMBER KEELS: You're essentially in the hot seat for a minute.

MS. EMRICH: If I may, another point of clarification. There is a position on this committee that is currently unfilled, and that is the Ohio Board of Nursing Member position, okay. Erin had been filling that position. She has already served her two terms according to the statute, so she was not eligible for a third term. And there is not currently another APRN member of the Board of Nursing. That position on the Board is currently vacant.

So you can -- I think this Chair can serve for -- it's up to this committee. You can -- The Chair can serve for a limited amount of time or for the year. It's just however -- what the Committee chooses to do.

MEMBER GRAHAM: Are you saying that if a Board Member is appointed, that person would be Chair?

MS. EMRICH: Not -- no, no. It's not necessarily. Historically that seemed to be more the precedent, but it's not in statute. The statutory requirement for this Committee says that the Committee will select a Chair among its members. So it does not have to be a Board Member, but I just wanted to -- to raise that -- that as a point, so....

MEMBER ZAMUDIO: Well, I would like to nominate Sherri Sievers and not because I'm sitting next to her. Usually she's over there.

MEMBER GRAHAM: I would second that.

MEMBER ZAMUDIO: Sorry....

MEMBER BRAZEE: If you didn't, I would have.

MS. EMRICH: Sherri, do you accept that nomination?

CHAIRPERSON SIEVERS: Yes.

MS. EMRICH: All in favor for the
nomination? All in favor for the nomination?
CHAIRPERSON SIEVERS: Anyone else?
MS. EMRICH: Okay. It's one, two, three, four, five, six in favor. Okay. Any other nominations?
(No response.)
MS. EMRICH: Having none, do I have a motion for -- so let's put that aside for -- So, Sherri, do I have a motion for a nomination by acclamation since there are no other...
MEMBER GrahAM: I so move.
MS. EMRICH: Okay, Margaret.
MEMBER TYSON: Lee Tyson, I'm happy to second.
MS. EMRICH: Election by acclamation.
Sherri Sievers. Thank you, Sherri.
(Applause.)
CHAIRPERSON SIEVERS: Thank you. All right.
MEMBER ZAMUDIO: I didn't mean you couldn't sit next to me.
CHAIRPERSON SIEVERS: I should have been quicker on that.
MS. EMRICH: One side note, Tom had -- will be here very soon, but he's been delayed by some other work, so we might have to skip over him for a moment.
CHAIRWOMAN SIEVERS: Thank you. Honored to wear the skirt. All right, shall we move on to -- We didn't do public comments, right?
MS. EMRICH: Well, we have none.
CHAIRWOMAN SIEVERS: We have none, all right.
MS. EMRICH: We have no public comments.
CHAIRWOMAN SIEVERS: So it's now lunchtime. All right, how about the APRN licensure and practice, review requested update.
MS. EMRICH: So we made the updates as requested to that practice document, and we sent you the track changes. So of course those would be fluffed up and prettied up before they would be posted, but we wanted you to see where they were inserted.
MEMBER ZAMUDIO: I have a question.
CHAIRWOMAN SIEVERS: Michelle.
MEMBER ZAMUDIO: Michelle Zamudio. I have a few questions. Sorry, I'm looking for them.
On Page 3 of the numbered pages, I love that on the, let's see, one, two, three, four... under the Certifying Exams and National Certifications, the fourth bullet, thank you for putting that in there that the member's responsible for having their results sent. I hear all the time, like, "Oh, I did my recert but they didn't know to send it to you."
So I was wondering should we -- is there a way to emphasize that one, but should we also add where it says, "...and request their National Certification," should we add "and recertification," so that when they recertify, they know that to be -- that's on them to send it as well?
MS. EMRICH: Yes, we can add that as we're -- included with the other updates that you have if it's the agreement of the Committee.
MEMBER GrahAM: I think that's good.
MS. EMRICH: So just to make a note to add certification and any new certification.
MEMBER ZAMUDIO: That's great. I love that that was added.

Then on Page 6, let's see, this is just I think a clarification where it says under the one, two, three, four, fifth bullet point at the top, "Pediatric Primary Care, the ANCC will require its exam," so I read a little bit about that. If it's replaced by another exam, do we have to then change this because it looks like it might be?

How is that going to work? Or do we need to even add that it will soon retire as an exam. I just wasn't sure what to do with that.
MS. EMRICH: Where are you, I'm sorry?
MEMBER ZAMUDIO: Page 6 of the numbered pages, and the top bullet "Currently Available Certifications" --
MS. EMRICH: Oh, got it.
MEMBER ZAMUDIO: Under "Pediatric Primary Care," I went on the website and was reading about it there. Apparently it was a volume issue, but it looks like another body may take up that exam. I'm not sure if we should -- what to do with that.
MS. EMRICH: So this is the PNCB currently has that exam and has been utilized, so it's my understanding it's basically that exam will be provided by PNCB and not ANCC, and ANCC had a prior exam. I would need to look at the date that was retired.
CHAIRWOMAN SIEVERS: I think it might be.....
MS. EMRICH: Already retired, so....
MEMBER ZAMUDIO: So do we write the new one in there, or do we write -- mention the exam?
MS. EMRICH: No, we would probably in
time just remove this reference to the ANCC.

retirement is what we would do.

MEMBER GRAHAM: PNCB would keep theirs?

CHAIRWOMAN SIEVERS: Yes, PNCB's current.

MEMBER ZAMUDIO: Okay. And then on Page

7, I appreciate the Board adding the definition of
abortion, thank you, under section 2919.11 of the
ORC. When I read this in its entirety, I'm wondering
if we could leave out the Attorney General's opinion.
It seemed to -- to muddy it even further if we
already have the definition there.

I went back to the Attorney General's
opinion that was written in 2005 that's quoted here.
It says basically the same thing as the one above it,
but the verbiage is a little different. I'm
wondering if we -- can we just leave the 2919.11 and
then take out the OAG's opinion from 2005.

I went to the -- It looks like the OAG,
the opinion was requested specifically for the
administration of Cytotec or methotrexate, and they
mentioned in that opinion that it was to address nurses
giving Cytotec. So they just clarified further that
it's okay if it's other than a live -- I mean, if
and that it's okay to give it if there's a live birth
that's intended.

So I don't know that it helps this any.

It just seemed very -- it seemed a little convoluted
with the OAG opinion. If we just stop at the ORC,
we're -- we're recording the statute but we're not
kind of muddying that there. It also kind of takes
it out of -- that statement's out of context of the
entire opinion, so I don't know that they need to
read that entire opinion.

CHAIRWOMAN SIEVERS: Yes.

MS. EMRICH: Just some information. So
the formal Attorney General opinion was requested by
the Board of Nursing in 2005. It was specific. I
mean, the issue at that time was about nurses in
general administering a medication for purposes of
inducing an abortion and whether or not that was a
violation of 151(C). okay, of the Nurse Practice
Act.

We do utilize and refer inquiries to that
opinion because it's still a valid opinion that
is out there and published. I'm general -- From --
from -- from a staff perspective, I'm concerned or
would think it would be more -- it's there, it's
informative. I have to think that any person who's
looking at this document is looking for information,
and that's just one more piece of information that

they can look at and put into proper context when
they're looking at whether or not they can prescribe
or administer any drugs and for what purpose. So
that's just some historical context and some -- and
the staff perspective.

MEMBER ZAMUDIO: Which I totally
appreciate. I actually liked reading it. So I did
go back and read the entire thing. I think the --
the context of it applying to Registered Nurses is
maybe helpful for the Registered Nurse, but in this
and in answering this for APRNs, this is more about
administration versus prescribing.

And I know we should know that, what our
nurses can and cannot do, but I thought -- The reason
I requested the definition of abortion is, and this
is the section 2919.11 of ORC, it says that it's
defined as a purposeful termination of a human
pregnancy by any person including the pregnant woman
herself with an intention other than to produce a
live birth or to remove a dead fetus or an embryo.

We know that ectopic pregnancies are one
of the most life threatening conditions that a
pregnant woman will have, accounting for about three
percent of actual maternal deaths, and there's delays

in care at times because of who can and cannot
administer.

And they concurred, well, you cannot
prescribe Cytotec or you cannot prescribe such and
such. I've actually seen a delay where one woman was
transferred from one hospital to another, so that can
cannot end someone's life. I don't want the -- There's -- I
don't want the conflict to be evident between the OAG
who said, "Yes, RNs cannot administer this medication
versus APRNs cannot induce or induce or perform
abortions by any method." So the OAG didn't address
miscarriage or ectopics; the ORC does.

So my thought was to stop at the end of
the sentence that says -- I liked this quote too, you
added the ORC about "Abortion is the practice of
medicine or surgery for the purposes of this
section," which that's excellent to put in there
because OAG referenced that, but then maybe stop at
the end of that sentence.

And I guess if we wanted an FAQ for
nurses, for RNs to administer that medication, put
that somewhere else. The two are in conflict of each
other or at least one has a limit and the other
doesn't.

MEMBER DIPIAZZA: From an educational
standpoint reading this, it appears that it's giving
the -- I could be reading this incorrectly, but it
appears to be saying for nurses that they can
administer other than -- or in the event for
producing live birth or as a result of, right, so
could it be educational just for the APRN as a
reminder that they can administer under these
circumstances and is that important for the APRN to
know.

MEMBER ZAMUDIO: Right. The only problem
is -- This is Michelle Zamudio, sorry -- but it
doesn't include the disclaimer from the ORC for the
death fetus or embryo, in other words, miscarriage or
ectopic without the heartbeat, and those are
critically important.

MEMBER DIPASQUALE: I guess I'm just -- I'm
reading into it as terminating a pregnancy.

MEMBER ZAMUDIO: There's many methods to
do that.

MEMBER GRAHAM: So this is Margaret.

I -- so your concern is if we leave this here, the
whole idea that an APRN can prescribe to remove a
death fetus or embryo may be missed or may be
misconstrued because of what's happening, because of
what's the follow-on which really is related to the

RN versus the APRN --

MEMBER ZAMUDIO: That's correct.

MEMBER GRAHAM: -- and that might be a
safety -- more of a safety issue? So I think -- I
think we have to give that a lot of consideration
because if the person is quickly read
administration by a nurse and they're not -- you
know, they're dealing with a dead fetus or embryo or,
as you say, an ectopic pregnancy and the emergency
for that, that could be confusing. So I feel like if
we do leave that part in, it has to be better
explained.

MEMBER ZAMUDIO: Yeah.

MEMBER GRAHAM: I'm -- I'm okay taking it
out just for the purpose of safety.

MEMBER ZAMUDIO: Yeah, I've read a great
deal about this topic, and I like that we added the
medicine and surgery, that was very important, that
is, abortion is under the -- is the practice of
medicine or surgery, so that's also very clear that
we should -- that's not in our scope.

But I think this last part about the OAG,
if they go to that last sentence, you know that
employers, other boards, et cetera, not just the APN
reading this, other people can pull that sentence out

and say absolutely not, you cannot do this. But the
statute currently says that the APRN cannot perform
or induce abortion, and by abortion we mean
administering anything other than with the intent of
a live birth or to remove a dead fetus or embryo.

So I think leaving 2919.11 in there is
great. I think leaving the reference to the practice
of medicine and surgery from 4731.41 is great. I
don't think we need that last sentence, and I think
it could be a safety issue.

MEMBER DIPASQUALE: So there's a concern
this dead fetus or embryo is in -- in there?

MEMBER ZAMUDIO: Correct, yes.

CHAIRWOMAN SIEVERS: Could we leave the
link and just take out the quote?

MEMBER ZAMUDIO: We could leave
references, like if someone -- yeah.

CHAIRWOMAN SIEVERS: Like leave the link
there so they can access that, but they would have it
in the full context of that whole opinion and not
just an excerpt, right?

MEMBER ZAMUDIO: That would be helpful
and it would allow I guess the APRN to then recognize
also where it says the nurse's role, not the -- At
the time this was written, I believe much of the

verbiage said nurse. I remember this Committee
asking for it to be changed to nurse practitioner.
So I wouldn't be opposed to putting a link on there
if they wanted that. That way, it's not like we're
hiding something. It's just that I don't want to
confuse this and make this an issue with a hospital
system or an employer saying you can't treat this
miscarriage or ectopic pregnancy without a heartbeat.

MS. EMRICH: So I'm hearing to leave the
link in and perhaps just use it as a reference or --
or

CHAIRWOMAN SIEVERS: Remove the
parenthesis.

MS. EMRICH: -- yeah, yeah, remove the
parenthetical.

MEMBER ZAMUDIO: So if the Committee
feels like leaving the link would be helpful, that's
fine. My request would be that we delete that part
of the quote. It's something new that was added. I
don't -- I'm not sure that it helps clarify.

MS. EMRICH: So is there someone that
could talk about a different parenthetical?

MS. DIPASQUALE: I don't recall, but the
current direction is leave the reference to the AG
link for those who might want to read more but take
MEMBER GRAHAM: Right.

MS. EMRICH: Yeah, I understand, and we can add a lead-in to that, you know, but I do want -- An APRN also would not be -- would be prohibited from administering a medication the same as an RN would in those particular circumstances, so there is no --

MEMBER GRAHAM: Which I think is clear when it says abortion is the practice of medicine. I mean, I do think that is clear in that bulletin.

MEMBER ZAMUDIO: I like that.

MS. EMRICH: I just don't want to give any false sense of --

MEMBER GRAHAM: Right.

MS. EMRICH: -- this may be permitted if you are an APRN versus an RN, so that's my -- that is my other point, so yeah.

MEMBER ZAMUDIO: I think we have two references up there saying don't do it, so I think those are -- were clear. The 2919 and the 4731.41 are both clear, so I think for clarity and safety removing that last part is the best course.

MS. EMRICH: Okay.

CHAIRWOMAN SIEVERS: So you're still proposing to remove the whole entire thing?

MEMBER ZAMUDIO: Only from the word "See" also because... a

CHAIRWOMAN SIEVERS: Okay.

MEMBER ZAMUDIO: -- it really, the Ohio Attorney General opinion if you read it from 2005 validates the other statements which is don't do it, but the verbiage is different.

CHAIRWOMAN SIEVERS: And we would be -- the statute would be a higher power anyway in this situation.

MS. EMRICH: It -- it's -- I mean... a

MS. DIPASQUALE: I -- Oh, I'm sorry.

MS. EMRICH: No, no, please go ahead.

MS. DIPASQUALE: I mean, an AG opinion has the force and effect of an elected state -- state office holder has opined in his official capacity.

There's nothing outdated or invalid about the AG's opinion and it's congruent with 151. The only question is if people feel that it invites confusion.

CHAIRWOMAN SIEVERS: It doesn't add anything. So can we agree to remove the whole thing after "See" -- starting with "See also"? Any objection to that?

(No Response.)

MEMBER ZAMUDIO: I do -- I want to say thank you for adding those definitions. I think it
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<td>1. just needs to be very clear to the Nurse Practitioners not to do that.</td>
<td>1. interpreted and applied to some of the questions they asked.</td>
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<td>2. CHAIRWOMAN SIEVERS: All right. Anything else on that page?</td>
<td>3. MEMBER DIPAZZIA: Well, I wouldn't -- I don't -- I don't know if I'd recommend using the word interpretive because you can interpret one way, I can interpret another. These responses are based on the rules of the State of Ohio, and they are what they are, right?</td>
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<td>4. MS. EMRICH: So just for clarity, it will end with the closed parenthesis that ends of section 4731.41 of the Revised Code?</td>
<td>5. MEMBER ZAMUDIO: Not all of them.</td>
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<td>6. CHAIRWOMAN SIEVERS: Correct.</td>
<td>7. MEMBER DIPAZZIA: Well, no, not all of them, but I mean... so I don't know that I'd use interpretive. Here's how we apply the Nurse Practice Act to the following questions or... I mean, I...</td>
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<td>8. MEMBER ZAMUDIO: When that's printed out, Lisa, is that a link where they can click on 4731 or would they -- they just need to go research it?</td>
<td>9. MEMBER BRAZEE: Kim Braze.</td>
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<td>10. MS. EMRICH: That would not be a link.</td>
<td>11. MEMBER DIPAZZIA: I don't know what the right word is.</td>
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<td>12. MEMBER ZAMUDIO: Okay. I was just curious.</td>
<td>13. CHAIRWOMAN SIEVERS: Kim.</td>
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<td>14. MS. EMRICH: We could have the AG opinion in there as a link which it is but not -- that code is not.</td>
<td>15. MEMBER BRAZEE: 1 -- I feel that the statement is easily interpreted, I believe. I believe this is a statement that these are frequently asked questions related to the Nurse Practice Act and administration -- administrative rules for APRNs. And I think that one can assume that somebody could read these questions and find them applicable to their current situation or not. I'm</td>
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<td>16. CHAIRWOMAN SIEVERS: Other comments?</td>
<td>17. MEMBER ZAMUDIO:</td>
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<td>18. MEMBER ZAMUDIO: Michelle Zamudio, sorry. So I had just two more. Where we lead into the FAQs, the many years of work --</td>
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<td>22. MEMBER ZAMUDIO: It's at the bottom of the new numbered Page 8.</td>
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<td>1. MEMBER ZAMUDIO: I think as important as these are, we should highlight those FAQs as a reference for them, and my thought was to say something along the line that these are interpretive examples added for clarification, something in there to -- to get their attention to say these FAQs are examples of how we are going to interpret these other statutes and rules, some -- don't know if everyone thinks that's as important as I do. Instead of just &quot;Below are the FAQs, let's make a statement there,&quot; but that these are interpretation or interpretive examples of how to apply the 4723.</td>
<td>1. not sure if we need to further clarify what we're doing because, again, with all of these questions, there's always the ability to evaluate them in your current situation, so I'm not sure we need to change that is what I'm saying.</td>
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<td>2. MEMBER GRAHAM: To make it a stronger --</td>
<td>3. I would be supportive of either way, but I think that it's -- it's very clearly stated that these are frequently asked questions and these are the responses in relation to Nurse Practice Act, just -- just the comment.</td>
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<td>4. MEMBER ZAMUDIO: Yes.</td>
<td>5. CHAIRWOMAN SIEVERS: I would agree. I don't think there's a question about what they are.</td>
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<td>5. MEMBER GRAHAM: Stronger than just --</td>
<td>6. I mean, I think we all probably have seen frequently asked questions.</td>
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<td>6. CHAIRWOMAN SIEVERS: So you would on the bottom of Page 8 where it says FAQs add...</td>
<td>7. MEMBER ZAMUDIO: And I think they would be very appreciated.</td>
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<td>7. MEMBER ZAMUDIO: Is there a better word than what I was thinking, I was thinking interpretive examples, but I --</td>
<td>8. CHAIRWOMAN SIEVERS: I don't think we need to add too much language in there.</td>
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<td>8. MEMBER DIPAZZIA: But these aren't really interpretive, though.</td>
<td>9. MEMBER ZAMUDIO: Okay, thank you.</td>
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<td>9. MEMBER ZAMUDIO: Well, applying or active. I don't know the right verbage, but I think a statement there that this is how the ORC's being</td>
<td>10. MEMBER BRAZEE: Less is better sometimes.</td>
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<td>10. MEMBER DIPAZZIA: But I --</td>
<td>11. MEMBER ZAMUDIO: Thank you.</td>
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<td>11. CHAIRWOMAN SIEVERS: I do have a comment, though. When it says NPA, did we somewhere else in this document already say what Nurse Practice Act</td>
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MEMBER DIPIAZZA: Yes.

CHAIRWOMAN SIEVERS: Okay.

MS. DIPASQUALE: Sherri, could I add something? It relates a little bit back to something you said on the last topic but really is relevant to the entire document. On Page 17 at the very bottom, there is a link to the Ohio Revised Code. So we have not embedded a link to every Code section that's cited because the whole document would be linked to law and rule, but at the bottom there, you can see that there's a link.

And also if you go to the Board's web page, there's a law and rules page, and that will also take you to the Ohio Administrative Code, Ohio Revised Code. So I just wanted you to know that, that is in the document, but it's one spot for all references.

MEMBER ZAMUDIO: Thank you.

CHAIRWOMAN SIEVERS: All right. Looks like the next addition is Page 11 with the Consult Agreement.

MEMBER ZAMUDIO: I thought that part was great.

CHAIRWOMAN SIEVERS: All right. Then I think if I'm following correctly, Page 17.

MEMBER ZAMUDIO: Sherri.

CHAIRWOMAN SIEVERS: Yes.

MEMBER ZAMUDIO: This is Michelle Zamudio. I was going to comment on Page 11 under where we got to scope of practice FAQs. The Women's Health Nurse Practitioner, I tried to read this as though I don't already understand an issue. When those two questions are linked, it talks about the management of an adolescent or an adult female, I went back to the NCC guidelines and also to the NPWH comments. I tried to reach their representative but wasn't able to to clarify this, their guidelines do discuss puberty, premenopause and postmenopausal care.

So I feel like the answers -- if we answer both of those FAQs together, it's saying that at the top of Page 12 the answers that the NCC 2021 Candidate Guide, Women's Care -- Health Care Practitioner discusses the care of women and does not address the topic of pediatrics, children or growth and development, but it actually describes women in all of their core competencies as pubertal, that's the word.

So I'm worried that this answer makes it sounds like that a Women's Health Nurse Practitioner can't see adolescent oncology patients, and we know that's a common practice and is covered in their NCC recommendations.

I went through and clicked on -- clicked on their core competencies, and it -- it's also a tested material for them. So I wasn't sure if we can maybe pull those two questions out separately because one addresses age and one addresses taking care of a male.

And the answer for the male was appropriate. The male is tested by a Women's Health Nurse Practitioner under physical exam, STDs or STIs and infertility. So they can perform physicals and order tests for men in that situation, and that's out their NCC guidelines and that's addressed in the answer appropriately, but maybe answer those questions separately?

CHAIRWOMAN SIEVERS: Or since they're both scope, could we on this Page 12 at the top, is there something you could have as a clarifier when it says Growth and Development and add in the pubertal? Is that the only thing you think is missing?

MEMBER ZAMUDIO: Yeah, pediatrics and children are definitely not in there. Growth and development, I think that's in a lot of our background, and that's broad -- that's a broad topic, so they do talk about development related to puberty and adolescent gynecology and how to -- that there -- one of their core competencies was menstrual disorders. And so is a woman defined as when they reach puberty? I don't know if we want to hang our hats on that word "woman" and then limit their scope in here.

MEMBER GRAHAM: So this is Margaret. I think when I think about puberty happening at the age of ten, many people are going to consider them children, but yet if it is menstrual disorders at the age of ten, the Women's Health Nurse Practitioner can definitely do that. So -- so I think how do you define children? You know, are children considered up to the age of 21, the way we think of our Pediatric Nurse Practitioners or are children at the -- for Women's Health at the age of menarche or just prior to that?.

MEMBER DIPIAZZA: Well, is it better to have a definition of puberty versus age?

MEMBER ZAMUDIO: Yeah, my concerns were just I didn't want to limit them from the -- There are Nurse Practitioners who are -- Women's Health

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Nurse Practitioners who have pre- -- or have pubertal
oncology patients and do egg preservation. So
there -- this is -- it's a common practice that they
practice adolescent gynecology. So perhaps we could
say the words prepubertal since their NCC guidelines
started at puberty?

MS. EMRICH: Since the question itself
pertains to gender and not age, I'm wondering if we
could answer the question and then just refer to those
nurse practitioners to NCC's guide for information
regarding age or developmental -- you know,
developmental age for -- for -- for females.

MEMBER GRAHAM: So the second question --
MEMBER ZAMUDIO: The first question is
age.

MS. EMRICH: Okay, got it. Is there a
second --

CHAIRWOMAN SIEVERS: From adolescence.

It's the first part.

MS. EMRICH: Oh, I hadn't gone down that
far. I hadn't gone down that far. Sorry, sorry, I
didn't go down that far.

CHAIRWOMAN SIEVERS: Yeah, but it sounds
like we're just missing -- What if we just add -- I
mean, I know it's in quotes but if we added

prepubertal, right, Michelle, because would you take
care of a patient who had -- who was not pubertal at
all for anything? I mean, would you do a child who
had like a precursor to puberty or something like
that? You probably would not. I would get an
endocrinologist.

MEMBER ZAMUDIO: So, and just to -- for
clarification, as a nurse midwife, my role and scope
is different than the Women's Health Nurse
Practitioner.

CHAIRWOMAN SIEVERS: Okay.

MEMBER ZAMUDIO: So the Women's Health
Nurse Practitioner is, from everything I could read,
I'm happy to go get more information, but from NCC
and from the NPWH, their -- the education and the
examination questions begin at puberty. Would there
be perhaps times when it was prepubertal but related
to gynecology, like precocious puberty? I don't
know. I'm thinking that would be endocrinology or at
least a team approach. Perhaps they would do a
physical.

CHAIRWOMAN SIEVERS: A topic of
prepubertal pediatrics or children.

MEMBER GRAHAM: This is Margaret. Could
we just go to that question when it says the scope

and practice and are they limited to managing the
health care of less than an adult female patients,
could we make that are they -- is it within their
scope to manage adult and adolescent patients, take
out that "can they manage male or pediatric patients"
because we address that, the male patients, in the
next question, so that we separate those out?

So we just say are they -- are they
limit -- you know, are they -- instead of are they
limited, are they -- is it within scope for them to
practice health care of adolescent patients. And
then our answer could be prepubescent forward o-
however it's said in that section. I think -- I
think we're confusing it when we have a male --

MEMBER ZAMUDIO: I do too.

MEMBER DIPIAZZA: And rely on that
answer.

MEMBER ZAMUDIO: That was the point.

Good summary. And do we need more information about
the prepubertal? I'm going on what information I
could get with the research. Like I said, I did call
the NPWH. I haven't gotten an answer yet, but
perhaps we could get more information on that.

I'm envisioning that precocious puberty
or premature menarche patient who needs a gynecology

sensitive exam by a Nurse Practitioner and the
endocrinologist managing medications, that perhaps
that's a team approach.

I'm just basing my -- My concerns were
that we were putting the questions together and that
we were limiting them by saying that it doesn't
address the topic of pediatrics, children or growth
and development when, in fact, it mentioned that in
some of that in different verbiage in the NCC and the
NPWH.

CHAIRWOMAN SIEVERS: Uhmm....

MS. DIPIAZZA: So -- Oh.

CHAIRWOMAN SIEVERS: Go ahead.

MS. DIPIAZZA: I'm sorry, did someone
else have something? Okay. So I think what I'm
hearing is it sounds like there's consensus to just
respond to these questions separately because they
address two separate things, gender versus age
range or developmental range which is what I think
most of the standards are moving toward, away from
any kind of age.

And then reword it as opposed to are they
limited -- is it within the scope to manage. And
then kind of echoing what Lisa said, the -- the
response can very much direct people to the current
<table>
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| 1 NCC test plan, et cetera, which itself can change over time. | 1 sexual and reproductive health, is that a broader --
| 2 So it's very good for us, I think, in | 2 I don't -- Would that be a broader spectrum? I think it would be. |
| 3 responding to questions to direct people to the thing that isn't static, it can change. So I think I'm hearing what everybody is -- some consensus on | 4 "MS. EMRICH: Yeah."
| 4 crunching it that way? | 5 MEMBER GRAHAM: And so I feel like that we should do the focus on what they can do. They can do STIs and they can do infertility. |
| 5 MEMBER ZAMUDIO: Agreed. | 6 MEMBER ZAMUDIO: I don't remember if it was STIs or sexual health. |
| 6 CHAIRWOMAN SIEVERS: Is that what we're proposing? | 7 MEMBER GRAHAM: Oh, okay.
| 7 MS. EMRICH: Yes, we're going to respond to both questions individually, and then with the developmental specific question, we will generally refer them to NCC's candidate handbook and to that reference, to that. | 8 CHAIRWOMAN SIEVERS: But they couldn't -- sexual health, they couldn't like prescribe Viagra or anything, right? |
| 8 MEMBER ZAMUDIO: Michelle Zamudio, Lisa, on the -- on the question about the males -- | 9 MEMBER ZAMUDIO: Here it is on the NCC guideline under their core competencies in section 4, it says, "Males' sexual and reproductive health," and underneath that it says "sexuality, contraception, infertility and STIs." |
| 9 MS. EMRICH: Yes. | 10 MEMBER GRAHAM: Oh. That's a broad category. |
| 10 MEMBER ZAMUDIO: -- I'll get your opinion on this. It -- it says that they -- on Page 12 at the top, it says, "It addresses the diagnosis and management of male patients only in the context of sexual and reproductive health." Does it matter if it's covered under like physical exam? They did -- |
| 11 | 11 |
| 11 BOARD MEMBER KEELS: Does that get into gender identity issues -- | 11 |
| 11 MEMBER DIPIAZZA: Is it assumed that you would have to do a physical exam to get the diagnosis of sexual -- | 12 MEMBER DIPIAZZA: I would leave it being as sexual and reproductive and let them vote for that. |
| 12 MEMBER ZAMUDIO: I try to never assume anything. | 12 BOARD MEMBER KEELS: I can't vote for anything, but I would stick with that, whatever they were there. |
| 13 MEMBER DIPIAZZA: I'm thinking... | 13 MEMBER ZAMUDIO: Well, sexual would cover sexuality and STIs and reproductive would cover both contraception and infertility. |
| 14 MEMBER ZAMUDIO: I just wanted to be sure -- to be sure we're thorough. So do we need to write physical exam in there is the question. | 15 CHAIRWOMAN SIEVERS: And we're going to link back to that document too, right? |
| 15 CHAIRWOMAN SIEVERS: Tell me again exactly where you are. | 16 MEMBER DIPIAZZA: Yes, yes, yes. |
| 17 CHAIRWOMAN SIEVERS: Page 12. | 18 |
| 18 MEMBER ZAMUDIO: I should say that different, Page 12, the answer to the question that we were talking about already. It says, "It addresses the diagnosis and management of male patients only in the context of sexual and reproductive health." | 19 |
| 19 MEMBER GRAHAM: So this is Margaret. I have a question about in the context of sexual and reproductive health, what they can do is manage STF -- STIs and infertility. If we use the term |

10 (Pages 37 to 40) Armstrong & Okey, Inc., Columbus, Ohio (614) 224-9481
MS. EMRICH: This is Lisa. We also provided just an alternative phrasing of the same information, whichever you would prefer, so...

MEMBER DIPIAZZA: I like how it's worded because to me one of the things I've always struggled with is does Ohio Board of Nursing recognize the Consensus Model, and so I think this -- while we know not everything is in rules or law, that part of the Consensus Model, that Ohio is recognizing the Consensus Models out there, I thought it was very helpful.

CHAIRWOMAN SIEVERS: I like the first comment, the first line in the paragraph.

MEMBER ZAMUDIO: It's Michelle Zamudio. So I -- I liked -- I appreciate that we're mentioning it because prior to joining this committee, I didn't know about it, so it's been educational for me.

At the end of that first sentence where it says, "It is not Ohio law or rule," it doesn't say we haven't achieved it. It says it's a separate document, okay. So it's saying this is not an Ohio law or rule. Is that where we should put the disclaimer "Nor has Ohio achieved all elements of the Consensus Model"?

Because the first sentence says this is the Consensus Model, but it's not in Ohio law, so I now we -- I think we should add something in there at the top of it if they're reading to say, "Nor has Ohio achieved all elements of the Consensus Model."

CHAIRWOMAN SIEVERS: But I think it's a qualifier for the next sentence. You go on. It says, "The Board's Advisory Committee recommended to the Board, the Board agreed the Consensus Model approach as to role in population is consistent." So I think it's a disclaimer for that next sentence. I mean, it would be duplicative, but I guess you could say up there instead of saying it is not in Ohio law, well, you could say there again not all elements are consistent with Ohio law or rule, just to be crystal clear twice, but, I mean, it's a little redundant but it just...

MEMBER DIPIAZZA: I wonder -- I wonder if stating just from a clarity standpoint if -- if switching the first and second so where we mention the Consensus Model, right, APRN regulation, it's a national model that explains the broad schematic for APRNs and then end it with, "This is not an Ohio law or rule." Just -- It switches -- So you put it forward as it's a national model but it's not -- it's not necessarily written in law or rules.

MEMBER ZAMUDIO: I think when you're writing these, you have to follow general education guidelines and not everyone reads to the last sentence, so I think putting that at the top for me just highlighted that the Committee -- the Committee recommended that we follow the Consensus Model and here's what it is, but it's not an Ohio law or rule.

But Sherri, to your point, I do see where it's a -- it's a lead-in to that next sentence, "It's a national model" --

CHAIRWOMAN SIEVERS: The whole paragraph is like describing what it is.

MEMBER CONTRERA: That's actually what the question is.

MEMBER DIPIAZZA: What is it, right.

CHAIRWOMAN SIEVERS: It says it's not a law or rule.

MEMBER DIPIAZZA: I'm just glad it's in there for recognition.

MEMBER ZAMUDIO: Do we need the part where it say the Board's -- from the Board's Advisory Committee down, do we need to write what the debates were?

MEMBER DIPIAZZA: I think it's important, though, that it's in there --

MEMBER BRAZEE: I do too.

MEMBER DIPIAZZA: -- because we spent three plus years talking about this.

MEMBER BRAZEE: I do, and I think that people need to see that the Advisory Board is working on their behalf and having these discussions mutually as a group. So I think that although it is wordy and I know the education rules, hopefully the people reading this are a little more educated than the fifth or sixth grade level that we write to, right so certainly they should in their best interests read the entire paragraph.

So in my opinion, I think the very first one is worded very nicely. It's succinct. Yes, it's a little wordy afterwards, however, it supports the efforts of this Committee.

MEMBER DIPIAZZA: Right.

MEMBER BRAZEE: So...

MEMBER ZAMUDIO: So I unfortunately wrote -- I drew a line through something and now I can't read it. In the middle of that paragraph where it says, "While recognizing that not all elements are -- of the Consensus Model are consistent with law and rule," should that be a new paragraph then? Because maybe that would help break up the here's...
what we've done and here's what -- here's how we
answered the question and then here's the background
information.

CHAIRWOMAN SIEVERS: So just starting it
there, the paragraph.

MS. EMRICH: Sure.

MEMBER BRAZE: There's your writing and
pointing to education, Michelle.

MEMBER ZAMUDIO: There you go, it's at
the top.

CHAIRWOMAN SIEVERS: Anything else on
this document?

(No response.)

CHAIRWOMAN SIEVERS: Yay, that was the
easiest we've gotten through that in forever.

Good morning, Mr. Dilling, I moved to the
front of the table, so welcome.

MS. EMRICH: Could I please introduce
Charity Robl. Members of the Advisory Committee, I'd
like to introduce you to our new Interim Executive
Director Charity Robl.

EXECUTIVE DIRECTOR ROBL: Hello.

MEMBER ZAMUDIO: Welcome.

EXECUTIVE DIRECTOR ROBL: Nice to meet
you all. I'm just here to observe. I'm learning a

lot more about everything that happens with the
Board, so thought I'd come and join today but really
great to meet all of you.

CHAIRWOMAN SIEVERS: Yes, thank you.

MEMBER ZAMUDIO: Thank you.

CHAIRWOMAN SIEVERS: Okay. So
Mr. Dilling with our legislative report.

MR. DILLING: Hi. Good morning.

BOARD MEMBER KEELS: Hi, Tom.

MR. DILLING: Good to see everybody.

Were you provided the last legislative report?

MS. EMRICH: September.

MR. DILLING: September? Okay. I kind
of give the Board in those reports the most -- the
bills that are kind of percolating at that moment in
time. So for the November Board meeting, we plan to
have kind of like a year-to-date memorandum. So I
will have -- ask Chantelle, Lisa and Anita to follow
up with you all and provide you with a copy of that.

It may be a little bit more expansive and I'll use
that to go through, you know, today's report.

Hopefully that'll -- that will help you as you go
through.

I would want to start, I guess, with
House Bill 122 which is the telehealth bill. And to

me, the telehealth bill is more of a -- it's more of
a reimbursement bill than anything. Obviously you
are all doing telehealth practices now, but as
telehealth expands, there are new practices and on --
licensing boards always have these grounds for
discipline that are intended to minimal standards of
care. So what are minimal standards of care?

They're often not defined. We do not have really
defined rules with respect to telehealth.

Now, the Medical Board, which the APRNs
have to follow those rules because you're in a
collaborative practice with, you know, the physician,
and you're bound by that rule and the extent of their
practice, they have a bit more expansive rules, but
they also have this FAQ document on their site too.

It's like two or three pages of rules and
then eight pages of FAQs. So you've got the feds
involved as well, and it is rather confusing,
especially in this growth period during the pandemic
where people are taking on new issues.

The telehealth bill significantly allows
for, gives specific authority to all the boards to
draft up rules with respect to telehealth. So
obviously there's going to be the overlap. You've
got the Venn diagram if you wanted to to explain, you

know, the interaction between the APRN and the -- and
the physician, but I think that that is in allowance
for this growth and, you know, where -- where rules
are needed, but that will come into the future.

They're not answering these questions up front, you
know, in the telehealth provision.

The reimbursements I think split too
between Medicaid program that Ohio administers, as
well as general allowances too and, again, partly
because the state spends a lot of money on Medicaid,
and so they have to make certain that they can't pay
for, you know, what they are allowing. So it's a
growth area.

Just want to point that to your
attention, and it's something that we will see, you
know, on into the future, but for the most part, that
bill is to my way of thinking drafted rather broadly
and it is moving, though. So it's over in the Senate
Health Committee, and I believe that they're having
another hearing this week, and they're going to take
on some amendments too. So conventional wisdom would
tell you that sometime this year by the end of the
year, that that bill will become law.

MEMBER ZAMUDIO: Tom, can I ask you a
question?
MR. DILLING: Sure.

MEMBER ZAMUDIO: Limited understanding here. So the bill kept mentioning synchronous and asynchronous telehealth. Is that e-mail versus us being on video? What is that?

MEMBER DIPIAZZA: Telephone.

MEMBER ZAMUDIO: Telephone is not synchronous, is that what they're -- I just wasn't familiar with that verbiage.

MR. DILLING: Right. So in the old days and maybe today too, asynchronous would be like I believe filling out a form, you know, like you fill out something, you've got these questions and so forth, and some people may prescribe certain types of drugs, you know, that way and so forth. And then we get into that standard of care along with what are those laws and rules that might specifically apply to prescriptions and so forth.

Where synchronous, I think that they're trying to talk about -- you know, you're on the phone or you're on a video and it's happening in time there, and, again, you like to think that it's tied to standards of care so that you have the ability to ask that person questions, there may be you want to have that ability to actually see that live, whatever -- whatever you're treating, you know.

I'm guessing too that like asynchronous stuff might be for pictures of things that are sent and I'm throwing out maybe dermatology would be something where -- along with a synchronous something, you could use synchronous --

MEMBER TYSON: Asynchronous would also be like, you know, in the world of telehealth which I do a lot of is somebody e-mails you through a HIPAA compliant patient portal and they're saying, "I'm having a side effect of this medication" and you end up spending a great deal of time reviewing their chart and you decide you want to bill for that service, you respond to them asynchronously and so, you know, you can bill for those times, so...

MEMBER ZAMUDIO: I was like I generally understood what the word meant, but the concept of billing for that was intriguing.

MEMBER TYSON: Right, yeah.

MEMBER CONTRERA: Through My Chart.

MEMBER ZAMUDIO: Yes.

MEMBER CONTRERA: My daughter has like an app on her phone where she messages her NP and gets things done that way without ever connecting in realtime.

MEMBER ZAMUDIO: Right. It was interesting to me that people were -- it was mentioned in the compensation bill.

MEMBER CONTRERA: Right. So now you can be able to bill for things, some things done in My Chart.

MEMBER ZAMUDIO: Interesting. Thank you.

MR. DILLING: Some people that know my history on it, they'll come up to me and start talking to me about it, you know, "Yeah, but Tom -- yeah, right, but I'm on an app, but I've never seen my doctor and they're giving me this such and such." Things have, you know, grown by leaps and bounds as -- as the standard for, again, for -- for certain aspects of care. That's where the rule making will come in in the future probably.

Again, insurers have the right to reimburse you or not reimburse you for the things that you do, so I've had this debate first. What comes first, reimbursement or standards. Sometimes reimbursement leads to, you know, written standards at least or reflect those -- those standards of care.

MEMBER ZAMUDIO: Thanks.

MEMBER TYSON: Can I just ask a --

MR. DILLING: Sure.

MEMBER TYSON: -- a quick question, and this is just I guess an opinion question, you know. Right now there is what is called parity, you know, versus in -- whether it's telemedicine or whether in person. Do we see -- now that that horse is out of the barn, do we see that going away or do we think it will be maintained?

MR. DILLING: Yeah, that's hard for me to predict, you know. From a -- from a regulator perspective, I don't really understand the ins and outs of reimbursement models and so forth. I will tell you I've been in enough meetings where clearly years ago there were certain groups that wanted to push further into the telehealth, but health care is a business, right. So you've got to be able to shift your costs and so forth. And that's part of the interplay and part of the evolution, is to -- to be able to do it. The pandemic kind of forced that issue --

MEMBER TYSON: Right.

MR. DILLING: -- issue in many ways, but I guess from a global perspective, isn't reimbursement to some degree when you get into the nitty gritty, that reimbursement's based upon all kinds of a series of questions on how you do your
work, who else is helping you in the work, what's the
overhead, you know, for your office and so forth.
You would think that you had -- you might
have parity at the moment but somebody's going to go
in there and go, "Why are we paying you, you know, at
that rate. We should be bringing everybody down.
And over on this side of the equation, maybe we
should be bringing some people up in this." And I
think that that's probably what you'll get into the
future. That's economics but, again, a part of
health care today.
MEMBER DIPIAZZA: I actually have a
question, but CMS actually has some open period for
comment too about reimbursement because they came out
for their rules with telehealth just working in the
outpatient space. They'll likely reduce the
reimbursement because of the cost of care being much
cheaper. You no longer have brick and mortar or
support staff or that kind of stuff which they take
into account.
But I have a question about the
telehealth bill and disciplinary actions. So if I am
seeing a patient in Florida through telehealth,
advise event, and the board there decides to
discipline me, does the Board of Nursing as well,
sometimes that's lost, you know, in the shuffle. You
always have to abide by, you know, what the state's
laws are.
MEMBER DIPIAZZA: Where the patient's at.
MR. DILLING: Yeah, where we're in Ohio,
yes, where that -- that patient has, that's what
we've always addressed, and I believe that crossed the
50 states. It's probably a place that you start
with.
But California, if they're running fraud
out of some type of health care center there that's
going across there and they say, "Well, we don't have
a California license, all these patients, we're not
treating any California patients, it's all being done
by the outside," somebody's coming in and stopping
them and going to assert jurisdiction based upon the
acts that are occurring in that state.
So whether it's acts occurring or action
that a licensing board takes, there's generally going
to be something that attaches, you know. Then you
get into complicating factors of how to get that
evidence and either do you have the right to go in
and subpoena documents from -- from these different
places. And some of that is contained in these
compact agreements of which Charity right now would

will they discipline me here in Ohio if I'm licensed
in Ohio too? Do we know that?
MR. DILLING: There's a difference
between will or possibly could. And so that would
take you back to a more traditional example, would be
some board in another state where you're licensed
disciplines you but you also have a license here in
Ohio. We have that jurisdiction to take action based
upon that other action. Now we're into the compact
licensure and that gets kind of complex as to you
know, who's investigating when and what the effect of
that licensure action is here.
But basically the same I like the term
schematic works, you know, in both instances. We
would -- we have some kind of jurisdiction, and --
and we'll see how those, you know, are resolved, but
that's a big debate in the whole telehealth universe.
And I believe this bill says if a patient's here in
Ohio, the place where the patient is, you know, is
where that action is occurring.
But realistically if you're in California
and you're reading that x-ray, you're also practicing
in California. Just because you’re practicing on an
x-ray that was sent to you from Ohio doesn't mean
that you're not also practicing there, okay. So

be -- as the Director would be sitting on that group,
you know, in the way that people are
operating within that agreement.
So, yeah, it's a little bit more
complicated world, but, again, it's things that are
being kind of filtered out as they're laid out there,
but the practical aspects of them are kind of being,
you know, filtered out.
I always ask people as like where do you
get taxed at? Who's being taxed in this situation?
You know, no -- nobody's given me an answer yet or at
least one that's -- that's learned, you know, so God
only knows.
I would -- I would leave you with... so
the Medical Board rules that are governing you now in
these telemed rules are more based upon years ago
when it was more simple as to who the bad actors were
and how they were doing it, you know, by
telemedicine. There -- there were statements as to
before prescribing to somebody, you need to see them
first, okay, and some of the stuff might even be
couched in those terms.
That's the big one that's being changed,
you know, now. What does seeing you mean over
synchronous or asynchronous and, you know, all of

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that, but you know, back then at the start of this,
there really were people in Ohio who as physicians
were prescribing to people and you'd be on the old
computer and typing away and answering a form and
then they would send you some type of drug that --
that -- that you wanted and said that that's not
right.

Ohio was very aggressive back then in the
Medical Board and the Pharmacy Board took out some of
those guides. So we were seen as kind of not a place
to move to, you know, at the beginning of this. And
I think that the Medical Board remained tight to that
rule, but, again, that's -- that's evolved over the
years, but it still has that kind of backbone to it.

And that's something I think you'll see
in this next generation as things kind of move along
or be more expansive in terms of what they're trying
to do and develop and how they -- how they regulate
as well.

Moving on to House Bill 138, I think,
boy, I for one am very happy to finally see this, and
this -- this -- this is more about the APRNs were on
these DNF -- DNR orders when they changed those laws,
when -- when they changed them and then there was
rule making through the Department of Health on

somebody forgot to go into the EMS statutes and say
that the EMS could listen to or take the orders from
an APRN.

Even though everything else in -- in --
in this mix was -- was focused that way, that wasn't
there. So all their implementation kind of took a
dive when the EMS personnel couldn't establish that.
It was actually a physician who had given this order
and not the APRN who they were dealing with probably
on a more regular basis.

And that occurred a couple years ago, and
you might remember there were articles in Momentum
and, you know, those rule changes and so forth.
They're getting around -- That bill will pass before
the end of the year.

Along with that bill, the EMS scope can
be done by rule or enlarged on. I shouldn't use the
word enlarged. Certain aspects of the scope can be
done by rule of the EMS board. And so I've had some
APRNs come back and ask me about "Why's that? Is
that a bad thing" and so forth, you know. Like
that's a legislative thing.

Most of the legislation on scopes is done
in statute, but I said you have to remember that in
the rule making process, there's public hearings.

Those -- those rules have to go through JCARR and the
Common Sense Initiatives through the Governor's
office. So they're asking a lot of questions as to
is this consistent with the statutory grant of scope
of practice and what you do and so forth.

So from that perspective, I'm not worked
up like I think a few individuals may be just because
that's a kind of a national thing too. Whenever
people bleed into other people's scopes or do things
that are different, you know, things evolve in the
nursing practice, they're going to evolve in other
practices as well, and there's going to be a
spillover. So, again, I just want to make you aware
of that, but, you know, to me, that's not a big deal.

142 is the doula services, and we have
talked in the past here in Committee about that.
Unfortunately for the doula services bill,
Representative Crawley became a Franklin County
Commissioner, and so when that happened, she kind of
fell off. And she was the main -- It was a
bipartisan bill, but she was the one that the other
sponsor let kind of drive the bill and talk to
different people and so forth. Now she's gone and so
the sponsor is trying to pick up on this.

And at the moment, they were focused on

the Nursing Board being the house of the -- the doula
regulation even though, again, it also encompasses
Medicaid and, you know, other state agencies. I -- I
talked with the other sponsors -- the other co-sponsors
with Representative Franklin's office, and so they're
looking into the background of it, and we shared some
questions in that recently.

I don't think it's going to happen at the
end of the year even though it had a hearing, and it
did have support from like OSU and the Cleveland
Clinic and, you know, others came in and said, "Hey
this is going to help us out in the these areas." I
don't think there's a -- too much of a question about
that.

Again, it's money too. And if you put
yourself in the shoes of the legislator, before they
start saying, "Okay, go ahead and do this," they want
to say is it working and is it working the right way
and -- and so forth. I think that they're probably
in that zone.

Hey, it could all of a sudden pop up and
move. I'm just telling you that this kind of slowed
things down a little bit; whereas, you know, in June,
July when I reported back, they seemed really hot
about it, and we went in and answered some questions
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for them and asked some questions. We just haven't
1 got those -- got questions answered yet.
2 176 is the -- they revised the athletic
3 training laws and increased their scope of practice
4 some. I just wanted to point you -- to you the
5 language that will authorize the athletic trainer to
6 practice -- continue to practice under the referral
7 of the Certified Nurse Practitioner. That is law.
8 I would say that after the fact, I can
9 tell you that that statute wasn't really written all
10 that well, you know, either in terms of how far an
11 athletic trainer -- who they should be taking those
12 orders from and referrals and that.
13 But the athletic trainers were always
14 very deferential to try to make practice work, and
15 they knew that these collaboration agreements were in
16 effect and they said we're going to tie in and allow
17 referrals to come directly from the APRN as coming
18 through that physician who they're collaborating with
19 and never forced an issue that probably legally could
20 have been forced if they wanted to, so we appreciate
21 that.
22 They did come to the Board a long time
23 ago and kind of asked them, "Can you help explain how
24 everything works," and they seemed more than happy
25
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with one of her bills, and so potentially possible
1 that that's another reason why we haven't seen too
2 much of --
3 MEMBER TYSON: Are there -- are there
4 passionate, aspiring people to kind of fill in their
5 shoes and fill the gap or is there a lack thereof?
6 MR. DILLING: Yeah, I would say you've
7 probably have to go back to the APRN association, you
8 know, and more of the grassroots proponents to that to
9 see, you know, how they want to handle that. That's
10 not -- This is not a bill that the Board can lead on,
11 although we are an interested party and we've, you
12 know, given counsel at times but not as to, you know,
13 how to move that directly. In fact, you tell me.
14 Who's a member of the APRN association?
15 (Hands raised.)
16 MR. DILLING: Who's your --
17 MEMBER TYSON: 1 -- I just haven't heard
18 anything. It's just been radio silence from my end
19 of things, so I was --
20 MR. DILLING: Yeah. Who -- who's your
21 legislative counsel now because Andrew has left?
22 CHAIRWOMAN SIEVERS: It's Porter Wright.
23 MR. DILLING: Okay. So I have -- Nobody
24 from Porter Wright's asked us any questions or
25
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introduced themselves, you know, at this period of
1 time, so we might be in that zone where -- and I
2 believe you guys just had an annual meeting too in
3 October, so they might -- very well might have been
4 talking about these type of things, and we'll hear
5 from them, you know, in the near future.
6 MEMBER DIPIAZZA: You know, when I -- I
7 had a question about House Bill 176, but --
8 MR. DILLING: Okay, I'm sorry.
9 MEMBER DIPIAZZA: -- when I met with
10 Allison Russo about the APRN bill, she had -- she was
11 pretty adamant that it wouldn't move because of
12 Gross, that no one could even tolerate her walking
13 into the room based on her Covid bills that she's
14 introduced.
15 MEMBER GRAHAM: She's no longer on the
16 House Committee, so that makes her less...
17 MEMBER DIPIAZZA: Yeah, less of an issue.
18 MEMBER GRAHAM: I mean, it makes her
19 response less effective, thank you.
20 MEMBER DIPIAZZA: Right, right.
21 MR. DILLING: Yeah. Well, I can simply
22 say, you know, this is politics, I mean, you know, at
23 the state legislature, so I don't think we need to go
24 any further than that.
25
16 (Pages 61 to 64)
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MEMBER DiP!AZZA: In regards to House Bill 176, the bill would authorize the athletic trainer to practice under the Certified Nurse Practitioner. I'm curious, because we have to practice in light practice, could you have a collaborative with an athletic trainer if your physician, your collaborating physician, didn't or did not want, and what's that hierarchy look like?

MR. DILLING: Yeah. Well, I would simply say that -- or try to simply say that the way the statutes are constructed, yes, you still need -- you know, this is under the referral, and you still need to have a collaborative arrangement. And your practice is tied to that position and you're supposed to be in the same or similar practice area.

And just as any other type of practice, you've got to be linked somehow, right, and that's not changed by this bill. And 176 too is -- there's the level of referral that's under the standard scope, but they can do some more things, the athletic trainer, under the order of a physician that's not coming from the APRN, you know. They -- they have this -- they created a collaboration agreement. Basically, you know. Some people were out there crying, you know, that that is, but, again, it's also a model for an evolutionary track of -- of of practice and they used it, you know, to their -- to their advantage. We can figure that sometime into the future. Someone can say, "I don't want to be collaborating anymore, I don't want this, you know, written agreement," but that -- that's -- that's where we're right now in the practice.

But yeah, you're still -- the APRN's still bound by those collaboration agreements and all the rules and laws that apply to their practice under that. This -- this does not have any exceptions to that. You can always write to Anitha if you have specific questions. She loves those kind of questions.

MS. DiPASQUALE: I'm sorry, I didn't hear that comment.

MR. DILLING: House Bill 402 is the Ohio Midwife Practice Act. Again, just throwing that out to you because on -- on a certain level, the APRNs are the CNMs and the Professional Midwives are kind of fast friends, and they share on a licensing exam with the Professional Midwives under certain circumstances. And nationally if you were to go and look at different statutes, some states are treating them, you know, more equivalent and trying to fit them within that CNM rubric.

So this here I think is more of an attempt to create some type of own entity for the Professional Midwives and with the reality that Ohio is a -- is a big state, we have a lot of rural areas, we have a lot of Amish who date back 20 years ago to a lot of the Professional Midwife issues at the time.

It's just this bill comes back periodically. Hasn't been around for a while. It -- it's back. Somebody's going to take it on in a different way, I believe. There's been some discussion along those lines, and I'm sure next year we'll hear a little bit more about that bill --

MEMBER ZAMUDIO: Tom.

MR. DILLING: -- or one like it.

MEMBER ZAMUDIO: So Michelle Zamudio.

MR. DILLING: Yes. MEMBER ZAMUDIO: So just to be clear, the ACNM at this point is not an interested party. My concern is that it's entitled the Midwife Practice Act but it does not apply at all to Certified Nurse Midwives or to Certified Midwives. So for the information for the Committee, a CNM, or Certified Nurse Midwife, is educated in two disciplines, nursing and midwifery and we're board examined and then practiced.

A Certified Midwife, a CM, is someone who is educated in midwifery. Their undergraduate degree may have been biology or a different area, right, much like medicine. It's not required you have a nursing background, a midwife. So they also take the same exam, same scope of practice. They're recognized in last time I looked I think it was nine states, nine or -- nine. So the CM is very similar.

The CPM, which is what this bill references, that's called a Certified Professional Midwife. That's what many people think of as the lay midwife. That's -- This bill requires them to be 18 years old, have a high school diploma and then do a midwife educational program under what's called NARM, I think it's National Association of Registry of Midwives, so it's a registry that they participate in.

And what this bill does is try to also give them prescriptions to use in obstetrical emergencies for home birth. So that it gave them IV fluid access, anti-hemorrhage medications like Cytotec, Pitocin, et cetera. It doesn't say they can prescribe. I read the bill with interest, and it...
1 said they can have them and they can give them.
2 So many times the freestanding birth
3 centers or the home birth midwives have a
4 relationship with an OB/GYN who then can prescribe
5 those medications for that patient. As a safety net,
6 they have a Transfer Agreement with the local
7 hospital, as well as with an OB/Gyn. This bill does
8 say that they can manage high risk conditions outside
9 of a hospital setting if they do an informed consent
10 discussion with the patient so the patient
11 understands what the risks are.
12 And to Tom's point, many of our rural
13 communities and religious sects use midwives for the
14 majority of their deliveries. So the intent was
15 somewhat to also make that a safer situation where
16 they can treat an obstetrical hemorrhage, one of the
17 leading causes of maternal mortality.
18 The other is to get more midwives in the
19 community such as hopefully some day with our prison
20 systems, etcetera, because we know there's firm
21 research now that including midwives on your care
22 team improves maternal outcomes, and that's the goal
23 right now because of our abysmal rates for maternal
24 mortality.
25 So I'm not part of this bill. I'm not

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1 speaking on behalf of anyone related to it, just as a
2 person who read it with interest, I read the entire
3 bill. But the ACNM stepped back, they're not an
4 interested party for this bill. That's just some
5 background information.
6 MEMBER DIPIAZZA: Do they support the
7 bill?
8 MEMBER ZAMUDIO: We don't have a position
9 one way or the other, and we're not an interested
10 party. I clarified that yesterday interestingly. So
11 there's the CM, a CNM, CM, and CPM. Now, CPMs, for
12 example, in my city recently opened a birth center.
13 It's very close to the hospital. Many people right
14 now are seeking out-of-hospital births.
15 In this pandemic, people I know who are
16 CPMs, their numbers exploded because people didn't
17 feel comfortable going to a hospital. And there's
18 good research showing the majority of the time, these
19 outcomes are very safe. So I think the intent was to
20 give them the tools to manage these obstetrical
21 emergencies. I'm not familiar with their exams.
22 That might be something that they're tested on, but
23 that's what's in the bill.
24 MEMBER GRAHAM: So does anyone regulate
25 CPMs?

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1 MS. EMRICH: But right now they're not
2 regulated.
3 MEMBER ZAMUDIO: No.
4 CHAIRWOMAN SIEVERS: It says create.
5 MEMBER ZAMUDIO: Create. There isn't
6 one.
7 MR. DILLING: Yeah, all right. I'll try
8 to fill you in here following Michelle. And thank
9 you, Michelle, all that's good clarification and
10 that's it for the most part, clarification now. The
11 question of who regulates Professional Midwives is
12 nobody here in Ohio regulates Professional Midwives
13 as such, okay, not the ones -- not the people we're
14 talking about outside Certified Nurse Midwife.
15 Before I came to the Board and before I
16 came to the Medical Board I think, on years and years
17 in the past the Medical Board used to regulate the --
18 the CNMs, okay, or what was called the midwives,
19 okay, at that time. Then they came to the Nursing
20 Board, and then we have the birthing of, pardon the
21 pun, you know, APRNs and CNMs.
22 When that occurred, let's just say again
23 they didn't do the greatest job of differentiating,
24 you know, who had jurisdiction, who didn't, okay. So
25 some of my early years was spent talking to the
Nursing Board when I was at the Medical Board, a
complaint would come from someone and they'd go, "You
guys take it," "No, you're supposed to take it", you
know, type of thing.
And that culminated in a kind of a more
famous case in the '90s, I believe, where there was a
Professional Midwife and she was getting drugs from
some physicians and using those drugs, Pitocin I
think, I recall most specifically, and the Pharmacy
Board and the Medical Board went in and said, "Look,
this is the unlicensed practice of medicine at the
very least."
Nursing Board can come in and say too
it's the unlicensed practice of nurse midwifery, but
we're going to say that, and we're going to say no
matter how screwed up you think these statutes are
and that, it's not screwed up if this person's giving
Pitocin, prescribing it, whether we call it an order
or what you want to call it. She is giving it out
not based upon a physician saying at the time you
give this under this circumstance to this particular
patient at this particular time which they needed to
have there.
So she was in trouble. Judge asks her to
answer a lot of questions. She wouldn't do it. She
sat in jail for a long time. That, you know,
increased everybody's eyes on this. Then she
eventually entered into an agreement with the
Prosecutor's Office to stop what she was doing and
then they let her out and life went on, and -- so
that kind of took everybody back a step or two that
was doing the professional, you know, midwifery
because it was such a cause celeb at the time.
Fast forward to today, yeah, I'm not so
naive to think that, again, there are Professional
Midwives out there who are practicing in Ohio whose
jurisdiction it is I'm saying is less than clear, but
in my way of thinking, it would be hard to practice,
maybe impossible, you know, under the current laws.
And anybody who does choose to is taking some risk
along those lines, okay.
This idea that they aren't -- they
wouldn't be prescribing under the bill and so forth,
remember, we kind of went through this with the CRNAs
too, "Oh, the bill told us that we could prescribe"
and, you know, all that. Somebody better go talk to
the Pharmacy Board because those are very complicated
laws, and nowhere in there, nowhere in the statute,
you know, in order for them to do it, they'd have to
fit within those prescribed bill -- or laws which I
kind of think they do.
I believe what they're saying in this
bill is we're not really prescribing yet, we're going
to fill all the different statutes that we need to in
order to prescribe, you know, which is a -- more of a
political thing.
You cannot give that Pitocin from my
understanding of the law to someone on game day who
needs it without having some ability to prescribe.
You can't go based upon some OB/GYN that I'm working
with told me, yeah, when something bad happens, use
it, you know, when something bad happens like this,
and that's -- that's kind of a bad recipe there. So
I'm just giving you some background on the
technicalities.
From the bigger perspective, Michelle, I
believe, is spot on, you know. This -- this -- The
bigger debate is about do you want to bring those
people in who are practicing and you want to make
things potentially safer by bringing them in. On the
flipside, people are going to argue and say, you
know, unless you bring them in from all different
aspects to a greater degree, it's not going to be the
safe thing that you think it is, and so that will be,
you know, the battleground for it.

And, you know, we can -- we can -- we can
take a time trip back to 2000 when they have the
study committee and, you know, there was some crazy
things being said, you know -- you know, in that
committee because the bill in -- in the discussion
envelopes everybody. It's -- You know, we can talk
about what other states are doing and what tests are
out there and calling them Professional Midwives and
that, but the end goal here of the people I believe
that are proponents, at least from the ones I've
initially spoken to, they want everybody
grandfathered in, you know, that -- that -- that has
worked in that and that -- that's going to be a big
bite, you know, to -- to -- to chew on here.
MEMBER GRAHAM: There was a time I can
remember the hearings from the committee. It was
very interesting that Professional Midwives would
come in with their quilts and put their -- you know,
their -- they would have their Pitocin in their -- in
their pockets of the quilt. It was the most
amazing... To think the challenges we were having to
to get prescription authority and we were watching this
and they were coming in and telling this to the
legislators...
But from that study committee, nothing
happened, right? I mean, didn't we have all these
hearings and then -- and wasn't -- didn't they back
off again because -- primarily because of the
religious communities? It was happening there, and
it was going -- if there was legislation that went
forward, then these people would be breaking the law,
so they just kind of walked away. So it's
interesting now to hear that there's a birthing
center set up in Cincinnati where they're...;

MEMBER ZAMUDIO: CNM. To be clear, it's
also a CNM in that birth center, yeah, and then some
CPMs. So, you know, they usually partner with a CNM
in some way. It does -- This bill also does give
them newborn care which I thought was interesting
since Certified Nurse Midwives give the immediate
care but not the -- and, again, that's with these
rural communities, we want to build access to midwife
care to all women and all communities.
This is I think also addressing those
communities that don't have a Nurse Midwife and don't
have a Certified Nurse Midwife. Again, it's just
global to say the Midwifery Practice Act, so my
concern was with the title of it. But like if
there's Group B Strep, this -- this proposed
legislation will allow them to administer IV

antibiotics for Group B Strep.
MEMBER CONTRERA: So -- This is Peggy
Conterrra -- since they are certified, who certifies
them?
MEMBER ZAMUDIO: So -- and, again, I am
not an expert on -- on a Certified Professional
Midwife, but I believe it's NARM, N-A-R-M. Is --
is -- Have you heard of them before?
MEMBER GRAHAM: Yes, I have.
MEMBER ZAMUDIO: Yeah. So -- so NARM I
believe is there.
MEMBER CONTRERA: And that stands for?
MEMBER ZAMUDIO: I know it's a registry
of midwives. I'm assuming the N is for National, and
I don't know what --
MR. DILLING: I think that's North
American Registry of Midwives.
MEMBER ZAMUDIO: There you go, North
American Registry of Midwives. Sorry if there's any
CPMs listening, but I knew that -- So that's my
understanding of it when I looked at this.
And to put this in a different context,
the ACNM Ohio affiliate, recently the person in
charge of the Ohio affiliate, stepped down, so we now
have an interim person with us. So that may account
for us not being an interested party or having a
comment about the bill at this time.
MEMBER DIPAZZA: Is there a risk at all
for this group to be regulated out of practice?
MEMBER CONTRERA: They don't even have a
Bachelor's degree; is that right?
MEMBER ZAMUDIO: No, they'll be under the
Ohio Department of Health as a licensed midwife. So
in other words, any other -- like any other license
in Ohio, it will be under ODH is the proposal, right,
Tom, if I'm correct?
MR. DILLING: Yeah, but it would be a
stand-alone under that, I believe.
MEMBER ZAMUDIO: Yeah.
MR. DILLING: Yeah. And -- and -- and,
again, based upon politics and who's sponsoring it
it -- this bill's not going the way that it's drafted
here, but that doesn't mean that there aren't people
on both sides of the aisle who represent rural areas
and people who want to help achieve the -- the bigger
goal.
It's just how do you go about doing that.
And Peter asked, you know, are you risking being
somebody coming in and clarifying the statutes so
that it's easier for somebody to come in and say, you
know, "No, you can't do that," sure, that's always
going to be a risk, but, hey, back in 1999, it was
pretty clearly set up -- set forth because I could do
it in writing and not just talk about it, you know
that here's this statute, here's this statute, this
is what you've got to fix and so forth and, you know,
obody went after it because of, you know, again, it's
a -- it is kind of a unique situation.
And there -- the Department of Health
does have some birthing centers that they regulate
and Professional Midwives may be involved in, you
know, up around the Amish area and so forth, and
other people are involved as more of a collaborative
thing because, again, they want to bring people
into -- into those centers and they're set up in that
way, so very difficult issue.
We will hear more about that, and I will
have more information about that for you into the
future because that's one of the things when they
call over and ask these questions or whatever, ask
questions too, and they'll go back and try to get a
little bit more definition to what -- what's
happening in some areas, so...
MEMBER ZAMUDIO: I can do the same. I'll
bring -- I can bring back some information as far as

20 (Pages 77 to 80)
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MEMBER ZAMUDIO: Okay.

MR. DILLING: And they also just recently introduced this House Bill 466 with health care staffing agency requirements which -- not really our bill, but, of course, we always -- you know, we get phone calls from staffing agencies about, "Hey, we need so and so to be licensed," you know, and so forth, but this is a lot of regulation in the health care staffing agencies, so...

And yet I throw this back to you. I wanted you to be aware of it, just got introduced. I haven't listened to any testimony on -- on either side, but if somebody has some APRN-related -- nursing related issues that -- that they want the Board to consider, please let us know as well and put that out there.

And then finally, Senate Bill 151, which is specific infant medical treatment for moms and their children who are in emergency distress in between certain weeks of the pregnancy, early on in the pregnancy and the transfer of those patients to a level 3 or a level 4 facility, again, I just don't know well enough how the OB/GYN and the CNM are practicing together in a small rural hospital and one of these patients comes in and -- you know, and how

and so forth, it's tough to tell from -- from -- from this bill.

And then people are -- The patients themselves are able to face themselves out of the registry, you know, for -- for into the future. So I bring it to your attention, I'd love for you to go back and find out how this interacts with the APRNs and let me know, you know, how -- how this applies more to -- to -- you all.

And then, Michelle, they talk about the CNPs and CNMs because it's -- and they keep saying primary care, primary care, and of course the CNM considers themselves and others consider CNMs as primary care for -- for various reasons. So I was trying to rack my brain as to, you know, how do you connect up to Michelle who's caring for somebody with Parkinson's? Can you?

I -- I don't know. I haven't really asked that question, but, again, I throw that out there as -- as something to think about just because CNM is not mentioned and primary care is mentioned over and over.

MEMBER ZAMUDIO: What bill was that, I'm sorry? I missed the number.

MR. DILLING: It's House Bill 476.
You know, for the viable infants at the age of about 23 to 24 weeks gestation, there's a very, very well articulated way that people resuscitate those infants through NRP and then transport those babies to a NICU ASAP. They're born out in the rural areas.

This is really looking at pushing those boundaries, as well as I think really mandating that providers resuscitate in many situations which is actually a little bit in conflict with current standards of care through NRP and AAP, and so it will be interesting to see how it goes. Now, in this state, it seems like we're going that way. To me, it's just one of those other add-ons for the whole right to life and protection of life and abortion sort of umbrella.

MEMBER GRAHAM: Which leads me to the question of House Bill 480. Will we do anything and will the Board of Nursing, is there any stand that we'll take on that or... that's the -- I understand that that's similar to the Texas abortion bill that, except for in Texas, it was up through six weeks and we are zero, and there's no allowance for it is my understanding just from looking at the bill.

MR. DILLING: Yeah. I -- I've never placed a bill like that on -- in -- in a memorandum. We're on the Board's radar in considering that, that is something that's not within our direct jurisdiction. Certainly we would, you know, like I'll read about it to see what might be added on, but that is more of a legal, more political decision that's above and outside the Board's immediate jurisdiction.

MEMBER ZAMUDIO: So just a follow-up comment on 151, it's called Emery and Elliot's law.

MR. DILLING: Yes.

MEMBER ZAMUDIO: And so it was named specifically after this couple and their children. So one of the reasons I think that this was also wrote about was because in improving maternal safety and reducing our maternal mortality, the American College of OB/GYN has established not just levels of care for newborns but maternal centers of excellence for maternal, for example, the University of Cincinnati.

So -- so these higher level of care, not just of the baby but of the mom, so that we would be able to timely transfer a mother who would have one of these infants at the perinatal institute at the appropriate hospital.

The second was to mandate resuscitations at an earlier gestation if based on the clinician's provider that was the thing to do, and the reason behind that is because there can be inaccurate dating. And so we all know that that is kind of a fluid event during pregnancy. We're a little better than, "Oh, you'll have your baby at planting time," we're like a little bit better than that now, we know when they're due, but with parents stating, they're saying, "No, I know I was farther along in this, please resuscitate my baby," it can get very intense.

So that was one of the objects, was to get accurate data, transfer to the appropriate level of maternity care, and then to resuscitate infants who have disabilities. So that's kind of where this Emery and Elliot's law came from, and it's -- it's a good read -- thing to read about if you get a chance.

MEMBER PIASAZZA: So is there room in the law for parents to decide they don't want their child resuscitated?

MEMBER ZAMUDIO: There's room in that for an NRP. I don't recall specifically it's in the proposed legislation.

BOARD MEMBER KEELS: I believe I think -- I think I saw some language in there. I mean, NRP, the basis of that is a thorough assessment at birth. It's based on physiology and response to the birth. You know, there's an evaluation that's done, there's a very in-depth training that people go through.

In the rural communities, it's very challenging. It is even challenging even having EMTs, non-necurial or non-pediatric personnel with these tiny babies. The -- you know, the skill level is really hard for them to like intubate.

Sometimes we can't intubate a 20-week-old infant, so some of it -- you know, we'll see what washes out, but I worry that legislation is creeping in on medical advice, assessment, evaluation, clinician expertise. So, I mean, that's -- that's what we do through NRP and the hospitals that are accredited have to be a very -- of course, there are hospitals that are not accredited but have to have that established.

MR. DILLING: Well, it's in the legislative process, so you are having people, proponents, opponents, interested parties, you know, filling in all that testimony. I'm sure that it will move on from there. Yeah, there -- there's a lot of these subjects they're not easy to explain that's for sure, so I appreciate your expertise. That's it.
Again, I appreciate all your assistance.

Oh, you're not going to ask me...

BOARD MEMBER KEELS: I am going to ask you. Any update of APRT, their scope of practice licensure legislation?

MR. DILLING: Honestly, Erin, I haven't

BOARD MEMBER KEELS: We've got students who have graduated from the program and they have no -- they have no jobs because there's no license, no title or protection for them, no practice.

MR. DILLING: I'll go and I'll make a phone call and see what I can find out, but I have avoided that...

BOARD MEMBER KEELS: I know. It's okay.

MR. DILLING: -- in the last two months.

It's just... you know, it is cut there, again, which comes first and so forth. In this case, the school came first. And you can question how certain clinical aspects are being taught and so forth, but I don't know. I don't know the answers to those things.

And it does put the students in a precarious situation. I would assume that clearly everybody knows that it isn't a licensed practice at this point in time, and so they're going to...

they start to create their own scope outside of the statute.

MR. DILLING: Yeah, if we were to go back into discussions --

BOARD MEMBER KEELS: Can they do that?

MR. DILLING: They could. If we were to go back into discussions as to, you know, years ago, there -- there was a bill for a kind of advanced respiratory care, and that was a Schuring bill, I can't give you the number, you know, exactly, but the Nursing Board and the Medical Board went in and raised questions as to there's not any definition here as to what's going on, you know, within the scope and what -- what do you all want to be doing and so forth.

Again, my -- my professional guess is that that was -- it was a twinkle in somebody's eye at that point in time and this is where we were going. Now they went -- Those questions weren't answered, I will tell you, by the different proponents at that time and the sponsors that -- You know, if you can't answer this guy's question, I'm not going any further than this with this.

So then it falls aside for, you know, a session. Then we have this grand two years of meetings without seeing any language, and then at the end saying we're doing it a different way, but we'll start talking to different people about this language at different times. So we fell back into the old way again because it's going to come back to the same types of arguments and the same ways.

So what I'm telling you is, to go back in time and try it now as saying this is advanced, politically somebody might say that's -- that's a pathway, but certainly everybody who goes down that path would know now besides just one or two people. Now everybody knows you're going down this pathway for a reason, and this is what you want to do.

We'll see if -- if that occurs. I will not say anything's impossible. It's just it's a more -- it's a more difficult thing once you've kind of established where you're headed even -- even under a ruling authority.

CHAIRWOMAN SIEVERS: Thank you.

BOARD MEMBER KEELS: Thank you, Tom.

MR. DILLING: You're welcome. Thanks.

It was great to see everybody.

CHAIRWOMAN SIEVERS: Okay. Well, how much do we think we have left? I know there's a few updates and then just a couple document reviews. Is
anyone opposed to sort of pushing through? We're at 12:00. Does anyone need a bathroom break? We can do that.

MEMBER DIPIAZZA: Bathroom break.

BOARD MEMBEE KEELS: Bathroom break is good.

CHAIRWOMAN SIEVERS: Okay. Does that sound good, and then just come back and finish up and not do a lunch? All right. Ten minutes? Okay. So we'll say it's 12:00 -- I have 12:03, so by 12:15, how's that?

(Recess taken.)

CHAIRWOMAN SIEVERS: So we are down to general information and updates.

MS. EMRICH: Would you like me to add those?

CHAIRWOMAN SIEVERS: Yes, please.

MS. EMRICH: So first I've already announced our new Interim Executive Director, and we were pleased that she was able to join us for a brief time today, and I hope you get an opportunity to say hello and meet her.

The next is the Board Nursing -- Board of Nursing offices in contact. As you're well aware, the Board of Nursing staff went remote with the Covid conditions and all. We have re-- The lobby reopened to the public on October the 1st. So persons may walk in during business hours if needed and assist, though, I have to be quite -- quite frankly, I think so much work is used to be done through e-mailing staff and through teams and different things, we have had very, very, very minimal traffic into the lobby, so I think most persons have already found alternative methods in getting there.

But I did want to let you know that the lobby is open -- the Board has been open for business throughout, but the lobby itself is -- is open for someone who actually walked in.

All of the Board's meetings now have been returned to in-person meetings. With House Bill 404, all of the authorization to hold virtual meetings went away, so the Board's Advisory Committees and the Board meetings themselves resumed in person back in July.

Contacting the Board. I want to let you know that we have -- it's taken some significant steps, and Charity has helped to -- has taken the lead on getting us some resources to assist with contacts. We are now utilizing a call center, and they are taking 100 percent -- as of the last I saw the report today, all calls are being answered.

There are no calls that are not being answered by a person.

So I just want to let you know that we have heard concerns about calls and soon we will be getting e-mails also readily -- more readily addressed, and those are already improving.

The Board's licensure resources, as you are well aware, are limited with the additional volume of work that came with both House Bill 197 and House Bill 6 last summer. We are now with the call center. We're able to -- I know the licensure Program Manager is able to focus her team just on issuing licenses rather than the calls and all.

So thank you for your patience. And any concerns that any of you may have, please feel free to contact me, contact Pat Simmons who's the Program Manager for Licensure. We are happy to get those addressed for you and for that, so we appreciate that.

CHAIRWOMAN SIEVERS: Thank you. On behalf of our colleagues across the state because I know it's been hard.

MEMBER DIPIAZZA: Is the call center Monday through Friday 8:00 to 5:00?

MS. EMRICH: It currently is, but it's planned to be also on Saturdays. It's just a -- It's just a technical issue with it now being 8:00 to 5:00, but it's -- it's -- we're looking at it being greater than that time. It has something to do with our phone system linking with the call center. So we're working out that bug.

MEMBER DIPIAZZA: That's nice.

MS. EMRICH: So it will be extended.

Moving on, APRN and RN renewal ended on October the 31st. Compared -- I -- I thought that the last renewal period went reasonably well. This renewal period to my observation went very well.

And it's -- you know, we're -- we're past that. I -- I do -- A very positive note, for those individuals who may have unintentionally lapsed on November the 1st, the Board implemented an enhancement to eLicense whereby if a person has lapsed, if they submit their reinstatement application, if they have been lapsed or inactive for less than five years, that reinstatement or reactivation once it's submitted will automatically go through similar to a renewal. So there's no manual processing for those.
So if you have anyone who, you know, their RN license lapsed and, thereby, their APRN lapsed, you know, if they just go in and submit their reinstatement application, you know, it's an automated process, so -- and their license will be active again and, you know, they're -- they're good to go rather than waiting for somebody to do something, so that's good. I think we had well over 200 and -- well over 209,000 persons who reapplied, so it was good.

We -- During the summer and actually prior to that, we were looking on moving on to the APRN application and application guidance. So at the time when -- And I was working more directly with licensure at the time before it was separated back out, we were looking at the APRN application process and we were realizing that, you know, APRNs -- and this is initial licensure -- they were declining and then we would look at their application and then realize, oh, well, we don't have their national certification yet or we don't have their transcripts yet.

And we realized then that persons were submitting their application before they had even completed graduate school or before they had taken the exam. So we started looking back at the statute for APRNs, and when you really look at the statute, you can tell it was intended that they should already have their graduate degree or already be -- hold their cert- -- have their national certification.

So we changed to increase the efficiency and use of staff time which was just priceless at the -- at the time, staff time, and make things more efficient, we changed the application so that you could not apply until after you had those items. So you have to have already graduated with your graduate -- or with your Master's or doctoral degree, whichever one is applicable, and you must already have obtained your national certification before it will permit you to submit your initial application.

So that is being helpful so staff, once they get to that application, everything should be here rather than waiting. Because then what happened was we had the application and we say, "Oh, we don't have these two items," and then time goes on and then they have to circle back to it. So we want it where staff are not having to circle back to the application.

So with that said, I quickly distributed to you sort of a guidance document that -- where we provided for initial APRN applicants in Ohio. So it's applicable to both new graduates, as well as APRNs who in another state are applying here. So we're -- we're hoping that that would be -- will be helpful. I think we dis-- we've distributed it to you all a few months ago, a couple months ago before.

So feel free to -- to send that out to persons, you know, let them know. We're hoping it will be helpful to streamline the process for everyone.

BOARD MEMBER KEELS: And then the goal to issue the license after all of those have been submitted is what right now?

MS. EMRICH: The goal would be within a week. I'm sorry, I don't have that timeline as to what's happening right now. I know the -- we did implement some dating of receipt of information within the cl.license itself so that we're going to be able to track that, those guidelines. I would need to get with -- with Pam, a Licensure Manager, and see how those are tracked.

BOARD MEMBER KEELS: Thank you.

CHAIRWOMAN SIEVERS: Would it be possible for where it says Initial APR License, I see this question put out kind of on the blog groups

for the Ohio education laws and rules and maybe not list them here, but we used to have a document that linked out to actual courses and what is -- how many -- how many CE's do they need for that cause I know we just need that one hour of law, they might ask somebody who says, "Oh, it's one hour of law," but I think it's more. Isn't it six hours?

MEMBER ZAMUDIO: It's two for out-of-state.

CHAIRWOMAN SIEVERS: Maybe a link or something to either the courses or some other information specific to that because this is an excellent document. I would use this all the time for folks cause I have to kind of gather what they need to do, but that might be helpful for that and same with where -- Well, it does say out-of-state down below.

BOARD MEMBER KEELS: Yeah. You want the link there to the actual CE's or...

MS. EMRICH: The two CE's that are available and are on the document in the APRN licensure web page, those two CE's are each four hours, though, it's -- for out of state applicants, we're looking at two hours is the minimum.

For initial applications -- applicants,
if -- if -- if the individual completed a non-Ohio program or institution, we ask them to supplement their advance pharmacology course with Ohio law -- with content in Ohio law governing prescribing Schedule 2s because it's expected that that content haven't been included in their advanced pharmacology course. There is no -- You know, we tell them we'll accept one of those two CEs for it. It's not really a minimum of two hours or four hours, but we do need that supplemental course content, so...

CHAIRWOMAN SIEVERS: Actually what that last -- second to last bullet should say on the first page is "See below" because it looks like it probably should just say if you completed a program outside of Ohio, see below because then it says out-of-state and there's all the stuff, and it actually does say two hours, but then you could maybe even if there's any further information, you could provide these people because I would -- I would be like, okay, what do I do for that, and I'm having to call you and say, "How do I get this?"

So if you want to -- you know, if you want to save calls for somebody providing just a little bit more information about that where it says out-of-state, well, this could say see below and they go to below to this out-of-state and it could right there, I've got to do this, I click here, take this class. I think the rest of it was really good.

BOARD MEMBER KEELS: Yes, it was very helpful.

CHAIRWOMAN SIEVERS: It was very helpful because it's so hard to keep up.

BOARD MEMBER KEELS: Well, it's always nice to give them a checklist.

CHAIRWOMAN SIEVERS: Oh, love checklists.

Yeah, Anything else?

(No Response.)

CHAIRWOMAN SIEVERS: Great. Thank you.

MS. EMRICH: Then we have the sample questions which are your favorite, what to do. These are actual questions received, and then we provided response as well.

MEMBER ZAMUDIO: Was I was impressed with the mobile IV hydration. I never heard that.

MS. EMRICH: Popular question.

MS. DIPASQUALE: Very popular.

MS. EMRICH: Very popular with RNs and APRNs.

MEMBER ZAMUDIO: I think of all those patients I had with hyperemesis....

the question a little more generic and applicable to many areas as opposed to being so specific?

As I read the one where the person is practicing in Pennsylvania, does it need to say Pennsylvania? Can it be -- you know what I mean? Is there an opportunity to make the question reach more people to yield the same answer? Just wondering....

MS. DIPASQUALE: Yes, these are not FAQs. These are a sampling just for this group to review.

MEMBER BRAZEE: Oh, this group, I see.

Okay, thank you, I didn't understand that.

MS. DIPASQUALE: If they became FAQs, certainly we could --

MEMBER BRAZEE: You do make them generic, okay, thank you.

MS. DIPASQUALE: More generic.

MEMBER BRAZEE: I was thinking this is like really specific, but thank you for clarifying that.

CHAIRWOMAN SIEVERS: It's more informative with the questions they get and they're showing us how they answered them and....

MEMBER BRAZEE: Got it. Thank you.

MS. DIPASQUALE: And we're also trying to avoid as much as possible not repeating the questions
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<td>from the last maybe six or these, so it kind of... you know. So these are not your FAQs, if you will, because many of those are in the prior six samples.</td>
<td>MS. EMRICH: For 2021, it was March, July and November. Typically on -- It could be any day of the week. We just have to avoid Board meeting days.</td>
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<td>MEMBER BRAZEE: Okay, thank you. CHAIRWOMAN SIEVERS: Okay, anything else on general information updates? That was it.</td>
<td>CHAIRWOMAN SIEVERS: Thoughts? Does Tuesdays -- We should maybe start with the day of the week. Tuesday is working?</td>
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<td>Next topic is agenda building for 2022. And Lisa and I were talking, she added that just to see if there's any discussion, nothing specific to be accomplished with this discussion, but is there any thoughts -- those of you who are newer may not have like an opinion, you're just getting started, but if there's anything that comes to mind that we should be covering or included, let us know.</td>
<td>MEMBER ZAMUDIO: Tuesday is good.</td>
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<td>MS. EMRICH: Those coming a good distance, do you have a preference for March versus February?</td>
<td>MS. EMRICH: Those coming a good</td>
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<td>And then anything that the Board determined should be reviewed by this committee will come to it as well. If there are any other particular topics or things that you would like to see, you know, let Sherri know or contact Sherri and I'll work with her with agenda building as each meeting comes about.</td>
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<td>MEMBER ZAMUDIO: Lisa, will you be going to that meeting, that roundtable?</td>
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<td>MS. EMRICH: I would expect I would, but it's not -- nothing's in stone yet.</td>
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<td>MEMBER ZAMUDIO: That's great. BOARD MEMBER KEELS: Last year it was distance.</td>
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<td>MS. EMRICH: Yeah, it was just a -- it was virtual. BOARD MEMBER KEELS: I guess they talked about the essentials of the document that's -- Is it final yet? Is the task force finally final? That was the majority of the meeting I thought.</td>
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<td>CHAIRWOMAN SIEVERS: Okay, good. That brings us to 2022 meetings. So we typically do three...</td>
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<td>MS. EMRICH: Yeah, we did four one year, but it was because that was because of different extra rules that needed to be approved but three typically.</td>
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<td>CHAIRWOMAN SIEVERS: Right. I think I want to say Januaryish or did we do March?</td>
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MS. EMRICH: Board meeting is what, the
20th or 21st?

MS. DI PASQUALE: I do not have that.

MS. EMRICH: So the 12th should be fine.

CHAIRWOMAN SIEVERS: I like November.

October seems really busy with things. Election day
will be the first, right, the first Tuesday, so the
8th, almost a year from today.

MEMBER ZAMUDIO: I don't know why but my
planner says election day on the 8th.

MEMBER TYSON: Yeah, it sounds like it
would be an election day, on a Tuesday.

CHAIRWOMAN SIEVERS: Is that second
Tuesday or first Tuesday?

MEMBER GRAHAM: Mine says second.

CHAIRWOMAN SIEVERS: Second Tuesday, the
8th. Okay, the 15th?

MS. DI PASQUALE: Is that the Board
meeting scheduled, Lisa?

CHAIRWOMAN SIEVERS: Oh, yeah, that might
be the Board meeting because the next week would be
Thanksgiving.

MS. WARREN: The Board meeting is the
16th and 17th.

CHAIRWOMAN SIEVERS: Okay, yeah. How
about the 1st? Well, that's bad.

MS. EMRICH: Did you check the Board
meeting in July?

MS. WARREN: That was the week after.

MEMBER ZAMUDIO: We can do the 1st and
just bring all your Halloween candy.

CHAIRWOMAN SIEVERS: So March 22nd,
July 12th and November 1st.

Okay, very good. Any other items for
today?

BOARD MEMBER KEELS: Good job, Madam
Chair.

CHAIRWOMAN SIEVERS: Thank you.

Adjourned.
(The meeting was concluded at 12:40 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, November 9,
2021, and carefully compared with my original
stenographic notes.

________________________
Cynthia L. Cunningham

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