EXHIBIT C

Sample List of OAAPN Member Concerns

The following is a list of concerns raised by OAAPN members concerning the proposed 30 MED rule language.

1. Not all patients have a "treating physician" in every situation. It is possible that an APRN is the sole treating provider. As such, the 30 MED rule does not account for those situations.

2. The Board of Nursing states in its Business Impact Analysis that it consulted stakeholders regarding the proposed rule changes to OAC §4723-9. It also states that it was made aware in September 2017 that the Medical Board allows physician assistants to exceed the 30 MED limits set forth in the Medical Board's rule. The Board of Nursing states that it met with the Pharmacy and Medical Boards, the Administration and other interested parties prior to authorizing amended language to implement "a similar narrow exception for APRNs who collaborate with the treating physician." First, it should be noted that the Board of Nursing failed to consult key interested parties in crafting the language for the proposed 30 MED exception. In particular, the Board of Nursing should at the bare minimum have consulted the Advisory Committee on Advanced Practice Nursing and the Committee on Prescriptive Governance since this is an APRN prescribing issue.

3. APRNs often see patients that a physician may not see. As such, the APRN restrictions on 30 MED prescribing should mirror those provisions in the Board of Medicine's rule for 30 MED prescribing. See OAC §4731-11-13(A)(3)(c).

4. The proposed 30 MED rule places an undue burden on many APRNs in their daily practice and creates an adverse impact on private businesses. Instead of permitting the APRN to make a clinical decision that the APRN is qualified to make, the proposed rule requires the APRN to ask the collaborating physician to become involved (i.e. become a treating physician) with patient care for a patient the collaborator may know nothing about and to accept sole responsibility for the patient's care with regards to the opioid analgesic prescribing to exceed 30 MED. Many collaborators will not want to accept such risk, which in turn will limit patient access to appropriate care and harm APRN practice.

5. The proposed 30 MED rule does not provide for the necessary prescriptions APRNs current write for post-operative patients, trauma patients, patients who have not yet met the criteria for chronic pain, etc.

6. Four (4) Tylenol 4 (a Schedule 3 drug) exceed the 30 MED limit. Over 300 mg of Tramadol (a Schedule 5 drug) will also exceed 30 MED. This is a very low threshold. Not all patients have the same threshold for pain or pain control. The proposed 30 MED rule does not allow the APRN the flexibility to provide individualized care for patients without asking their collaborating physician to assume liability for a patient the collaborating physician may not be treating but now must become a treating physician.

7. Yes, the Board of Medicine permits physician assistants to utilize the 30 MED exception, since they are supervised by their supervising physician and attached to that physician's license. However, the APRN-collaborating physician relationship is different. The APRN is not attached to either the treating physician's or the collaborating physician's license; and the collaborating physician may never be involved with the patient's care. As such, it does not make sense that a physician should assume liability for a prescribing decision that the APRN is competent to make.

8. The proposed 30 MED rule is a step backwards for APRN practice. Generally, a physician will not be liable for an APRN's prescribing activities. However, the proposed 30 MED rule creates liability for the physician.

9. APRNs are qualified to make decisions regarding opioid analgesic prescribing and whether a patient should be given a prescription exceeding 30 MED. APRNs are educated, have prescriptive authority, hold DEA numbers, complete required pharmacology training, hold medical malpractice insurance policies, and treat patients without physician supervision. APRNs are held liable for their own clinical decisions, so prescribing in excess of 30 MED should not be any different.

10. The proposed 30 MED rule is a restraint of trade for practicing APRNs. The proposed provision will make APRNs less desirable to hire in certain fields even though they are academically qualified.

11. Ohio case law has generally found that an APRN is directly responsible for the APRN's own clinical decisions. A physician is only liable to the extent the physician became involved with the patient's care. Many physicians will not be willing to assume this liability when they would not otherwise be liable if the APRN was permitted to make the clinical decision that the APRN is competent to make.

12. Some APRNs own their own businesses. In those situations, a physician would likely never interact with the APRN's patients. The 30 MED rule creates an incredibly low

barrier to patient care and would make it difficult for APRNs to provide necessary care to their patients in their private businesses.

13. The proposed 30 MED rule adversely affect nursing homes and hospitals who rely on APRNs for patient care. In nursing homes, a patient could have acute pain and the only provider who ever sees the patient is an APRN. In hospitals, a patient could have acute pain and an APRN would be the provider writing a prescription for the patient to take home with them upon discharge.

14. The proposed 30 MED rule restricts patient access to necessary care by creating an unnecessary process for a patient to receive a prescription in excess of 30 MED in the event it is medically necessary.