Acknowledgement

to
Mary Jane Maloney, DNP APRN – CNP FAANP
Director, Government Relations
&
Christine Williams MSN APRN-CNP FAANP
Director, Reimbursement and Full Practice Authority
&
Jeana Singleton, JD
OAAPN Legal Counsel
for this presentation

Objectives

- Discuss law and rules pertinent to APRN practice in Ohio.
- Review most recent changes to the OBON Formulary.
- Review 2016 and 2017 changes to the SCA.
- Review 2017 statute and rule changes resulting from HB 216
- Brief review of OARRS and new requirements for Opioid Prescriptions, effective 4/6/2017
- Brief review of proposed prescribing rules for scheduled drugs Rx for acute pain and proposed new formulary
- Review Current Practice Issues in Ohio and Common APRN pitfalls; ACNP/FNP/AANP acute care issues; ratios; more
- State what APRNs should do when contacted by the OBON: “The Board comes Knocking”.
APRN Law and Rules

Ohio Revised Code (ORC) is the LAW.
- Passes Senate and the House
- Signed by the Governor
- The Nurse Practice Act is ORC 4723.

Ohio Administrative Code (OAC): Rules that explain how the law will be implemented
- Written by the regulatory board, BON
- Rules cannot conflict with or expand the law, they can be more restrictive
- Nursing Rules OAC 4723.

Where to Find APRN Law & Rules

- APRN State Law
  - [APRN State Law](http://codes.ohio.gov/orc/4723)
- APRN State Rules
  - [APRN State Rules](http://codes.ohio.gov/oac/4723)
- APRN Federal Law
  - United States Code of regulations
  - Center for Medicare and Medicaid Services (CMS)
- Board of Nursing (BON)
  - [http://www.nursing.ohio.gov/Practice.htm#AdvancedPractice](http://www.nursing.ohio.gov/Practice.htm#AdvancedPractice)
- Board of Medicine – No direct APRN authority
  - [http://codes.ohio.gov/orc/4731](http://codes.ohio.gov/orc/4731)
- Board of Pharmacy – No direct APRN authority, all prescribers must adhere to BOP rules
  - [http://codes.ohio.gov/orc/4729](http://codes.ohio.gov/orc/4729)

Title Protection

- Provides legal recognition for practice
  - Only individuals who meet the requirements of APRN can use the title (ORC 4723-8-03)
- Ties reimbursement to the title:
  - RNs cannot bill for physician services; APRNs can
- Advanced Practice Registered Nurse
  - Umbrella term for the four APRN types
  - CRNA, CNM, CNS, CNP
- Signature: APRN-CRNA, APRN-CNM, APRN-CNS, APRN-CNP or APRN (NEW 2017)
  - Use of subspecialty or national certification credentials are NOT in law, i.e. FNP BC or NP-C.
APRN Licensure – General

- APRN License renews every 2 years with RN license;
- Within thirty days of recertification by national certifying organization:
  - APRN license holder must request that the national certifying organization provide, directly to the OBON, documentation of recertification (OAC 4723-8-08). Current national certification must be continuous:
  - If national certification lapses by even one day, APRN license is not active, no grace period in Ohio; and, must cease APRN practice.
  - Practicing without a license
  - Reimbursement Fraud
- Renewal: submit name and business addresses of CP every 2 years (4723-8-08).
- If APRN license is on inactive status, then the RN license is inactive – (4723-8-08).
- CE's Required for 2019 licensure period: 48 hours of CE total. The 48 hours includes 24 hours of CE to renew the RN license and 24 hours of CE to renew the APRN license, which includes 12 hours of advanced pharmacology with one hour of Category A included.

Qualifications for licensure:

- Individuals currently with a COA – but without a CTP, or CTP-E, and without the 45 hour advanced pharmacology course in the past 5 years, are not eligible for licensure without the course.
- They must take the 45 hour pharmacology FIRST and apply for APRN license after the course. MAY apply for APRN license beginning 7/1/17-12/31/17. (4723.482, ORC)
- Individuals currently with a COA – but without a CTP or CTP-E and have taken the 45 hour pharmacology course in the past 5 years are eligible for licensure, no need to repeat the 45 hour course, may apply for APRN license after 7/1/17.
- Apply for RN license renewal between 7/1/17 – 10/31/17 (no matter when the APRN license is renewed)

APRN Licensure: With COA & NO CTP or CTP-E

Qualifications for licensure:

- COAs and CTPs remain valid until 12/31/17.
- Apply for RN license renewal between 7/1/17 – 10/31/17 (no matter when the APRN license is renewed)
- APRNs with active COA/CTP apply for the RN license and APRN license between 7/1/17-10/31/17. (Late fee for applications after September 15)
- Must renew APRN license by 10/31/17 IF YOU HAVE COA AND CTP.
- APRN renewal period: 7/1/17-10/31/17
- CNs, CNMs, CNPs with CTP or CTP-E: must renew by 10/31/17
- COAs are not recognized as of 1/1/18, YOU MUST STOP PRACTICE.
APRN Licensure Renewal Dates and Other

Licensure:
- APRNs, CRNAs, and CNSs, CNMs, CNPs with a CTP or CTP-E: must renew between 7/1/17 and 10/31/17
- No COAs, CTP/CTP-Es will be issued after 4/6/17
- New Graduates ONLY: may become APRN licensed on or after 4/6/2017, since they will have completed the 45-hour pharmacology course and they will be able to prescribe with that license. RN re-licensure is after July 1, 2017
- Inactive or lapsed COAs or CTPs or CTP-Es before or after 4/6/2017 must apply for APRN licensure reactivation or reinstatement after 7/1/17. No COAs or CTPs will be issued after 3/23/17. You will not be able to prescribe until after you have received your license after July 1, 2017
- Reciprocity: after 4/6/17, out of state applicants must attest to completing a MSN that included a 45-hour pharmacology course and upload documents (need to address those who have years of experience prescribing in other states)
- The board must issue or deny the license within 30 days (previously they had 60 days)

Scope of Practice

Scope: defined by national certifying organizations, prevailing standards of care and parameters of education and training.
Legal Scope: Scope of practice is limited by law and rule.

NO OHIO LAUNDRY LIST OF PERMISSIBLE SERVICES for APRN PRACTICE.

Recent BON Statements on Scope found in Momentum, Fall 2016, with controversial interpretations of current law
- Ratio: per BON, no ratio of APRN/CP exists for APRNs who are not prescribers. New ratio of 5 APRNs to one CP of prescribing APRNs at any one time (Changed with HB 216, 4/6/2017 – ratio is 5:1)
- Scope: Contradictory statements. BON states in the Momentum 2016 publication, “interpretive guidelines”, that CNPs can only manage patients and conditions consistent with formal education. The BON Scope Decision Decision Making Tool confirms if a procedure is within scope AND recognizes educational experience, both formal and informal.
- OAC(4723-8-02): APRNs can use knowledge and skill obtained from advanced formal education which includes a clinical practicum and clinical experience.
- Ohio BON appealed to the Ohio Attorney General for a ruling on the matter, 3/13/17 and refused to meet with stakeholders regarding this issue.
- OAAPN and OHA submitted documents with the Ohio Attorney General

OBON SEEKS AG OPINION ON ACNP/FNP/ANP/PNP ISSUE

Why did this happen?
- Did the OBON talk with stakeholders, other than ACNP faculty from Wright State University?
Did OAAPN or OHA meet with the OBON before OBON ACTED
- What does it mean?
- What is the driving force behind this?
- What does this mean for Ohio’s APRN Adult, Family and Pediatric NP providers?
- What does this mean for Ohio’s hospital and health systems?

Additional Considerations:
- An Emergency Department Certification Process for Family Nurse Practitioners, in place since January, 2017, allows FNPs to become certified and to sit for certification through multiple pathways. (Only FNPs can apply for this certification, which recognizes that almost 80% of all EDs are staffed by FNPs)
Common Questions about Scope

How to determine if a procedure is within my scope?

Utilize the "Decision-Making Guide for Determining Individual APN Scope of Practice". Follow this guideline and/or ask the BON


CNMs, CNSs & CNPs are not supervised in Ohio.

CRNAs are supervised in Ohio

- Must a physician be on site where I practice? No.
- Must a physician co-sign my notes? No.

Standard Care Arrangement

- Must have SCA before you practice (OHC 4723.431 & OAC 4723-8-04).
- Specifies APRN & CP relationship
- Must be signed by all CPs unless signed by "physician’s designated representative", example: Department Chair
- Signed & reviewed every two years
- Must be kept by the APRN’s employer (effective 4/6/17)
- New SCA is needed when APRN is employed with different employer & engages in practice with a different CP.
- SCA must state that prescribing is inclusive of scheduled drugs to minors, must comply with OAC 3719.061

Standard Care Arrangement

- APRNs must engage in own specialty (CNM, CNS, CNP) & enter into a written SCA with one or more CPs.
  - CP practice must be the same or similar to the APRN.
  - Only Psychiatric CNS may also collaborate with Family Medicine, Internal Medicine or Pediatrics, why?
- All APRNs, with exception of the CRNA must have a SCA to be licensed as an APRN
- See OAC 4723-8-04 for inclusionary components for the SCA.
- Must have the scope of prescriptive practice statement incorporated into the SCA.
- Every two years, APRN shall verify licensure status of each CP with whom APRN has an active SCA. APRN shall document that such verification was obtained.
- Updated (2017) sample SCAs will be available from OAAPN: info@oaapn.org
Scope of Prescriptive Practice

Required provisions (OAC 4723-8-04) for SCA:
• Additional prescribing parameters for drugs or therapeutic devices established in the current formulary, [http://www.nursing.ohio.gov/Practice-CTP.htm](http://www.nursing.ohio.gov/Practice-CTP.htm) including:
  – Use of drugs not approved by FDA for off label uses
  – Use of drugs ON EXCLUSION FORMULARY but approved by FDA for new indications. (must petition CPG)
  – Use of schedule II controlled substances.
  – If prescribing to minors, must have provisions for complying with section 3719.061 of the Revised Code when prescribing an opioid analgesic.
  – Obtain & review OARRS reports, and engage in physician consultation c/w ORC 4723.487 and OAC 4723-9-12.

NEW EXCLUSIONARY FORMULARY

Exclusionary Formulary Effective May 17, 2017

A Certified Nurse Practitioner, Clinical Nurse Specialist and Certified Nurse Midwife shall not prescribe any drug in violation of federal or Ohio law.

The prescriptive authority of a Certified Nurse Practitioner, Clinical Nurse Specialist or Certified Nurse Midwife shall not exceed the prescriptive authority of the collaborating physician or podiatrist.

Excluded: abortifacients, schedule I, follow buprenorphine federal regulations and BOP rules, and must meet federal regulations and CE educational requirements for buprenorphine.

SCA and Prescriptive Practice continues ...

• Procedure for APRN & CP, or a designated member of a quality assurance committee, composed of at least one physician of the institution, organization, or agency where APRN has practiced during period covered by review, to conduct a periodic review, at least semiannually, of:
  – A representative sample of prescriptions written by APRN with;
  – A representative sample of schedule II prescriptions written by APRN;

• Provisions to ensure APRN is meeting requirements of OAC 4723-9-12 related to:
  – Review of a patient’s OARRS report,
  – Consultation with CP prior to prescribing, based on the OARRS report if potential signs of drug abuse or diversion
  – Documentation of receipt & assessment of OARRS report information in the patient’s record.
SCA and Prescriptive Practice continues ...

• APRN’s prescriptive authority shall not exceed the CP’s prescriptive authority, including restrictions imposed on CP’s practice by action of the U.S. DEA or state medical board.
  – Example: if the internal medicine CP does not prescribe chemotherapy; nor can the APRN.
  – Exception (NEW, 4/6/2017): Psych CNS (NP to be included in future) may have SCA with Family Medicine, Internal Medicine or Pediatrician (cannot prescribe what they do not prescribe in their practice).

SCA – Clarification of PI/PC
(Use only if the CP requires)

• Physician Initiated (PI): Means APRN may continue/refill the medication after the physician has examined the patient in accordance with OAC 4723-11-09 and initiated therapy.

  Physician Consult (PC): Means the APRN may initiate and continue the medication after direct communication with the collaborator and documentation of consult in patient record.

A Word on Newly Approved FDA Drugs...

– REVIEW OF DRUGS BY THE CPG Rule 4723-9-
  – New drug(s) approved by the FDA, may be prescribed by the APRN unless the drug is added to the exclusionary formulary by the CPG if all the following are met:
    • Ability to prescribe the drug is within the APRN’s scope of practice;
    • Drug type is NOT included in the OBON exclusionary formulary. NEW
Standard Care Arrangement: Required BON Notification

- APRN must submit to OBON the name and business address of each CP no later than 30 days after APRN first engages in practice
- APRN must notify OBON of any changes in CP within 30 days after change takes effect.
  - Forms are found at nursing.ohio.gov
- Copies of previous SCAs shall be retained by APRN for three years and provided to the board upon request. (4723-8-04 (NEW).
  - Start with 2015 SCA.

SCA: Quality Assurance Measures (OAC 4723-8-05)

Is a process for improvement that includes:
- QA Committee Members: Must include at least one physician (could be part of the prescriptive chart review)
- Chart Review: regular (once a year minimum with document outcomes and improvement, if applicable).
- Prescriptive review (twice a year minimum and document) inclusive of a representative sampling of schedule II, if applicable.
- NEW April 2017 NO MORE CP review of referrals and referral outcomes eliminated from SCA

APRN Required Continuing Education

- Required CE (OAC 4723-14-03): 1 hour
  - Category A, Nursing Practice Act – one hour every two years & must be approved by OBON or offered by OBN approved provider (required for RN license)
  - Controlled substance requirement of APRN license: recommend one hour (Rule not specific on how many CE).
- Youth Concussion (OAC 4723-8-11) APRN must complete 1 CE for detection of concussion, its clinical features, assessment techniques, and principles of safe return to play protocols c/w “Zurich Guidelines” if caring for this population.
Youth Concussion Law

- Youth Concussion Assessment and Clearance (2013)
  - CNS or CNP may assess and clear youth to return to sports if:
    - APRNs specialty and CP practice includes care of patients aged 4-19
    - APRN has completed education and training on detection of concussion, “consistent with Zurich Guidelines”
    - APRN uses the medical clearance return to play form located at [http://nursing.ohio.gov/forms.htm](http://nursing.ohio.gov/forms.htm) (2015)
    - APRN has maintained competency and completed CE in detection of concussion, clinical features and assessment techniques
    - Principles of safe return to play protocols are consistent with Zurich Guidelines
    - APRN uses the medical clearance return
  - (Effective 9/17/15)

ORC 3313.539; 4723.8-11

2019 Required APRN Continuing Education

- 24 hours needed for RN license
  - Save documentation of all CEs for 6 years
    - 1 hour of CE for law
- 24 hours needed for APRN license **NEW in 2017**
  - 12 of these hours must be in pharmacology
  - Save documentation of all CEs for 6 years
- Total CE for RN and APRN license (both required for 2019) **NEW 2017**
  - 48 hours
- May use CEs used for national certification to apply toward Ohio CE requirements for RN & APRN license if CE is obtained through:
  - A program approved by OBON or by an OBON approved CE Provider (ONA, ANCC, etc.)

Prescribing Principles and Standards

- APRN License confers prescribing authority - **NEW 2017**
  - CTP and CTP-E eliminated with HB 216 **NEW 4/6/2017**:
  - SCA must include statement of prescribing authority of APRN to include off label and Schedule II (OAC 4723-9-10)
  - Must prescribe within scope of practice: congruent with specialty area of CP & APRN
  - May not prescribe any drug/device that induces an abortion
  - Follow Federal and State Laws
  - No restrictions on sample or stock Drugs **New with HB 216**
    - No samples of DEA controlled substances
      - (4723-9-09: 4723-9-08 OAC: 4723.50 ORC)
Prescribing Principles and Safety Standards
OAC 4723-9-08 & ORC 4723.481

- Furnishing Standards: (no controlled)
  - Provide directions for Stock Medication use:
    - Affix label & include: name of APRN, name of patient, name and strength of drug: directions for use; date furnished
  - Must maintain record of all stock drugs and devices personally furnished by APRN

- Prescribing Standards:
  - Valid prescriber-patient relationship:
    - Assessment/exam, diagnosis, document
    - Advised not to prescribe for friends or family members (no controlled meds prescribed to friends or family)
    - Must use DEA if prescribing controlled meds.
    - Colleagues: if in valid prescriber patient relationship - document
    - According to APRN SCA & OBON Exclusionary Formulary

Prescribing Principles and Safety Standards

- Issuance of a Prescription: (4729-5-30)
  - Must Have: Date, APRN name, address, title, telephone, same identifiers for patient; drug, quantity, strength, directions for use; refills: no refills for schedule II
  - May provide multiple prescriptions for schedule II with start dates (no more than 90 days)
  - DEA for scheduled drugs
  - Fax: not appropriate for schedule II: exception in LTC and Hospice
    - Follow Hospice Patient prescription format (OAC 4729-5-15)
  - All controlled drugs quantity written numerically and alphabetically (4729-5-13)

- Exclusionary Formulary:
  - One page exclusionary only as of 5/17/17. Changed with HB 216

Prescribing to Persons, not seen by Physician
(OAC 4731-11-09 (BOM))

** Controlled or Dangerous Drugs:

Not approved, except in institutional settings, on call situations, cross coverage situations, situations involving new patients, protocol situations, situations involving nurses practicing in accordance with standard care arrangements, and hospice settings, as described in paragraphs (D) and (E) of this rule,

**A physician shall not prescribe, dispense, or otherwise provide, or cause to be provided, any controlled substance to a person who the physician has never personally physically examined and diagnosed, except in institutional settings...
Prescribing to Persons, not seen by APRN
[OAC 4723-9-09(C)(BON)]

- “A nurse who holds a current valid certificate
to prescribe (APRN license) shall prescribe in
a valid prescriber-patient relationship. This
**may include**, but is not limited to:

  - Obtaining history of patient;
  - Conducting physical or mental exam of patient;
  - Rendering a diagnosis;
  - Prescribing medication, ruling out contraindications;
  - Consulting with collaborating physician when necessary;
  - Properly documenting these steps in patient’s medical
    records”

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Delegated authority by APRN to
administer drugs (ORC 4723.489)

- APRNs may delegate medication admin to non-licensed
  staff if:
  - Drug is not listed in exclusionary formulary
  - **Can NOT** administer controlled substances or IV meds.
  - Site restrictions:
    - **Can Not Delegate** at a hospital inpatient care unit, ED, freestanding
      ED or an ambulatory surgical facility.
    - Delegatee has successfully completed education based on a
      recognized body of knowledge concerning drug
      administration & demonstrates to person’s employer
      knowledge, skills, & ability to administer drug safely.

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Delegated authority by APRN to
administer drugs continues...

- Delegatee’s employer has given APRN access to
documentation, in written or electronic form,
  showing the person has met conditions of
  education.
- **APRN must be physically present** at location where
drug is administered.
Schedule II Prescribing

- Pharm CE requirements – 12 pharm hours with some component for controlled substances
  - In course objectives
  - IN COURSE TITLE
  - No specific # of CE required for controlled substances, recommended to get one hour
- QA requiring representative sampling of schedule II drugs if prescribed
- Must adhere to standards & rules of OARRS
- Must be vigilant as new legislation introduced frequently

Schedule II Prescribing

- Site Restrictions:
  - If not prescribing at authorized sites (must meet all 3):
    - Only in terminal condition where there can be no recovery
    - Physician initially prescribed substance for the patient
      (CP requirement changed to physician, not only CP) NEW 2017
    - Amount does not exceed a 72 hour supply (ORC 4723.481)
      (Changed with HB 216 to 72 hour supply) NEW 2017
  - NO CONVENIENCE CARE CLINICS.

Approved Schedule II Sites

- Hospitals and any entity owned or controlled in whole or part by hospital
- County Home
- Health care facility operated by department of mental health or developmental disabilities
- Nursing Home:
- Hospice care program (home, outpatient, inpatient etc.)
- Community Mental Health Facility
- Ambulatory Surgical Facility
- Free Standing Birthing Center
- FQHC or FQHC look a like
- Health Care Office/facility operated by ODH or board of health of city/general district
- Physician owned offices/practice
- Assisted Living (NEW 2017)
Schedule II Prescribing Highlights

- **Amphetamines:**
  APRN may prescribe with formal established diagnosis or per SCA if no formal diagnosis (formal diagnosis may be completed by APRN)

- **Opioid Analgesics:**
  SCA must state that initial prescriptions for > 14-day supply require or do not require physician initiation or consultation.
  - Pharmacist is prohibited from dispensing initial opioid script that is more than 14 days old (14 days have elapsed since prescription was issued) NEW
  - 14 day limit on age of script only applies to filling of the initial opioid analgesic, not to refills of schedule III-V opioid analgesics (OBOP)

- Subsequent prescriptions may be written in accordance with the SCA.

- If initial prescription is for > 7 days, must check OARRS

- Minors must have informed consent from legal guardians before prescribing opioids (ORC 4723.48)

Schedule II Requirements for SCA

- **SCA Must Include:**
  The exact authority to prescribe schedule II drugs
  Example: May prescribe all scheduled drugs NOT on OBON exclusionary formulary; or may prescribe all schedule II drugs with exception of stimulants; or May not prescribe schedule II drugs

- QA standards must be inclusive of schedule II drugs with a representative sampling review

- APRN must follow all standards & procedures for the utilization and review of OARRS reports (OAC 4723-9-12).

New Requirements for Opioid Prescriptions – Effective 4/6/2017

Outpatient Prescriptions for Opioid Analgesics:
- Law prohibits pharmacist from dispensing an opioid analgesic if prescription is more than 14 days old (since it was issued or signed)
- 14 day limit applies only to filling the initial opioid prescription of (Schedule II-V)
- It does not apply to refills of schedule III-V opioid analgesics
- Law limits pharmacist to dispense or sell more than a 90 day supply
- Law does not prohibit a prescriber from writing more than 90 day supply
- Enforcement of the law falls on the pharmacist.

Prescriber may continue to issue multiple concurrent prescriptions for schedule II opioid analgesics if all of the following apply:
1.) Prescriber has provided written instructions indicating the earliest date on which the script may be filled
2.) Prescription is one of multiple prescriptions for the opioid analgesic issued by prescriber to patient on same day
3.) When combined the prescriptions do not authorize the patient to receive more than 90 day supply of the opioid analgesic.

**14 day requirement. Starts on the date indicated on the script when it may be filled. Example (do not fill until 7/1/17 is valid until 5/14/17)**
Proposed New Limits on Prescription Opiates for Acute Pain BON 4/28/17

- For treatment of acute pain, APRN shall not prescribe long-acting or extended release analgesics.
- Before prescribing opioid analgesics, APRN shall consider non-opioid treatment options.
- If opioid prescription is required, it should be for minimum quantity and potency needed.
- For adults, no more than 7-day supply with no refills.
- For minors, no more than 5-day supply with no refills, see section 4723.481 of ORC – comply with 719.061 of ORC regarding guardian consent.
- May exceed 7 day limit for adults and 5 day limit for minors if expect pain to persist for longer. Must document why limits are being exceeded and reason non-opioid analgesic medication was not utilized.
- May prescribe a different opioid medication if patient is allergic to initial opioid medication.
- Total morphine equivalent dose (MED) shall not exceed an average of thirty MED per day.

Proposed New Limits on Prescription Opiates for Acute Pain BON 4/28/17 (cont.)

The requirements of this rule apply to treatment of acute pain and DO NOT apply when opioid analgesic is prescribed:
- To hospice patient in hospice care program;
- To individual receiving palliative care;
- To individual diagnosed with terminal condition;
- To individual with cancer or condition associated with individual's cancer or history of cancer;
- To chronic pain (per BOP);
- Requirements to not apply to prescriptions for opioid analgesics for treatment of opioid addiction utilizing controlled substances approved by FDA for opioid detox or maintenance treatment.
- Does not apply to Inpatient Prescriptions.

OPIOIDS AND ADDICTION

- As of October 2015 may now prescribe opioids for neonatal abstinence syndrome (NAS).
- NAS prescribing, previously not allowed, changed from prescribing for addiction to prescribing for abstinence syndrome.
- NPs may not prescribe opioids for drug addiction – UNLESS NP is a registered prescriber under the Federal CARA Act (July 2016).
- Must meet all requirements to be a registered suboxone prescriber as do physicians.
  - APRNs restricted to no more than 30 patients, physicians no more than 275. (Must follow Ohio BOM AND OBOP rules governing suboxone prescribing)
  - Required 24 hours of training.
Buprenorphine (Suboxone) to Treat Opioid Addiction  NEW 2017

• OBON- CPG (NEW 2017) revised OBON formulary to enable qualified CNPs, with SAMHSA training and DATA-waiver to prescribe suboxone for Medication Assisted Therapies
• The CNP’s CP must also have a DATA-waiver
• CNP must engage in practice consistent with ORC 4723-43
• CNP must incorporate the BOM OAC rule 4731-11-12
• CNP must complete 24 hours of required training per CARA.
• Courses are offered through SAMHSA. CNPs may take the 8 hour course offered free (also AANP). Authorization to prescribe includes NPs and PAs as prescribers of Suboxone to treat opioid addiction per federal law (CARA)
• APRNs restricted to no more than 30 patients, physicians to 275

Terminal Distributor License Required for Office-Based Addiction Opioid TX  NEW 2017

• Effective 8/4/2017
• Any location/facility where prescriber is treating >30 patients for opioid dependence/addiction using a controlled substance must obtain a TD license with office-based opioid treatment classification
  – BOP will start licensing beginning late spring
• Treating opioid addiction/dependence does not necessarily mean on-site drugs. It includes writing a prescription for these drugs.

Office-Based Opioid Treatment continues....

• Exemptions:
  – Hospitals; Opioid licensed Facilities owned by a hospital
  – Physician practices owned or controlled by hospital
  – Research Facilities – clinical research using opioids
  – Facilities with TD license, certified by SAMSA
  – Programs/facilities certified by ODMHAS
• Rules mirror Pain Management Practices
• APRN owned practices may NOT participate in Buprenorphine Program per Ohio law.
• If prescribing Buprenorphine for chronic pain management, no 30 patient limit
• More information: www.pharmacy.ohio.gov
**OARRS Highlights**

**revised and effective 2/1/2016**

- Before initially prescribing benzodiazepines or opioids, must obtain OARRS report that covers the 12 months immediately preceding date of request.
- Red flags: an APRN shall obtain and review an OARRS report when any red flags pertain to the patient (OAC 4723-9-12)
- If practice area adjoins another state, must request a report of any information available in state’s controlled drug database that pertains to prescriptions issued or drugs furnished to the patient. (ORC 4723.487)
- Must request OARRS and other state report every 90 days until prescription stopped.
- OARRS review for reported drugs that are not opioid analgesics or benzodiazepines:
  - Obtain and review an OARRS report following a course of treatment for a period > 90 days if treatment includes the prescribing or personally furnishing of reported drugs that are not opioid analgesics or benzodiazepines;
  - Obtain and review an OARRS report at least annually thereafter until the course of treatment utilizing these reported drugs has ended.

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**OARRS continues...**

- APRN shall document in the patient’s record that report was received and information was assessed.

**Exemptions to OARRS Requirement:**

- A drug database report is not available. APRN must document in the patient’s record why the report is not available, if known.
- Drug prescribed in an amount indicated for a period not to exceed 7 days for new patient and no previous opioid prescription unless it is documented that 14 days is approved in SCA.
- Drug prescribed for the treatment of cancer or another condition associated with cancer.
- Drug prescribed to a hospice patient in a hospice care program or any other patient diagnosed as terminally ill.
- Drug prescribed for administration in a hospital, nursing home, or residential care facility.
  - Must check OARRS if prescribing benzos or opioids for any discharged patients.

OARRS reports may be requested by the APRN’s delegate but APRN must personally review.

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**OARRS continues...**

- Physician consultation:
  - APRN must first consult CP prior to prescribing a scheduled drug at the patient’s next visit when a determination has been made based on OARRS report or finding red flag(s) that there may be abuse or diversion of controlled substances.
- Consultation shall include and result in:
  - Review & documentation of the reason(s) why APRN believes that the patient may be abusing or diverting drugs;
  - Review and documentation of the patient’s progress toward treatment objectives over the course of treatment; and
  - Review & documentation of patient’s functional status including ADL’s, adverse effects, analgesia and aberrant behavior over the course of treatment.
OAARS continues...

• Consultation may include and result in:
  – Utilization of patient treatment agreement that includes more frequent and periodic review of OARRS reports, more frequent office visits, different treatment options, drug screens, use of one pharmacy, use of one provider for the prescription or personally furnishing of reported drugs, and consequences for non-compliance with the terms of the agreement.
  – The patient treatment agreement shall be maintained as part of the patient record
  – Consultation with or referral to a substance use disorder specialist.

• All APRNs must be registered with OAARS even if APRN does not prescribe controlled substances.

Reporting Gabapentin Products to OARRS (OAC 4729-37-12)

• Effective 12-1-2016 NEW
• Prescribers are required to submit specified dispensing, personal furnishing, or wholesale sale information on all products containing gabapentin to OARRS
  – Must include personally furnished gabapentin to outpatients, including samples. (PRESCRIBING?)
• Not required to check OARRS before prescribing
  – Use professional clinical judgment on when OARRS should be checked

Determination & Pronouncement of Death (ORC 4723.36)

• CNS, CNP & RN can determine & pronounce death:
  – If respiratory & circulatory functions are not artificially sustained.
  – If individual is in LTC facility, residential care facility, assisted living or county home.
  – If CNP or CNS provides supervision of individual’s care through hospice care program or palliative care
• APRN may not complete individual’s death certificate.
• Attending physician must be notified within 24 hours.
Hospital Admission Authority
ORC 3737.06
APRNs with collaboration agreement with hospital staff physician if:
* Hospital privileged and credentialed
* Must notify CP prior to admitting patient
* No change in APRN scope – APRNs make admission decisions, this simply allows them to write the specific order to admit.
Face-to-face visit with physician is not required and not in law.
Hospital bylaws must allow.

Naloxone Prescription for a Non-Patient (ORC 4723.488)
• APRNs may personally furnish/issue naloxone prescription to friend, family member, or other individual in a position to provide assistance to individuals at risk of experiencing an opioid-related overdose;
• Grants immunity from criminal or civil liability or professional disciplinary action when acting in good faith;
• Requires health care professional to instruct individual to whom the drug is furnished/prescription is issued to summon EMS immediately before or immediately after administering naloxone.

EPT in Ohio
• Expedited Partner Therapy 4723.4810 [Effective 3/23/2016] Authority to prescribe or furnish drugs to sexual partner of a patient diagnosed with chlamydia, gonorrhea, or trichomoniasis.
• Health care prescribers are authorized to prescribe or furnish treatment for chlamydia, gonorrhea, or trichomoniasis “without having examined the individual for whom the drug is intended” if they are the sexual partner of the provider’s patient who was diagnosed with chlamydia, gonorrhea, or trichomoniasis, and other conditions are also met.
• Ohio Rev Code Ann. § 4723.4810 (nurses)
Expedited Partner Therapy (ORC 4723.4810)
An APRN who prescribes or personally furnishes a drug may contact the individual for whom the drug is intended.

– If APRN contacts the individual, the following shall be done:
  • Inform individual that the individual may have been exposed to chlamydia, gonorrhea, or trichomoniasis;
  • Encourage individual to seek treatment from a health professional;
  • Explain treatment options available
  • Document in patient’s record that the APRN contacted the individual.  
– If the APRN does not contact the individual, APRN shall document that fact in the patient’s record.
– May NOT disclose the source of the infection

Expedited Partner Therapy continues...
An APRN who in good faith prescribes or personally furnishes a drug under this section is not liable for or subject to any of the following:

– Damages in any civil action;
– Prosecution in any criminal proceeding;
– Professional disciplinary action.
– PNP may treat adult partner of a non-minor
– CNM or WHNP: MAY ONLY TREAT male partners of their female patients with PRESCRIPTION

What to do if the board comes knocking
Preventive Action – Most Important
• Follow practice laws & rules for Ohio APRNs
• Keep all documents available for review and up-to-date
  • CE - Keep for six years
  • SCA keep for three years
• Consult legal counsel – immediately
• OAAPN website for attorney list (must be a member)

Do not call BON before attorney is contacted!!
• Don’t represent yourself
• Know your rights
• Don’t sign anything
• Check malpractice insurance for discipline coverage.
Common APRN Practice Pitfalls

- Failure to have SCA signed by APRN and Collaborator
- Failure to review and re-sign SCA — every 2 years
- Practicing outside of scope of SCA
- Failure to complete all prescription reviews and QA measures
- Failure to notify BON within 30 days of CP change
- Failure to maintain 3 years of SCAs
- License/certification expiration
- Lapsed/terminated/inadequate SCAs
- Formulary and prescribing mistakes, especially schedule II
- SCA cannot expand scope, may restrict scope

Investigations also triggered by:

- A complaint, frequent complainer: Pharmacist
  - Diversion, prescribing to family members
  - Exceeding # of days on initial opioid drug
  - Failure to check OARRS
- Failure to renew is #1

OAAPN and OSANA reviewed current law and crafted desired changes. Document is sent to Legislative Service Commission and legislative document is version 1. Representative Pelanda agrees to sponsor the bill in the House, it is assigned to Health and Aging Committee of the House on May 26, 2015.

Proponent Hearings 1/20/2016
Opponent Hearings 3/2/2016
Health and Aging Committee & House vote version 8 of the bill on May 13, 2016. Opposition was formidable with numerous interested parties, meetings and multiple iterations of the bill. Elimination of the formulary and the SCA did not survive. CRNA bill components were removed by the CRNAs due to medical opposition.

Health and Aging Committee & house vote
version 9 of the bill out of the House 5/25/16
Assigned to committee in Senate 9/28/16
Passed the Senate on 12/7/16
Signed by Governor 1/4/17
Wait 90 days to become law on 4/4/17
Signed by Speaker of the House and President of Senate

HB 216 – Benefits All APRNs
Changes Effective 4/6/2017

- Licensure:
  - APRNs have two licenses. RN & APRN with role designation as CRNA, CNM, CNS or CNP
  - APRNs must have RN license to practice as APRN and an active APRN license
- CE Licensure Requirement Changes FOR 2019 LICENSE
  - APRNs who apply for license in 2019 must have 24 hours of CE for RN license, including Category A CE on nurse practice law, and
  - 24 hours for APRN license, which includes 12 hours of pharmacology
  - Total of 48 hours of CE every 2 years, minimum required
HB 216 – Benefits All APRNs

- Licensure continued:
  - APRN license is inclusive of prescriptive authority for CNMs, CNSs & CNPs (follows APRN Consensus model)
  - CTP and CTP-E have been eliminated
  - APRNs with COA and CTP/CTP-E are eligible for the new APRN license
  - APRNs without CTP – See OBON APRN Licensure

- Formulary Changes:
  - Formulary became exclusionary only (listing only drugs an APRN may NOT prescribe) 5/17/17

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HB 216 – Benefits All APRNs

- Formulary Changes continued:
  - All restrictions on furnishing sample and stock medications have been removed
  - APRNs may not provide samples of controlled substances
  - Collaborating ratio of 3:1 for prescribing component at any one time expanded to 5:1

- Schedule II Changes:
  - Expanded schedule II authorized sites to include Assisted Living facilities

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HB 216 – Benefits All APRNs

- Schedule II for non-authorized sites:
  - Patient must have terminal condition (no change)
  - Initial prescription for schedule II must be prescribed by a physician (no longer mandates CP only)
  - May prescribe for 72 hours (instead of only 24)

- SCA content changes- eliminates:
  - SCA has no requirement for review of referrals to other health professionals or chart review of referral outcomes
  - SCA has no requirement for Policy for care of infants up to age 1 and no recommendations for visits for children from birth to age 3
HB 216 – Benefits All APRNs

• SCA policy changes:
  – “Buffer Period”
    • 120 day buffer period allows APRN to use current SCA if CP terminates collaboration agreement with APRN
    • Upon notification by current CP of intent to end collaboration, APRN notifies the OBON (“as soon as practicable”)
    • OBON receives notification and 120 day “buffer” period begins.
    • APRN may practice during 120 day “buffer” period under previous SCA without a CP (allows increased time for APRN to search for new CP)

• SCA policy changes:
  – SCA must be kept by the APRN employer, work site mandate has been eliminated
  – All APRNs, except CRNA must have SCA

• Collaboration changes:
  – Psychiatric CNS may have psychiatric CP or primary care CP in family, pediatric or internal medicine.
  – Psychiatric NPs were not included in this change, they must still use psychiatric CP only (technical fix is in process)

• Testimonial Privilege:
  – Testimonial privilege extended to APRNs (same as physician, attorney, clergy) may not testify regarding communication made to APRN by a patient

• APRN Advisory Committee:
  – Ohio BON is required to have an APRN advisory committee to advise the board on APRN practice issues.
  – Responsible for making recommendations to BON on practice and regulation of APRNs
  – May also make recommendations to Committee on Prescriptive Governance
  – Committee members appointed by the BON must include: 4 APRNs in active practice, (one must be in primary care, one must be CRNA, and one CNM)

4723.493 ORC
HB 216 – Benefits All APRNs

- APRN Advisory Committee continued:
  - Two APRN faculty: Kris Scordo, ACNP, Wright State, Latina Brooks, FNP, CWRU
  - One CMN: Vacant
  - One CNP Primary Care: Candy Reinhart, OAAPN President, FNP
  - One CRNA: James Furstein
  - One BON member APRN: Vacant
  - One APRN employer: Sandy Esber, CNP, MetroHealth Hospital
  - Members chosen from recommendations made by:
    - APRN schools, APRN organizations, OAAPN recommendations
  - BON may appoint extra members if recommended by the Advisory Committee
  - Initial appointments are for 1 year and some for 2 years
  - Members may be reappointed for 1 term
  - 5 members of the 8 person committee is a quorum

HB 216 – Benefits All APRNs

- Hospital Staff Membership/Professional Privileges:
  - Hospital governing body sets standards and procedures for considering applications for staff membership or professional privileges
  - Current law prohibits governing body from considering or acting upon applications or from discriminating against qualified persons solely on basis of whether that person is certified to practice medicine, osteopathic medicine, podiatry, dentistry or psychology
  - APRNs are now included in this prohibition (ORC 3701.351)

- Insurance and Maternity Benefits:
  - All insuring corporations and benefit plans that provide maternity benefits, and coverage for certain care after delivery, must now cover care from either a physician or APRN (ORC 3701.351)

HB 216 Additional Components

- Changed CPG committee membership to: 3 APRNs and 3 physicians, one non-voting pharmacy member (improved ratio – previously outvoted)
- In case of tie vote, BON determines outcome but only after having a BON meeting 4723.49, 4723.492, 4729.50 ORC
- Includes APRNs and PAs as providers recognized to manage pediatric diabetes in school environments
- Extends validity period of advanced pharmacology course from 3 years to 5 years
- DNR orders extended to include CMNs, previously only CNSs and CNPs
- Professional discipline for all nurses:
  - BON authorized to discipline on additional grounds including: if clinical privileges are suspended, restricted reduced or terminated by VA and if DEA terminates or suspends DEA registration to prescribe.
- Notice of overdose death:
  - Authorized coroner to notify BON and state Dental Board of a drug overdose death. Notice includes information regarding the drug, and if it was prescribed and name of prescriber
  - Existing law provides this information regarding physicians to the BOM
HB 216 Additional Components

Advisory Committees
• APRNs may now be nominated to serve on the Board of Cosmetology
• APRNs may now be nominated to serve on the OBON’s Dialysis Advisory Committee

OBON
• Now required to have two APRNs on the board instead of one 4723.02 ORC
• Costs for RN & APRN licenses are unchanged from previous years
• That the Board issue or deny the license after receiving a complete application within 30 days rather than 60 days 4723.24, 4723.08 ORC

What is next?
• Removing Barriers to Practice for Psychiatric Mental Health APRNs – Spring of 2017:
  • House leadership approached OAAPN asking to address the Ohio mental health workforce crisis considered budget language that removed barriers for psychiatric mental health APRNs.
  • Proposed budget amendment was not pursued.
  • Seeking to include psych APRNs in exemption from PA for atypical psychogenic drugs. Heavy opposition from managed care.
  • Pursue FPA – Timeline not finalized

What is next?
• Removing Barriers to Practice Continues:
  • Will pursue FPA for all APRNs & removal of all barriers
  • OAAPN will pursue removing reimbursement barriers: particularly site differential, 85% in hospital site of service and 100% in non hospital site
  • APRN providers will be able to provide Telehealth services by April, 2017
  • Seek Signature Authority – or Global Signature, after budget is signed by the governor
  • OAAPN seeks removal of ratio language
  • Pink Slip Bill HB 111 which authorizes psychiatric APRNs to sign for pink slips, no opposition yet. Expected passage 2017
  • Tax credit for preceptors of APRNs: Legislative draft complete, seeking sponsor.
  • And much more…..

– HAVE A BARRIER LET OAAPN KNOW! –
How can YOU help?

- Become “Part of the Solution”
- Join OAAPN TODAY: The membership fee of $125 helps to fund legislative efforts ($45 FOR STUDENTS)
- Contact your legislator: 38 new legislators Contact your legislator by phone first, and by email, and most importantly, please visit
  - Educate the legislator: Tell the legislator how restrictive APRN practice laws affect your patients. Talk about what you do, what your role is and how prepared you are to do what you do.
- Share your story with OAAPN: Share your story with OAAPN, how you made a difference, what barriers to practice you face, have you practiced in another state that had Full Practice Authority and how was that different?
- Send additional forms that mandate physician signature only to OAAPN GRC Committee ASAP
- Look for updates on www.oaapn.org

Questions?

- APRN Practice Questions may also be answered by OAAPN attorney online.
- Members can submit questions at info@oaapn.org.

Christine Williams, APRN-NP, FAANP
christinewilliams01@gmail.com
216-538-3670, OAAPN Board of Directors:
Director for Reimbursement, Director for FPA

Thank You!