



AGENDA
POLICY COMMITTEE
NOVEMBER 10, 2020

1. Minutes Review
 2. Rule Review Update
 3. Rules at CSI
 - a. Controlled Substance Prescribing Rules
 - b. Personal Information Systems
 4. Initial Draft-PA consult rules
 5. Updated sexual misconduct draft legislation
 6. Telehealth FAQ updates
 7. Legislative Update
 8. Pharmacy Board updates
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State Medical Board of Ohio

POLICY COMMITTEE MEETING

October 14, 2020

via live-streamed video conference

<p>Members: Amol Soin, M.D., Chair Robert Giacalone, R.Ph., J.D. Mark Bechtel, M.D. Betty Montgomery Sherry Johnson, D.O.</p> <p>Other Board Members present: Michael Schottenstein, M.D. Kim Rothermel, M.D. Bruce Saferin, D.P.M. Jonathan Feibel, M.D. Harish Kakarala, M.D.</p>	<p>Staff: Stephanie Loucka, Executive Director Kimberly Anderson, Chief Legal Counsel Nathan Smith, Senior Legal and Policy Counsel Jill Reardon, Director of External Affairs Chelsea Wonski, Legislative Director Joseph Turek, Deputy Director for Licensure Cierra Lynch, Stakeholder Liaison Tessie Pollock, Chief Communications Officer Benton Taylor, Board Parliamentarian</p>
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Dr. Soin called the meeting to order at 9:36 a.m.

Minutes Review

Dr. Bechtel moved to approve the draft minutes of the September 9, 2020 meeting of the Policy Committee. Mr. Giacalone seconded the motion. The motion carried.

Rule Review Update

Ms. Anderson reported that the Board proposed rules for controlled substance prescribing, which include the weight loss medication prescribing rules, as well as the personal information systems rules have been filed with the Common Sense Initiative (CSI). The rules are currently in their comment period with CSI and those comments should be available for review by the Committee at its November meeting.

Rules to File with the Common Sense Initiative

Hearing Rules and Exposure Prone Invasive Procedure Rules: Ms. Anderson stated that the proposed hearing rules were circulated to interested parties for initial comments and two comments were received. One comment, received internally from Board staff, requested a change to extend the time period for respondents to request to address the Board when it deliberates a report and recommendation. The Board will still retain the authority to grant a request to address that is filed late. Ms. Anderson recommended approval of this request.

Ms. Anderson stated that one comment on the exposure prone invasive procedure rules was received from the Ohio Society of Respiratory Care about refining the types of procedures that respiratory care professional perform. The proposed change clarifies which respiratory care procedures are covered by the rule. Ms. Anderson recommended approval of the amended language.

Dr. Bechtel moved to approve the recommended changes to the proposed hearing rules and the proposed exposure prone invasive procedure rules. Mr. Giacalone seconded the motion. All members voted aye. The motion carried.

Licensure Eligibility Rule: Ms. Anderson stated that this proposed rule allows for some additional discretion in licensure eligibility for allopathic and osteopathic physicians. The comments received generally raised concerns about this proposed change. Ms. Anderson noted that two individuals wished to know why the Board was considering this change, and those individuals were provided with the Policy Committee meeting minutes from November 2019.

Dr. Schottenstein questioned whether the proposed rule addresses the concerns the Board had had in the matter of José Vargas, M.D. Dr. Schottenstein recalled that Dr. Vargas was an otherwise well-qualified physician who had taken the Federation Licensing Examination (FLEX) approximately 35 years prior and had scored a 74, whereas a passing score was 75. When Dr. Vargas applied for Ohio licensure, it was noted that under current rules the Board did not have discretion with regard to a score on a test. Despite this, the Board approved Dr. Vargas' application but also directed the staff to explore the possibility of amending the rule so that the Board would have more flexibility in similar cases. Dr. Schottenstein stated that the proposed new language is phrased so that any other examination would be acceptable. Dr. Schottenstein stated that the issue in Dr. Vargas' case is that he did not pass the FLEX examination, so he was uncertain if this new language would have addressed the Board's concerns in the Dr. Vargas matter.

Dr. Soin asked if Dr. Schottenstein had any suggestions for the proposed rule. Dr. Schottenstein replied that potentially the rule could state that the Board requires passing scores on examinations barring extenuating circumstances, or similar verbiage. Dr. Schottenstein commented that the proposed language in its current form seems vague and does not specify another examination that the Board would accept. Ms. Anderson opined that the proposed language addresses the issue by granting the Board discretion.

Mr. Turek stated that the issue in Dr. Vargas' case is that he did not pass a single three-day FLEX examination as required by the Board's rules. Dr. Vargas had initially taken a single three-day FLEX examination and did not pass, but another state had allowed Dr. Vargas to retake two of the three parts of the FLEX, which brought his cumulative score on the FLEX to a passing level and he was allowed licensure in that state. Although Dr. Vargas ultimately ended up with a passing score on the FLEX, it did not meet Ohio's requirements because he did not pass a single three-day FLEX.

Mr. Turek agreed that the proposed language was broad, as was pointed out in some of the public comments. Mr. Turek opined that under the proposed language the Board could be asked to accept examinations from other countries, which is not the intent of the rule.

In response to a question from Mr. Giacalone, Dr. Schottenstein stated that since becoming licensed by another state, Dr. Vargas had had a very distinguished, ethical career, and the Board decided to grant his request for licensure on that basis. Mr. Giacalone suggested that since the Board's decision in that matter had been driven by Dr. Vargas' experience and career, then perhaps the new language

should focus on the applicant's experience rather than an examination. Mr. Turek stated that the statutory requirement that an applicant must pass an examination cannot be waived.

In response to a question from Dr. Soin, Ms. Anderson stated that a physician may be granted Conceded Eminence if they meet certain requirements, such as having had a certain number of journal articles published. Physicians practicing under Conceded Eminence are limited to practicing in a specific health care system or facility. Dr. Bechtel agreed and added that Conceded Eminence was designed for physicians who have outstanding credentials and an exceptional record of research or clinical skills in a foreign country, but do not meet the regular licensure requirements in Ohio. Physicians with conceded eminence are limited to a specific academic institution and the dean of that institution has oversight of that physician.

Ms. Anderson noted that there are current legislative proposals involving licensure reciprocity which may resolve this issue if they are passed into law. Ms. Anderson stated that the Committee may wish to wait on this proposed rule until the issue of licensure reciprocity is decided in the legislature.

Dr. Saferin asked if a rule could be crafted to allow the Board to grant equivalency based on the applicant's career and skill, in much the same way the Board is able to grant equivalency in other licensure-based matters. Ms. Anderson stated that there may be issues with the ability to grant equivalency for an examination, but the matter can be reviewed again. Mr. Turek stated that statute requires applicants to have passed an examination prescribed in rules, so the Board is not able to pass a rule to say that having excellent experience is the same as passing an examination.

Dr. Soin suggested that this topic be tabled so that the staff can do more research based on the Committee's feedback. Dr. Soin stated that there seem to be four pathways that have been discussed:

- Dr. Saferin's concept of crafting language for granting equivalency, in line with statute.
- Addressing the fact that the Board has no way to police or understand foreign examinations.
- Making certain there is a mechanism, if possible, to address cases similar to Dr. Vargas'.
- Monitoring the legislature, where the passage of new proposals may resolve the issue.

Dr. Bechtel moved to table this topic. Dr. Johnson seconded the motion. All members voted aye. The motion to table carried.

Radiologist Assistant Rules: Ms. Anderson stated that radiologist assistant rules had been circulated to interested parties for public comment and no comments were received. The Policy Committee approved filing the rules with the Common Sense Initiative (CSI). In preparing the filing, it was discovered that modifications were needed to align the rules with statute. Ms. Anderson stated that the Committee can approve filing the proposed rules with CSI as amended because there will be a two-week comment period with CSI.

Specifically, Rule 4774-1-02 is being amended to align the radiologist assistant licensure rules with other license types. Also, Rule 4774-1-03, which deals with license renewal, had originally been proposed for rescission. However, in re-reviewing Section 4774.11, Ohio Revised Code, it was decided to keep the rule and include the standards and procedures for issuing and renewing licenses, including applications fees for initial licensure and license renewal. Ms. Anderson noted that whereas

application fees for other license types are set by statute, the Board is required by statute to set radiologist assistant application fees by rule.

Dr. Bechtel moved to recommend approval filing the radiologist assistant rules, as amended, with CSI. Mr. Giacalone seconded the motion. All members voted aye. The motion carried.

Consultation on Rule 5123:2-6-06, Department of Developmental Disabilities

Ms. Reardon stated that this proposed rule from the Ohio Department of Developmental Disabilities (DODD) requires approval from the Medical Board as part of the rule promulgation process. The proposed rule would approve DODD to conduct some of its education of new DODD personnel virtually. Ms. Reardon noted that the educational curriculum remains unchanged.

Dr. Bechtel moved to approve the proposed DODD rule. Dr. Johnson seconded the motion. All member voted aye. The motion carried.

Legislative Update

Dr. Soin stated that he, Ms. Wonski, and Ms. Loucka continue to work on the layout of the legislative tracker. One key change this month is that a delineated Board position is clearly listed for each bill. Examples of Board positions include “interested party,” “support,” and “strongly oppose.” Dr. Soin invited Board members to offer any further feedback for changes to the legislative tracker. Dr. Soin commented that Ms. Wonski and Ms. Loucka have expanded and improved the scope of how the Board is tracking bills to a level he has never seen.

Senate Bill 246, Occupational Licensing Reciprocity: Ms. Wonski stated that this bill is still awaiting adoption by the Senate committee, and no committee meeting is currently scheduled. The sub-bill addressed some of the original concerns the Board’s staff had brought to the sponsors, but the Board’s requested amendments were not included in their entirety. The staff went back to the bill sponsor and requested that the original amendments be added, especially those concerning fitness to practice. The Board’s staff continues to advocate for an unlimited historic lookback period for licensure applicants.

Senate Bill 364, Interstate Medical Licensing Compact: Ms. Wonski stated that this bill, introduced on September 16, would require Ohio to join the Interstate Medical Licensure Compact (IMLC). The Board’s policy team has met with the Executive Director of the IMLC and representatives of several member states. The issue was also briefly discussed with the Ohio State Medical Association (OSMA). Ms. Wonski noted that the compact language cannot be amended and, if it is adopted, must be adopted as written.

The bill’s sponsor is hosting an interested parties meeting next week and Board staff will be in attendance. A more comprehensive presentation of this issue will be provided at the next Policy Committee meeting.

House Bill 263, Occupational Licensing: Ms. Wonski stated that this bill would require the Board to provide a comprehensive list of criminal offenses that would prevent someone from being licensed in Ohio. Since the last Board meeting, the Board’s staff has been in contact with the bill’s sponsor and the Governor’s office to express the Board’s concerns.

Responding to a question from Ms. Montgomery, Ms. Wonski stated that House bill 263 allows for unlimited look-back for applicants with offences of a violent or sexual nature. Though Senate Bill 246 does not address that issue, Ms. Wonski can ask the sponsor of that bill to consider a similar provision.

House Bill 492, Physician Assistants: Ms. Wonski stated that this bill would expand the ability of physician assistants to perform procedural sedation and for purposes of rapid intubation. Ms. Wonski has sent a memo of the Board's opposition to this bill to the bill's sponsor, the Governor's office, and the Ohio Association of Physician Assistants.

Ms. Montgomery, noting that this legislation decouples national accreditation from licensure, asked if the bill is moving through the legislature. Ms. Wonski answered that the bill has not yet had its first hearing and it does not seem that there will be enough time for it to get through the legislative process. Ms. Wonski stated that she will continue to monitor that bill, noting that anything could happen in the lame duck session.

House Bill 679, Telehealth: Ms. Wonski stated that the telehealth bill continues to progress through the legislature. A package of the Board's proposed amendments has been submitted to the Chair and Vice Chair of the Senate Insurance Committee, to which the bill has been assigned. Ms. Wonski stated that she and other staff met with the Chair and Vice Chair and they seemed receptive to the Board's requests, though there was no official confirmation that the amendments would be added to the bill. The Chair and Vice Chair requested that the Board send them any feedback it receives from stakeholders.

Other Legislation: Ms. Wonski stated that several other bills have been added to the legislative tracker. Ms. Wonski commented that Senate Bill 238 would place the licensing of music therapists under the purview of the Medical Board. Also, House Bill 580 is another bill that seeks to expand telemedicine. Both of these bills are being analyzed by the Board's policy and legal teams and more information should be ready for next month's Committee meeting if it is believed that these bills will move forward.

Ms. Wonski stated that a memo has been provided to Board members outlining changes to the pharmacy consultation agreement language in House Bill 203. The Committee discussed the issue of consultation agreements between pharmacists and mid-level providers such as physician assistants and nurse practitioners. Of particular concern was the ability of pharmacists to prescribe opioids and whether those pharmacists would be required to have additional education in that regard. Dr. Bechtel stated that while pharmacists know a great deal about drugs and drug interactions, they are dealing with patients that may have co-morbidities that must be taken into account. With pharmacists consulting with physician assistants and nurse practitioners, Dr. Bechtel had concerns about the level of physician oversight. Dr. Bechtel was also concerned that pharmacists may order laboratory tests, but they cannot make a diagnosis. Dr. Bechtel questioned how confident the Board can be that physicians will have access to those test result and how those results will be acted on.

Ms. Wonski stated that the Medical Board will have the opportunity to create rules on these matters. Mr. Smith added that Section (C)(2) of the bill specifies that the diagnosis for which each patient has been prescribed drug therapy must be within the scope of the practitioner's practice. Also, Section (C)(3) requires that each pharmacist must have training and experience related to the particular diagnosis for which drug therapy is to be prescribed.

Dr. Soin questioned what would happen if a pharmacist orders a test and the physician has no access to the results. Dr. Soin stated that physicians are ultimately responsible for such things and he would hate to see a physician be subject to discipline or a malpractice complaint because of a test they did not order or have access to

Responding to a question from Mr. Giacalone, Ms. Wonski stated that a consultation agreement between a pharmacist and physician assistant or nurse practitioner is an extension of the physician assistant's or nurse practitioner's agreement with a physician. Mr. Giacalone stated that the physician, if he or she so desires, can ensure that any consultation agreement between a pharmacist and a physician assistant or nurse practitioner includes provisions such as barring the pharmacist from prescribing opioids or ordering imaging studies. Dr. Soin and Dr. Bechtel agreed with Mr. Giacalone's comments.

Mr. Giacalone asked about House Bill 747, which concerns prescribing or dispensing drugs for off-label use. Ms. Wonski stated that that legislation has not seen much movement, but she can look into it more closely and report back to the Committee. Dr. Soin commented that physicians regularly prescribe medications for off-label use. Dr. Soin noted that, for example, aspirin is not approved by the Food and Drug Administration (FDA) to treat acute myocardial infarction (MI), but it is commonly used for that purpose. Ms. Loucka noted that this bill was introduced the same day that the hydroxychloroquine issue occurred at the Board of Pharmacy, so it appears to be a response to that issue.

Dr. Schottenstein asked about Senate Bill 238, which would require the Medical Board to license and regular music therapists. Dr. Schottenstein was not opposed to the bill, but he was curious as to why the Medical Board was chosen to license that profession and not the Psychology Board. Ms. Wonski was uncertain why the music therapists chose the Medical Board, but in testimony the music therapists expressed all the benefits that music therapy has in conjunction with medical therapies. Ms. Loucka noted that the same bill would also require the Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board to license and regulate art therapists.

Mr. Giacalone asked about the chances of Senate Bill 238 being passed. Ms. Wonski stated that the bill has had its second hearing and would only need one more hearing to be passed onto the Senate floor, but it would have to move through very quickly to be passed in this legislative session. Mr. Giacalone questioned whether the Medical Board is the right place for music therapists and wondered if the profession is better situated in another board, particularly since the Medical Board's resources are already stressed.

Ms. Loucka stated that the music therapist licensing bill has been introduced in previous years, so she and Ms. Wonski can research that history and the Board's conversations at those times. Ms. Loucka wondered, since art therapists are also part of the bill, if those two professionals should be coupled together at the same board. Ms. Loucka also commented that the way music therapists are licensed is very different from the Medical Board's current licensure processes and there may be boards that are more similarly-situated for music therapists from a licensure standpoint.

Dr. Soin asked for a brief update on the bills that would authorize the use of medical marijuana to treat autism spectrum and opioid use disorder. Ms. Wonski replied that those bills are not expected to move through the legislative process.

Board of Pharmacy Updates

Ms. Anderson stated that there are no Board of Pharmacy items to discuss at this time.

Adjourn

Ms. Montgomery moved to adjourn the meeting. Dr. Bechtel seconded the motion. All Committee members voted aye. The motion carried.

The meeting adjourned at 10:23 a.m.

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MEMORANDUM

TO: Amol Soin, M.D., Chair, Policy Committee
Members, Policy Committee

FROM: Kimberly C. Anderson, Chief Legal Counsel

RE: Rule Review Update

DATE: November 4, 2020

Attached are the updated rule schedule and rule spreadsheet.

Action Requested: No action requested

Legal Dept. Rules Schedule

As of 11-4-20

To November Board Meeting for Adoption

4761-9-04

RULES AT CSI

Comment Deadline 2/28/20

4731-36-04

Comment Deadline 5/27/20

4731-18 – Light Based Medical Device Rules

Comment Deadline 6/12/20

4731-10-CME Rules

Comment Deadline 10/19/20

4731-8-01	4731-8-02	4731-8-03
4731-8-04	4731-8-05	4731-8-06
4731-11-02	4731-11-03	4731-11-04
4731-11-04.1	4731-11-07	4731-11-11

Comment Deadline 11/6/20

4774-1-01	4774-1-02	4774-1-03
4774-1-04	4731-17-01	4731-17-02
4731-17-03	4731-17-04	4731-17-05
4731-17-06	4731-17-07	

4731 Chapter 13 – 36 rules

Approved to File with CSI

4759-4-04	4759-4-08	4759-6-02
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RULES SENT FOR INITIAL CIRCULATION

Comment Deadline – September 25, 2020

4731-6-14

RULES AT JCARR

Filed 9/25/20 – Hearing to be held 10/27/20

Military Rules for all license types:

4730-1-06.1	4731-1-25	4731-6-35
4731-24-05	4731-36-01	4731-36-02
4731-36-03	4759-4-12	4759-4-13
4761-4-03	4761-8-01	4761-9-02
4761-12-01	4762-1-01	4774-1-02.1
4778-1-02.1		

Rule Number	Rule Description	Sent for Initial Comment	Board Approval to File with CSI	CSI filing	CSI recommendation	JCARR filing	Rules Hearing	JCARR Hearing	Board Adoption	New Effective Date	Current Review Date
4730-1-01	Regulation of Physician Assistants - Definitions		06/12/19							09/30/18	09/30/23
4730-1-05	Quality Assurance System		06/12/19							08/07/18	08/07/23
4730-1-06	Licensure as a physician assistant	03/22/19	06/12/19							09/30/18	09/30/23
4730-1-06.1	Military provisions related to certificate to practice as a physician assistant	03/22/19	06/12/19							09/30/15	09/30/20
4730-1-07	Miscellaneous Provisions		06/12/19							09/30/18	09/30/23
4730-1-08	Physician assistant delegation of medical tasks and administration of drugs		06/12/19							07/31/16	07/31/21
4730-2-01	Physician Delegated Prescriptive Authority - Definitions		06/12/19							9/30/18	09/15/19
4730-2-04	Period of on-site supervision of physician-delegated prescriptive authority		06/12/19							11/30/18	11/15/23
4730-2-05	Addition of valid prescriber number after initial licensure		06/12/19							11/30/18	11/15/23
4730-2-06	Physician Assistant Formulary		06/12/19							06/30/14	12/27/19
4730-2-07	Standards for Prescribing		06/12/19							9/30/18	12/27/19
4730-2-10	Standards and Procedures for use of OARRS		06/12/19							09/30/18	09/30/23
4730-4-01	Definitions									04/30/19	04/30/24
4730-4-03	Office Based Treatment for Opioid addiction									04/30/19	04/30/24
4730-4-04	Medication assisted treatment using naltrexone									04/30/19	04/30/24
4731-1-01	Limited Practitioners - Definition of Terms									03/30/20	03/30/25
4731-1-02	Application of Rules Governing Limited Branches of Medicine or Surgery									07/31/19	07/31/24
4731-1-03	General Prohibitions										08/31/23
4731-1-04	Scope of Practice: Mechanotherapy									12/31/18	12/31/23

Rule Number	Rule Description	Sent for Initial Comment	Board Approval to File with CSI	CSI filing	CSI recommendation	JCARR filing	Rules Hearing	JCARR Hearing	Board Adoption	New Effective Date	Current Review Date
4731-1-05	Scope of Practice: Massage Therapy				04/24/19	Refiled 8/20/19 4/29/19	06/05/19		10/16/19	11/05/19	11/05/24
4731-1-06	Scope of Practice: Naprapathy									08/31/18	08/31/23
4731-1-07	Eligibility of Electrologists Licensed by the Ohio State Board of Cosmetology to Obtain Licensure as Cosmetic Therapists Pursuant to Chapter 4731 ORC and Subsequent Limitations									12/31/18	12/31/23
4731-1-08	Continuing Cosmetic Therapy Education Requirements for Registration or Reinstatement of a License to Practice Cosmetic Therapy									09/30/19	09/30/24
4731-1-09	Cosmetic Therapy Curriculum Requirements										08/31/23
4731-1-10	Distance Education									01/31/19	01/31/24
4731-1-11	Application and Certification for certificate to practice cosmetic therapy									03/30/20	03/30/25
4731-1-12	Examination									11/30/16	11/30/21
4731-1-15	Determination of Standing of School, College or Institution									12/31/18	12/31/23
4731-1-16	Massage Therapy curriculum rule (Five year review)									01/31/19	11/30/21
4731-1-17	Instructional Staff									05/31/19	05/31/24
4731-1-18	Grounds for Suspension, Revocation or Denial of Certificate of Good Standing, Hearing Rights									03/30/20	03/30/25
4731-1-19	Probationary Status of a limited branch school									03/30/20	03/30/25
4731-1-24	Massage Therapy Continuing Education	03/09/16		10/26/16	04/24/19	04/29/19	06/05/19			Withdrawn 8/30/19	
4731-1-25	Determination of Equiv. Military Educ. For CT/MT	03/22/19	06/12/19							12/31/15	12/31/20
4731-2-01	Public Notice of Rules Procedure									12/07/17	12/07/22
4731-4-01	Criminal Records Checks - Definitions									09/30/19	09/30/24
4731-4-02	Criminal Records Checks									09/30/19	09/30/24
4731-5-01	Admission to Examinations									06/09/17	06/09/22
4731-5-02	Examination Failure; Inspection and Regrading									06/09/17	06/09/22
4731-5-03	Conduct During Examinations									06/09/17	06/09/22

Rule Number	Rule Description	Sent for Initial Comment	Board Approval to File with CSI	CSI filing	CSI recommendation	JCARR filing	Rules Hearing	JCARR Hearing	Board Adoption	New Effective Date	Current Review Date
4731-5-04	Termination of Examinations									06/09/17	06/09/22
4731-6-01	Medical or Osteopathic Licensure: Definitions									07/31/19	07/31/24
4731-6-02	Preliminary Education for Medical and Osteopathic Licensure									07/31/19	07/31/24
4731-6-04	Demonstration of proficiency in spoken English									06/09/17	06/09/22
4731-6-05	Format of Medical and Osteopathic Examination									07/31/19	07/31/24
4731-6-14	Examination for physician licensure									07/31/19	07/31/24
4731-6-15	Eligibility for Licensure of National Board Diplomats and Medical Council of Canada Licentiates									07/31/19	07/31/24
4731-6-21	Application Procedures for Certificate Issuance; Investigation; Notice of Hearing Rights									07/31/19	07/31/24
4731-6-22	Abandonment and Withdrawal of Medical and Osteopathic Licensure Applications									07/31/19	07/31/24
4731-6-30	Training Certificates									07/31/19	07/31/24
4731-6-31	Limited Preexamination Registration and Limited Certification									07/31/19	07/31/24
4731-6-33	Special Activity Certificates									07/31/19	07/31/24
4731-6-34	Volunteer's Certificates									07/31/19	07/31/24
4731-6-35	Processing applications from service members, veterans, or spouses of service members or veterans.									07/31/19	07/31/24
4731-7-01	Method of Notice of Meetings									07/31/19	07/31/24
4731-8-01	Personal Information Systems	02/20/19								04/21/16	04/21/21
4731-8-02	Definitions									04/21/16	04/21/21
4731-8-03	Procedures for accessing confidential personal information									04/21/16	04/21/21
4731-8-04	Valid reasons for accessing confidential personal information									04/21/16	04/21/21
4731-8-05	Confidentiality Statutes									07/31/16	07/31/21
4731-8-06	Restricting & Logging access to confidential personal information									04/21/16	04/21/21

Rule Number	Rule Description	Sent for Initial Comment	Board Approval to File with CSI	CSI filing	CSI recommendation	JCARR filing	Rules Hearing	JCARR Hearing	Board Adoption	New Effective Date	Current Review Date
4731-9-01	Record of Board Meetings; Recording, Filming, and Photographing of Meetings									09/15/19	06/17/24
4731-10-01	Definitions									02/02/18	02/02/23
4731-10-02	Requisite Hours of Continuing Medical Education for License Renewal or Reinstatement									05/31/18	05/31/23
4731-10-03	CME Waiver									05/31/18	05/31/23
4731-10-04	Continuing Medical Education Requirements for Restoration of a License									05/31/18	05/31/23
4731-10-05	Out-of-State Licensees									05/31/18	05/31/23
4731-10-06	Licensure After Cutoff for Preparation of Registration Notices									05/31/18	05/31/23
4371-10-07	Internships, Residencies and Fellowships									05/31/18	05/31/23
4371-10-08	Evidence of Continuing Medical Education									05/31/18	05/31/23
4731-10-09	Continuing Medical Education Requirement for Mid-term Licensees									05/31/18	05/31/23
4731-10-10	Continuing Medical Education Requirements Following License Restoration									05/31/18	05/31/23
4731-10-11	Telemedicine Certificates									05/31/18	05/31/23
4731-11-01	Controlled substances; General Provisions Definitions									12/23/18	12/07/22
4731-11-02	Controlled Substances - General Provisions	07/26/19								04/30/19	12/31/20
4731-11-03	Schedule II Controlled Substance Stimulants	07/26/19								12/31/15	12/31/20
4731-11-04	Controlled Substances: Utilization for Weight Reduction	07/26/19								02/29/16	02/28/21
4731-11-04.1	Controlled substances: Utilization for chronic weight management	07/26/19								12/31/15	12/31/20
4731-11-07	Research Utilizing Controlled Substances	07/26/19								09/30/15	09/30/20
4731-11-08	Utilizing Controlled Substances for Self and Family Members									08/17/16	08/17/21

Rule Number	Rule Description	Sent for Initial Comment	Board Approval to File with CSI	CSI filing	CSI recommendation	JCARR filing	Rules Hearing	JCARR Hearing	Board Adoption	New Effective Date	Current Review Date
4731-11-09	Prescribing to persons the physician has never personally examined.									03/23/17	03/23/22
4731-11-11	Standards and procedures for review of "Ohio Automated Rx Reporting System" (OARRS).	07/26/19								12/31/15	12/31/20
4731-11-13	Prescribing of Opioid Analgesics for Acute Pain									08/31/17	08/31/22
4731-11-14	Prescribing for subacute and chronic pain			3/21/19						12/23/18	12/23/23
4731-12-01	Preliminary Education for Licensure in Podiatric Medicine and Surgery									06/30/17	06/30/22
4731-12-02	Standing of Colleges of Podiatric Surgery and Medicine									06/30/17	06/30/22
4731-12-03	Eligibility for the Examination in Podiatric Surgery and Medicine (see note below)									04/19/17	04/19/22
4731-12-04	Eligibility of Licensure in Podiatric Medicine and Surgery by Endorsement from Another State									06/30/17	06/30/22
4731-12-05	Application Procedures for Licensure in Podiatric Medicine and Surgery, Investigation, Notice of Hearing Rights.									06/30/17	06/30/22
4731-12-06	Visiting Podiatric Faculty Certificates									06/30/17	06/30/22
4731-12-07	Podiatric Training Certificates									06/30/17	06/30/22
4731-13-01	Conduct of Hearings - Representative; Appearances									07/31/16	07/31/21
4731-13-02	Filing Request for Hearing									07/31/16	07/31/21
4731-13-03	Authority and Duties of Hearing Examiners									09/30/18	07/31/21
4731-13-04	Consolidation										04/21/21
4731-13-05	Intervention										04/21/21
4731-13-06	Continuance of Hearing									09/30/16	09/30/21
4731-13-07	Motions									09/30/18	04/21/21
4731-13-07.1	Form and page limitations for briefs and memoranda									09/30/18	09/30/23
4731-13-08	Filing									07/31/16	07/31/21
4731-13-09	Service									07/31/16	07/31/21
4731-13-10	Computation and Extension of Time									07/31/16	07/31/21
4731-13-11	Notice of Hearings									07/31/16	07/31/21

Rule Number	Rule Description	Sent for Initial Comment	Board Approval to File with CSI	CSI filing	CSI recommendation	JCARR filing	Rules Hearing	JCARR Hearing	Board Adoption	New Effective Date	Current Review Date
4731-13-12	Transcripts									07/31/16	07/31/21
4731-13-13	Subpoenas for Purposes of Hearing	05/09/19	06/12/19							07/31/16	07/31/21
4731-13-14	Mileage Reimbursement and Witness Fees										04/21/21
4731-13-15	Reports and Recommendations									07/31/16	07/31/21
4731-13-16	Reinstatement or Restoration of Certificate									07/31/16	07/31/21
4731-13-17	Settlements, Dismissals, and Voluntary Surrenders									04/21/16	04/21/21
4731-13-18	Exchange of Documents and Witness Lists									07/31/16	07/31/21
4731-13-20	Depositions in Lieu of Live Testimony and Transcripts in place of Prior Testimony									07/31/16	07/31/21
4731-13-20.1	Electronic Testimony									07/31/16	07/31/21
4731-13-21	Prior Action by the State Medical Board									04/21/16	04/21/21
4731-13-22	Stipulation of Facts									04/21/16	04/21/21
4731-13-23	Witnesses									09/14/16	09/30/21
4731-13-24	Conviction of a Crime									04/21/16	04/21/21
4731-13-25	Evidence									07/31/16	07/31/21
4731-13-26	Broadcasting and Photographing Administrative Hearings									04/21/16	04/21/21
4731-13-27	Sexual Misconduct Evidence									04/21/16	04/21/21
4731-13-28	Supervision of Hearing Examiners									04/21/16	04/21/21
4731-13-30	Prehearing Conference									04/21/16	04/21/21
4731-13-31	Transcripts of Prior Testimony									04/21/16	04/21/21
4731-13-32	Prior Statements of the Respondent									04/21/16	04/21/21
4731-13-33	Physician's Desk Physician									04/21/16	04/21/21
4731-13-34	Ex Parte Communication									07/31/16	07/31/21
4731-13-35	Severability									04/21/16	04/21/21
4731-13-36	Disciplinary Actions									07/31/16	07/31/21
4731-14-01	Pronouncement of Death									06/30/16	06/30/21
4731-15-01	Licensee Reporting Requirement; Exceptions									11/17/17	11/17/22
4731-15-02	Healthcare Facility Reporting Requirement									11/17/17	11/17/22
4731-15-03	Malpractice Reporting Requirement									11/17/17	11/17/22
4731-15-04	Professional Society Reporting									11/17/17	11/17/22

Rule Number	Rule Description	Sent for Initial Comment	Board Approval to File with CSI	CSI filing	CSI recommendation	JCARR filing	Rules Hearing	JCARR Hearing	Board Adoption	New Effective Date	Current Review Date
4731-17-06	Barrier Techniques										08/17/21
4731-17-07	Violations									11/09/16	11/30/21
4731-18-02	Use of Light Based Medical Devices	01/17/18	03/14/18							05/31/02	06/30/05
4731-18-03	Delegation of the Use of Light Based Medical Devices	01/17/18	03/14/18							06/30/00	06/30/05
4731-18-04	Delegation of the Use of Light Based Medical Devices; Exceptions	01/17/18	03/14/18							05/31/02	05/31/07
4731-20-01	Surgery Privileges of Podiatrist - Definition of Foot									05/31/18	05/31/23
4731-20-02	Surgery: Ankle Joint									05/31/18	05/31/23
4731-22-01	Emeritus Registration - Definitions									08/31/17	08/31/22
4731-22-02	Application									08/31/17	08/31/22
4731-22-03	Status of Registrant									05/12/17	05/12/22
4731-22-04	Continuing Education Requirements									05/12/17	05/12/22
4731-22-06	Renewal of Cycle of Fees									05/12/17	05/12/22
4731-22-07	Change to Active Status									08/31/17	08/31/22
4731-22-08	Cancellation of or Refusal to Issue an Emeritus Registration									05/12/17	05/12/22
4731-23-01	Delegation of Medical Tasks - Definitions									11/30/16	11/30/21
4731-23-02	Delegation of Medical Tasks									11/30/16	11/30/21
4731-23-03	Delegation of Medical Tasks: Prohibitions									08/17/16	08/17/21
4731-23-04	Violations									08/17/16	08/17/21
4731-24-01	Anesthesiologist Assistants - Definitions									07/31/19	07/31/24
4731-24-02	Anesthesiologist Assistants; Supervision									07/31/19	07/31/24
4731-24-03	Anesthesiologist Assistants; Enhanced Supervision									07/31/19	07/31/24
4731-24-05	Military Provisions Related to Certificate to Practice as an Anesthesiologist Assistant									07/31/19	07/31/24
4731-25-01	Office-Based Surgery - Definition of Terms										03/01/23
4731-25-02	General Provisions									05/31/18	05/31/23
4731-25-03	Standards for Surgery Using Moderate Sedation/Analgesia									05/31/18	08/31/23

Rule Number	Rule Description	Sent for Initial Comment	Board Approval to File with CSI	CSI filing	CSI recommendation	JCARR filing	Rules Hearing	JCARR Hearing	Board Adoption	New Effective Date	Current Review Date
4731-25-04	Standards for Surgery Using Anesthesia Services									05/31/18	05/31/23
4731-25-05	Liposuction in the Office Setting									03/01/18	03/01/23
4731-25-07	Accreditation of Office Settings									05/31/18	05/31/23
4731-25-08	Standards for Surgery									09/30/19	09/30/24
4731-26-01	Sexual Misconduct - Definitions									06/30/16	06/30/21
4731-26-02	Prohibitions									06/14/16	06/14/21
4731-26-03	Violations; Miscellaneous									06/30/16	06/30/21
4731-27-01	Definitions									02/04/19	02/02/24
4731-27-02	Dismissing a patient from the medical practice									05/31/19	05/31/24
4731-27-03	Notice of termination of physician employment or physician leaving a practice, selling a practice, or retiring from the practice of medicine									05/31/19	05/31/24
4731-28-01	Mental or Physical Impairment									08/31/17	08/31/22
4731-28-02	Eligibility for confidential monitoring program									08/31/18	08/31/23
4731-28-03	Participation in the confidential monitoring program									08/31/18	08/31/23
4731-28-04	Disqualification from continued participation in the confidential monitoring program									08/31/18	08/31/23
4731-28-05	Termination of the participation agreement for the confidential monitoring program									08/31/18	08/31/23
4731-29-01	Standards and procedures for operation of a pain management clinic.									06/30/17	06/30/22
4731-30-01	Internal Management Definitions									09/23/18	09/23/23
4731-30-02	Internal Management Board Metrics	07/26/19								09/23/18	09/23/23
4731-30-03	Approval of Licensure Applications									10/17/19	10/17/24
4731-31-01	Requirements for assessing and granting clearance for return to practice or competition. (concussion rule)					04/10/19	05/13/19			09/18/15	09/18/20
4731-32-01	Definition of Terms									09/08/17	09/08/22
4731-32-02	Certificate to Recommend Medical Marijuana									09/08/17	09/08/22
4731-32-03	Standard of Care									09/08/17	09/08/22

Rule Number	Rule Description	Sent for Initial Comment	Board Approval to File with CSI	CSI filing	CSI recommendation	JCARR filing	Rules Hearing	JCARR Hearing	Board Adoption	New Effective Date	Current Review Date
4759-8-11	<i>Computation and Extension of Time</i>	04/19/18	07/11/18	09/25/18							12/20/17
4759-8-12	<i>Transcripts</i>	04/19/18	07/11/18	09/25/18							12/20/17
4759-8-13	<i>Subpoenas for Purposes of Hearing</i>	04/19/18	07/11/18	09/25/18							12/20/17
4759-8-14	<i>Mileage Reimbursement and Witness Fees</i>	04/19/18	07/11/18	09/25/18							12/20/17
4759-8-15	<i>Reports and Recommendations</i>	04/19/18	07/11/18	09/25/18							12/20/17
4759-8-16	<i>Exchange of Documents and Witness Lists</i>	04/19/18	07/11/18	09/25/18							12/20/17
4759-8-17	<i>Pre-hearing conference</i>	04/19/18	07/11/18	09/25/18							12/20/17
4759-8-18	<i>Requirements for pre-hearing exchange of information</i>	04/19/18	07/11/18	09/25/18							12/20/17
4759-8-19	<i>Status conference</i>	04/19/18	07/11/18	09/25/18							12/20/17
4759-8-20	<i>Depositions and transcripts of prior testimony</i>	04/19/18	07/11/18	09/25/18							12/20/17
4759-8-21	<i>Prior action by the board</i>	04/19/18	07/11/18	09/25/18							12/20/17
4759-8-22	<i>Stipulation of Facts</i>	04/19/18	07/11/18	09/25/18							12/20/17
4759-8-23	<i>Witnesses</i>	04/19/18	07/11/18	09/25/18							12/20/17
4759-8-24	<i>Conviction of a Crime</i>	04/19/18	07/11/18	09/25/18							12/20/17
4759-8-25	<i>Rules of evidence</i>	04/19/18	07/11/18	09/25/18							12/20/17
4759-8-26	<i>Broadcasting and Photographing Administrative Hearings</i>	04/19/18	07/11/18	09/25/18							12/20/17
4759-8-27	<i>Sexual misconduct evidence</i>	04/19/18	07/11/18	09/25/18							12/20/17
4759-8-28	<i>Reinstatement of license</i>	04/19/18	07/11/18	09/25/18							12/20/17
4759-8-29	<i>Settlements, Dismissals, and Voluntary Surrenders</i>	04/19/18	07/11/18	09/25/18							12/20/17
4759-9-01	<i>Severability</i>	04/19/18	07/11/18	09/25/18							12/18/17
4759-10-01	<i>Definitions</i>	04/19/18	07/11/18	09/25/18							12/18/17
4759-10-02	<i>Procedures for accessing confidential personal information</i>	04/19/18	07/11/18	09/25/18							12/18/17
4759-10-03	<i>Valid reasons for accessing confidential personal information</i>	04/19/18	07/11/18	09/25/18							12/18/17
4759-10-04	<i>Confidentiality Statutes</i>	04/19/18	07/11/18	09/25/18							12/18/17
4759-10-05	<i>Restricting & Logging access to confidential personal information in computerized personal information systems</i>	04/19/18	07/11/18	09/25/18							12/18/17
4759-11-01	<i>Miscellaneous Provisions</i>	04/19/18	07/11/18	09/25/18							
4761-2-03	<i>Board Records</i>									02/28/19	02/28/24
4761-3-01	<i>Definition of terms</i>									02/28/19	02/28/24

Rule Number	Rule Description	Sent for Initial Comment	Board Approval to File with CSI	CSI filing	CSI recommendation	JCARR filing	Rules Hearing	JCARR Hearing	Board Adoption	New Effective Date	Current Review Date
4761-4-01	Approval of educational programs									02/28/19	02/28/24
4761-4-02	Monitoring of Ohio respiratory care educational programs									02/28/19	02/28/24
4761-4-03	Recognition of military educational programs for active duty military members and/or military veterans									11/15/18	11/15/23
4761-5-01	Waiver of licensing requirements pursuant to division (B) of section 4761.04 or the Revised Code	04/23/19	06/12/19							04/24/13	04/24/18
4761-5-02	Admission to the Ohio credentialing examination	04/23/19	06/12/19							05/06/10	05/06/15
4761-5-04	License application procedure	04/23/19	06/12/19							08/12/13	08/15/18
4761-5-06	Respiratory care practice by polysomnographic technologists	04/23/19	06/12/19							12/31/16	12/31/17
4761-6-01	Limited permit application procedure	04/23/19	06/12/19							02/28/19	02/28/24
4761-7-01	Original license or permit, identification card or electronic license verification									02/28/19	02/28/24
4761-7-03	Scope of respiratory care defined										11/15/23
4761-7-04	Supervision										11/15/23
4761-7-05	Administration of medicines										11/15/23
4761-8-01	Renewal of license or permits	03/22/19	06/12/19								08/15/18
4761-9-01	Definition of respiratory care continuing education										02/28/24
4761-9-02	General RCCE requirements and reporting mechanism	03/22/19	06/12/19								05/06/15
4761-9-03	Activities which do not meet the Ohio RCCE requirements									02/28/19	02/28/24
4761-9-04	Ohio respiratory care law and professional ethics course criteria										02/28/24
4761-9-05	Approved sources of RCCE										02/28/24
4761-9-07	Auditing for compliance with RCCE requirements										05/06/15
4761-10-01	Ethical and professional conduct									02/28/19	02/28/24
4761-10-02	Proper use of credentials										11/15/23
4761-10-03	Providing information to the Board	04/23/19	06/12/19								05/06/15
4761-12-01	Initial application fee									06/04/14	05/06/15
4761-15-01	Miscellaneous Provisions									02/28/19	02/28/24



MEMORANDUM

TO: Amol Soin, M.D., Chair, Policy Committee
Members, Policy Committee

FROM: Kimberly C. Anderson, Chief Legal Counsel

RE: Rules Filed with CSI

DATE: November 4, 2020

On October 5, 2020, two packages of rules were filed with CSI, rules regarding personal information systems and certain rules regarding controlled substance prescribing. The deadline for comments was October 19, 2020.

To date, we have received no comments on the personal information system rules.

We received one comment, from Jennifer Hayhurst of the Ohio State Medical Association with respect to rule 4731-11-04, Ohio Administrative Code, which is attached for your review.

Ms. Hayhurst proposes that the medical Board form a working group to further study the issue of bariatric prescribing and indicates that the OSMA would be willing to identify experts in this area of medicine.

Requested action: Discuss the proposal from OSMA for a working group related to bariatric prescribing.

From: [Jennifer Hayhurst](#)
To: [Reardon, Jill](#); [Rodriguez, Judith](#)
Cc: [CSIPublicComments](#)
Subject: Comments on Bariatric Rxing Rule OAC 4731-11-04
Date: Tuesday, October 20, 2020 9:33:53 AM

Thank you for the opportunity to comment on Ohio Administrative Code 4731-11-04, *Controlled substances: Utilization for weight reduction*.

Despite previous and ongoing objections from the OSMA and several others, and considering the advances in pharmaceutical obesity practices and the recognition of obesity as a chronic disease, limits set by the board in 1986 to curb abuse have relatively remained the same.

The OSMA, and our members who specialize in the practice of bariatric medicine, urge the medical board to form a working group to further study the issue of bariatric prescribing. Many Ohio (and national) bariatric medicine experts disagree with the board's decision continue placing time limits on prescribing and would appreciate an opportunity to work with the board on this issue.

We thank you for your consideration of our request and we will be happy to work with the board to assist in identify experts in this area of medicine.

Thank you.

Jennifer Hayhurst

Director, Regulatory Affairs
Ohio State Medical Association
5115 Parkcenter Ave. Ste.200
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OSMA Office (800) 766-6762, (614) 527-6762

Cell Phone (614) 282-7926

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MEMORANDUM

TO: Amol Soin, M.D., Chair, Policy Committee
Members, Policy Committee

FROM: Kimberly C. Anderson, Chief Legal Counsel

RE: Proposed Amendments to Consult Agreement Rules-Rules 4731-35-01, 4731-35-02
and 4730-2-07, OAC

DATE: November 5, 2020

HB 203 becomes effective on December 16, 2020 and makes changes to the Pharmacy Board's statute regarding consult agreement by adding physician assistants and clinical nurse specialists, certified nurse-midwives and certified nurse practitioners to the list of prescribers who may enter into consult agreements with pharmacists. The Medical Board's rules regarding consult agreements for physicians became effective on October 31, 2020.

Section 4729.39, Ohio Revised Code requires the Medical Board to consult with the Pharmacy Board in the promulgation of these rules and the Pharmacy Board and Nursing Board are both required to consult with the Medical Board in the promulgation of their rules. The Nursing Board is not planning to start the process for these rules until mid-2021. I am scheduled to meet with representatives of the Pharmacy Board on Thursday, November 12, 2020 to discuss requirements for terminal distributors and institutional settings and to discuss their plan for rule promulgation.

In reviewing the legislation and our current rules, it appears that the most efficient way to address the changes is to amend the existing consult agreement rules to include the addition of physician assistants and to amend Rule 4730-2-07, OAC to add the consult agreement rules to those required to be followed by physician assistants when prescribing.

Attached please find Section 4729.39, Ohio Revised Code and proposed amendments to Rules 4731-35-01, 4731-35-02, and 4730-2-07, OAC.

Requested Action: Circulate proposed amendments to PAPC, Board of Pharmacy, Board of Nursing and interested parties for input.

4729.39 [Effective 12/16/2020] Consult agreement with practitioners.

(A) As used in this section:

(1) "Certified nurse practitioner," "certified nurse-midwife," "clinical nurse specialist," and "standard care arrangement" have the same meanings as in section [4723.01](#) of the Revised Code.

(2) "Collaborating physician" means a physician who has entered into a standard care arrangement with a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner.

(3) "Physician" means an individual authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(4) "Physician assistant" means an individual who is licensed to practice as a physician assistant under Chapter 4730. of the Revised Code, holds a valid prescriber number issued by the state medical board, and has been granted physician-delegated prescriptive authority.

(5) "Supervising physician" means a physician who has entered into a supervision agreement with a physician assistant under section [4730.19](#) of the Revised Code.

(B) Subject to division (C) of this section, one or more pharmacists may enter into a consult agreement with one or more of the following practitioners:

(1) Physicians;

(2) Physician assistants, if entering into a consult agreement is authorized by one or more supervising physicians;

(3) Clinical nurse specialists, certified nurse-midwives, or certified nurse practitioners, if entering into a consult agreement is authorized by one or more collaborating physicians.

(C) Before entering into a consult agreement, all of the following conditions must be met:

(1) Each practitioner must have an ongoing practitioner-patient relationship with each patient whose drug therapy is to be managed.

(2) The diagnosis for which each patient has been prescribed drug therapy must be within the scope of each practitioner's practice.

(3) Each pharmacist must have training and experience related to the particular diagnosis for which drug therapy is to be prescribed.

(D) With respect to consult agreements, all of the following apply:

(1) Under a consult agreement, a pharmacist is authorized to do both of the following, but only to the extent specified in the agreement, this section, and the rules adopted under this section:

(a) Manage drug therapy for treatment of specified diagnoses or diseases for each patient who is subject to the agreement, including all of the following:

(i) Changing the duration of treatment for the current drug therapy;

(ii) Adjusting a drug's strength, dose, dosage form, frequency of administration, or route of administration;

(iii) Discontinuing the use of a drug;

(iv) Administering a drug;

(v) Notwithstanding the definition of "licensed health professional authorized to prescribe drugs" in section [4729.01](#) of the Revised Code, adding a drug to the patient's drug therapy.

(b)

(i) Order laboratory and diagnostic tests, including blood and urine tests , that are related to the drug therapy being managed, and evaluate the results of the tests that are ordered.

(ii) A pharmacist's authority to evaluate test results under division (D)(1)(b)(i) of this section does not authorize the pharmacist to make a diagnosis.

(2)

(a) A consult agreement, or the portion of the agreement that applies to a particular patient, may be terminated by any of the following:

(i) A pharmacist who entered into the agreement;

(ii) A practitioner who entered into the agreement;

(iii) A patient whose drug therapy is being managed;

(iv) An individual who consented to the treatment on behalf of a patient or an individual authorized to act on behalf of a patient.

(b) The pharmacist or practitioner who receives the notice of a patient's termination of the agreement shall provide written notice to every other pharmacist or practitioner who is a party to the agreement. A pharmacist or practitioner who terminates a consult agreement with regard to one or more patients shall provide written notice to all other pharmacists and practitioners who entered into the agreement and to each individual who consented to treatment under the agreement. The termination of a consult agreement with regard to one or more patients shall be recorded by the pharmacist and practitioner in the medical records of each patient to whom the termination applies.

(3) A consult agreement shall be made in writing and shall include all of the following:

(a) The diagnoses and diseases being managed under the agreement, including whether each disease is primary or comorbid;

(b) A description of the drugs or drug categories the agreement involves;

(c) A description of the procedures, decision criteria, and plan the pharmacist is to follow in acting under a consult agreement;

(d) A description of how the pharmacist is to comply with divisions (D)(5) and (6) of this section.

(4) The content of a consult agreement shall be communicated to each patient whose drug therapy is managed under the agreement.

(5) A pharmacist acting under a consult agreement shall maintain a record of each action taken for each patient whose drug therapy is managed under the agreement.

(6) Communication between a pharmacist and practitioner acting under a consult agreement shall take place at regular intervals specified by the primary practitioner acting under the agreement. The agreement may include a requirement that a pharmacist send a consult report to each consulting practitioner.

(7) A consult agreement is effective for two years and may be renewed if the conditions specified in division (C) of this section continue to be met.

(8) A consult agreement does not permit a pharmacist to manage drug therapy prescribed by a practitioner who has not entered into the agreement.

(E) The state board of pharmacy, state medical board, and board of nursing shall each adopt rules as follows for its license holders establishing standards and procedures for entering into a consult agreement and managing a

patient's drug therapy under a consult agreement:

- (1) The state board of pharmacy, in consultation with the state medical board and board of nursing, shall adopt rules to be followed by pharmacists.
- (2) The state medical board, in consultation with the state board of pharmacy, shall adopt rules to be followed by physicians and rules to be followed by physician assistants.
- (3) The board of nursing, in consultation with the state board of pharmacy and state medical board, shall adopt rules to be followed by clinical nurse specialists, certified nurse-midwives, and certified nurse practitioners.

The boards shall specify in the rules any categories of drugs or types of diseases for which a consult agreement may not be established. Each board may adopt any other rules it considers necessary for the implementation and administration of this section. All rules adopted under this section shall be adopted in accordance with Chapter 119. of the Revised Code.

(F)

(1) Subject to division (F)(2) of this section, both of the following apply:

(a) A pharmacist acting in accordance with a consult agreement regarding a practitioner's change in a drug for a patient whose drug therapy the pharmacist is managing under the agreement is not liable in damages in a tort or other civil action for injury or loss to person or property allegedly arising from the change.

(b) A practitioner acting in accordance with a consult agreement regarding a pharmacist's change in a drug for a patient whose drug therapy the pharmacist is managing under a consult agreement is not liable in damages in a tort or other civil action for injury or loss to person or property allegedly arising from the change unless the practitioner authorized the specific change.

(2) Division (F)(1) of this section does not limit a practitioner's or pharmacist's liability in damages in a tort or other civil action for injury or loss to person or property allegedly arising from actions that are not related to the practitioner's or pharmacist's change in a drug for a patient whose drug therapy is being managed under a consult agreement.

Amended by 133rd General Assembly File No. TBD, HB 203, §1, eff. 12/16/2020.

Amended by 131st General Assembly File No. TBD, HB 116, §1, eff. 8/31/2016.

Amended by 131st General Assembly File No. TBD, HB 188, §1, eff. 3/23/2016.

Effective Date: 02-12-2001 .

Note: *This section is set out twice. See also § [4729.39](#), effective until 12/16/2020.*

4730-2-07

Standards for prescribing.

- (A) A physician assistant who holds a prescriber number and who has been granted physician-delegated prescriptive authority by a supervising physician may prescribe a drug or therapeutic device provided the prescription is in accordance with all of the following:
- (1) The extent and conditions of the physician-delegated prescriptive authority, granted by the supervising physician who is supervising the physician assistant in the exercise of the authority;
 - (2) The requirements of Chapter 4730. of the Revised Code;
 - (3) The requirements of Chapters 4730-1, 4730-2, 4730-4, ~~and~~ 4731-11, and 4731-35 of the Administrative Code; and
 - (4) The requirements of state and federal law pertaining to the prescription of drugs and therapeutic devices.
- (B) A physician assistant who holds a prescriber number who has been granted physician-delegated prescriptive authority by a supervising physician shall prescribe in a valid prescriber-patient relationship. This includes, but is not limited to:
- (1) Obtaining a thorough history of the patient;
 - (2) Conducting a physical examination of the patient;
 - (3) Rendering or confirming a diagnosis;
 - (4) Prescribing medication, ruling out the existence of any recognized contraindications;
 - (5) Consulting with the supervising physician when necessary; and
 - (6) Properly documenting these steps in the patient's medical record.
- (C) The physician assistant's prescriptive authority shall not exceed the prescriptive authority of the supervising physician under whose supervision the prescription is being written, including but not limited to, any restrictions imposed on the physician's practice by action of the United States drug enforcement administration or the state medical board of Ohio.

- (D) A physician assistant holding a prescriber number and who has been granted physician-delegated prescriptive authority by a supervising physician to prescribe controlled substances shall apply for and obtain the United States drug enforcement administration registration prior to prescribing any controlled substances.
- (E) A physician assistant holding prescriber number and who has been granted physician-delegated prescriptive authority by a supervising physician shall not prescribe any drug or device to perform or induce an abortion.
- (F) A physician assistant holding prescriber number and who has been granted physician-delegated prescriptive authority by a supervising physician shall include on each prescription the physician assistant's license number, and, where applicable, shall include the physician assistant's DEA number.

4731-35-01

Consult agreements.

(A) For purposes of this chapter, practitioner includes the following:

- (1) Physician authorized to practice medicine and surgery or osteopathic medicine and surgery under chapter 4731 of the revised code.
- (2) Physician assistant who is licensed to practice as a physician assistant under chapter 4730 of the revised code, holds a valid prescriber number issued by the state medical board, and has been granted physician-delegated prescriptive authority.

~~(A)~~(B) Requirements of a consult agreement.

(1) A consult agreement shall include all of the following:

- (a) Identification of the ~~physician~~practitioner(s) and pharmacist(s) authorized to enter into the agreement. They may include:
 - (i) Individual names of ~~physicians~~practitioners and pharmacists;
 - (ii) ~~Physician~~Practitioner or pharmacist practice groups; or
 - (iii) Identification based on institutional credentialing or privileging.
- (b) A description of the patient's consent to drug therapy management pursuant to the consult agreement as set forth in paragraphs (H) and (I) of rule 4729:1-06-01 of the Administrative Code.
- (c) The specific diagnoses and diseases being managed under the agreement, including whether each disease is primary or comorbid.
- (d) A description of the drugs or drug categories managed as part of the agreement.
- (e) A description of the procedures, decision criteria, and plan the managing pharmacist is to follow in acting under a consult agreement. Such a description should provide a reasonable set of parameters of the activities a managing pharmacist is allowed to perform under a consult agreement.
- (f) A description of the types of blood, urine or other tests permitted pursuant to section 4729.39 of the Revised Code that may be ordered and

evaluated by the managing pharmacist as long as the tests relate directly to the management of drug therapy. This may include specific tests or categories of testing that may be ordered and evaluated.

- (g) A description of how the managing pharmacist shall maintain a record of each action taken for each patient whose drug therapy is managed under the agreement. All prescribing, administering, and dispensing of drugs shall be documented using positive identification pursuant to paragraph (N) of rule 4729-5-01 of the Administrative Code.
- (h) A description of how communication between a managing pharmacist and ~~physician~~practitioner acting under a consult agreement shall take place at regular intervals specified by the ~~physician~~practitioner who authorized the agreement. The agreement may include a requirement that the managing pharmacist send a consult report to each consulting ~~physician~~practitioner.
- (i) A provision that allows a ~~physician~~practitioner to override a decision made by the managing pharmacist when appropriate.
- (j) An appropriate quality assurance mechanism to ensure that managing pharmacists only act within the scope authorized by the consult agreement.
- (k) A description of a continuous quality improvement (CQI) program used to evaluate effectiveness of patient care and ensure positive patient outcomes. The CQI program shall be implemented pursuant to the agreement.
- (l) The training and experience criteria for managing pharmacists. The criteria may include privileging or credentialing, board certification, continuing education or any other training requirements. The agreement shall include a process to verify that the managing pharmacists meet the specified criteria.
- (m) A statement that the ~~physicians~~practitioners and pharmacists shall meet minimal and prevailing standards of care at all times.
- (n) An effective date and expiration date.
- (o) Any other requirements contained in rules 4729:1-6-01, 4729:1-6-02 and

4729:1-6-03 of the Administrative Code.

- (2) Institutional or ambulatory outpatient facilities may implement a consult agreement and meet the requirements of paragraphs (A)(1)(c) to (A)(1)(f) of this rule through institutional credentialing standards or policies. Such standards or policies shall be referenced as part of the consult agreement and available to an agent of the board upon request.
- (3) The agreement shall be signed by the primary physician, which may include a medical director or designee if the designee is licensed pursuant to Chapter 4731. of the Revised Code, and one of the following:
 - (a) The terminal distributor's responsible person, which may include the responsible person's designee if the designee meets the qualifications of the responsible person pursuant to Chapter 4729. of the Revised Code; or
 - (b) A managing pharmacist licensed pursuant to Chapter 4729. of the Revised Code if that pharmacist is not practicing at a pharmacy or institutional facility licensed as a terminal distributor of dangerous drugs.
- (4) All amendments to a consult agreement shall be signed and dated by the primary ~~physician~~practitioner, which may include a medical director or designee if the designee is licensed pursuant to Chapter 4731. of the Revised Code, and one of the following:
 - (a) The terminal distributor's responsible person, which may include the responsible person's designee if the designee meets the qualifications of the responsible person pursuant to Chapter 4729. of the Revised Code; or
 - (b) A managing pharmacist licensed pursuant to Chapter 4729. of the Revised Code if that pharmacist is not practicing at a pharmacy or institutional facility licensed as a terminal distributor of dangerous drugs.
 - (c) Amendments to the consult agreement are required when the scope of the managing pharmacist's permitted procedures expands past what was contemplated withing the agreement
- (5) A consult agreement shall be valid for a period not to exceed two years.

- (6) Only the following Ohio licensed ~~physicians~~practitioners practicing in Ohio and Ohio licensed pharmacists may participate in a consult agreement pursuant to section 4729.39 of the Revised Code.

(a) Physicians

(b) Physician assistants if entering into a consult agreement is authorized by one or more supervising physicians under a supervision agreement under section 4730.19 of the revised code

- ~~(B)~~(C) Recordkeeping. The primary ~~physician~~practitioner, ~~physician~~practitioner group or institution as defined in agency 4729 of the Administrative Code shall maintain a copy of the original consult agreement, and all amendments made thereafter, and a record of actions made in consultation with the managing pharmacist regarding each patient's drug therapy. These records shall be maintained in such a manner that they are readily retrievable for at least three years from the date of the last action taken under the agreement. Such consult agreements shall be considered confidential patient records.

~~(E)~~(D) Managing drug therapy.

- (1) For the purpose of implementing the management of a patient's drug therapy by an authorized managing pharmacist acting pursuant to a consult agreement, the primary ~~physician~~ practitioner must:

(a) Provide the managing pharmacist with access to the patient's medical record; and

(b) Establish the managing pharmacist's prescriptive authority as one or both of the following:

(i) A prescriber authorized to issue a drug order in writing, orally, by a manually signed drug order sent via facsimile or by an electronic prescribing system for drugs or combinations or mixtures of drugs to be used by a particular patient as authorized by the consult agreement. For all prescriptions issued by a pharmacist pursuant to this paragraph, the pharmacist shall comply with rules 4729-5-30 and 4729-5-13 of the Administrative Code; and or

(ii) With respect to non-controlled dangerous drugs only, an agent of the consulting ~~physician~~practitioner(s). As an agent of the consulting ~~physician~~practitioner(s), a pharmacist is authorized to

issue a drug order, on behalf of the consulting ~~physician~~practitioner(s), in writing, orally, by a manually signed drug order sent via facsimile or by an electronic prescribing system for drugs or combinations or mixtures of drugs to be used by a particular patient as authorized by the consult agreement, and

(c) Specifically authorize the managing pharmacist's ability to:

(i) Change the duration of treatment for the current drug therapy; adjust a drug's strength, dose, dosage form, frequency of administration, route of administration, discontinue a drug, or to prescribe new drugs; and or

(ii) Order blood, urine and other tests related to the drug therapy being managed and to evaluate those results, and

(d) Identify the extent to which, and to whom, the managing pharmacist may delegate drug therapy management to other authorized pharmacists under the agreement.

~~(D)~~(E) Review of consult agreements. Upon the request of the state medical board, the primary ~~physician~~practitioner shall immediately provide a copy of the consult agreement, amendments, and any relating policies or documentation pursuant to this rule and section 4729.39 of the Revised Code. The state medical board may prohibit the execution of a consult agreement, or subsequently void a consult agreement, if the board finds any of the following:

(1) The agreement does not meet the requirements set forth in section 4729.39 of the Revised Code or this division of the administrative code; or

(2) The consult agreement, if executed, would present a danger to patient safety.

Standards for managing drug therapy.

- (A) A physicianpractitioner may elect to manage the drug therapy of an established patient by entering into a consult agreement with a pharmacist. The agreement is subject, but not limited to, the following standards:
- (1) The primary physicianpractitioner must ensure that the managing pharmacist has access to the patient's medical record, the medical record is accurate, and that while transferring the medical record, the primary physicianpractitioner ensures the confidentiality of the medical record.
 - (2) The physicianpractitioner must have an ongoing physicianpractitioner-patient relationship with the patient whose drug therapy is being managed, including an initial assessment and diagnosis by the physicianpractitioner prior to the commencement of the consult agreement.
 - (3) With the exception of inpatient management of patient care at an institutional facility as defined in agency 4729 of the Administrative Code, the physicianpractitioner, prior to a pharmacist managing the patient's drug therapy, shall communicate the content of the proposed consult agreement to each patient whose drug therapy is managed under the agreement, in such a manner that the patient or the patient's representative understands scope and role of the managing pharmacist, which includes the following:
 - (a) That a pharmacist may be utilized in the management of the patient's care;
 - (b) That the patient or an individual authorized to act on behalf of a patient has the right to elect to participate in and to withdraw from the consult agreement.
 - (c) Consent may be obtained as part of the patient's initial consent to treatment.
 - (4) The diagnosis by the physicianpractitioner must be within the physicianpractitioner's scope of practice.
 - (5) The physicianpractitioner shall meet the minimal and prevailing standards of care.
 - (6) The physicianpractitioner must ensure that the pharmacist managing the patient's drug therapy has the requisite training, and experience related to the particular diagnosis for which the drug therapy is prescribed. PhysiciansPractitioners practicing at institutional or ambulatory outpatient

facilities may meet this requirement through institutional credentialing standards or policies.

- (7) The ~~physician~~practitioner shall review the records of all services provided to the patient under the consult agreement.
- (B) Quality assurance mechanisms. The following quality assurance mechanisms shall be implemented to verify information contained within the consult agreement, and ensure the managing pharmacist's actions are authorized and meet the standards listed in paragraphs (A) and (B) of this rule:
- (1) Verification of ongoing ~~physician~~practitioner-patient relationship. A ~~physician~~practitioner-patient relationship can be established by detailing criteria set forth in paragraph (A)(2) of this rule, within the consult agreement.
 - (2) Verification that ~~physician~~practitioner diagnosis is within the ~~physician~~practitioner's scope of practice. Establishing that a diagnosis is within the ~~physician~~practitioner's scope of practice may be established by detailing the criteria set forth in paragraph (A)(4) of this rule, within the consult agreement.
 - (3) Verification that pharmacist's training and experience is related to the drug therapy. Establishing that a pharmacist's requisite training and experience with a particular drug therapy is related to the diagnosis for which the drug therapy is prescribed, may be established by detailing the criteria set forth in paragraph (A)(6) of this rule, within the consult agreement.
- (C) Continuous quality improvement program. The following should be included in the development of a continuous quality improvement program in order to evaluate the effectiveness of patient care and ensure positive patient outcomes:
- (1) Notifications to primary ~~physician~~practitioner. The managing pharmacist must notify the primary ~~physician~~practitioner of the following situations regarding any pharmacist authorized to manage drug therapy under the agreement:
 - (a) A pharmacist has had their pharmacist license revoked, suspended, or denied by the state board of pharmacy;
 - (b) If prescribing controlled substances, a pharmacist has failed to renew their controlled substance prescriber registration;

- (c) If prescribing controlled substances, a pharmacist fails to obtain or maintain a valid D.E.A. registration;

- (D) Overriding decisions of managing pharmacist. Any authorized ~~physician~~practitioner identified under the consult agreement may override any decision, change, modification, evaluation or other action by any pharmacist acting pursuant to consult agreement or under the direction of the managing pharmacist, that was made with respect to the management of the patient's drug therapy under the consult agreement.



MEMORANDUM

TO: Amol Soin, M.D., Chair
Policy Committee Members

FROM: Nathan T. Smith, Senior Legal and Policy Counsel

DATE: November 5, 2020

RE: Sexual Misconduct Legislative Proposal responding to issues raised in the
Strauss Working Group Report

On October 14, 2020, the sexual misconduct draft legislative proposal was presented to the Sexual Misconduct Committee. The committee discussed the draft, and additional time was given for Board member input before the November Board Policy Committee meeting. Attached is the draft legislation for your review. Below is a summary of the legislative package.

1. Statutes on criminal conduct of specified licensees

Proposed amended R.C. 2907.03 Sexual Battery makes it a crime for a licensed medical professional (physician assistants, physicians [M.D., D.O., D.P.M. and training certificate holders], and massage therapists) to engage in sexual activity with a patient in the course of medical treatment. "Medical treatment" is defined to include in-person examination, consultation, health care, treatment, procedure, surgery or other in-person services provided by a licensed medical professional under the legal authority conferred by a license or certificate.

Sexual activity is defined in R.C. 2907.01(C) to include sexual conduct (intercourse and oral sexual conduct) and sexual contact (touching of the erogenous zones of another person, such as genitals or breast, for the purpose of sexual arousal or gratification of either person). Proposed R.C. 2907.03(B) differentiates the penalties for sexual battery as follows:

- (1) when the sexual activity is sexual conduct, it is a felony of the third degree, unless the other person is less than 18 years old then it is a felony of the second degree; or
- (2) when the sexual activity is sexual contact, it is a felony of the fifth degree. If the other person is less than 18 years old, it is a felony of the fourth degree.

With this sexual battery legislative proposal, there will no longer be a legislative proposal for misdemeanor sexual imposition in R.C. 2907.06. If the proposal is favorably received, it is expected that there will be input from other stakeholders and LSC to harmonize these proposed changes with other relevant sections in Chapter 2907 of the Revised Code.

2. Notification of Indictment and/or Conviction of Licensees in Revised Code sections 2907.17, 2907.18, and 2929.42

The legislative proposal amends three existing statutes to include prosecutor and/or court notification of the Medical Board when certain licensees are indicted or convicted of

certain crimes. This will provide the Board with greater notice and ability to discipline licensees indicted and/or convicted of certain crimes to protect the public. The proposal amends R.C. 2907.17 to add prosecutor notification to the medical board for an indictment for a licensed medical professional (as defined in R.C. 2907.01(Q)) for sexual battery. The statute currently requires the prosecutor to notify licensing boards related to an indictment of a mental health professional for sexual battery or sexual imposition.

Second, the proposal amends R.C. 2907.18 to include court notification of the Medical Board for a conviction of a licensed medical professional for sexual battery. The statute currently requires the court to notify the relevant licensing board when a mental health professional is convicted of sexual battery or sexual imposition.

Third, R.C. 2929.42 requires the prosecutor to notify licensing boards when certain licensees are convicted of specified offenses. The proposal amends the statute to include Medical Board's licensees in Revised Code Chapters 4759, 4760, 4761, 4762, 4774, and 4778.

3. Reporting Sexual Misconduct and Criminal Conduct

a. R.C. 2921.22 Failure to report a crime

The proposal amends this statute by adding division (F) which makes it a misdemeanor of the fourth degree to violate the following: any person who knows or has reasonable cause to suspect based on facts that would cause a reasonable person in a similar position to suspect that a licensed medical professional has committed a violation of a law within Chapter 2907. of the Revised Code against a patient or key third party of the patient shall report such knowledge or belief to local law enforcement authorities within seven days of obtaining this knowledge or belief. Further, (F)(2) provides immunity for timely reports or testimony in judicial proceedings resulting from those reports made in good faith without fraud or malice. People who have self-reported or participated in the violation of law being reported are not provided with immunity.

b. R.C. 2305.252 Peer Review,

The legislative proposal enables the Medical Board to issue an investigative subpoena to health care entities for peer review committee records related to allegations of sexual misconduct or criminal conduct by licensees as an exception to the confidentiality afforded to peer review. This will provide vital information of possible dangerous activity of Medical Board licensees to enhance the Medical Board's ability to protect the public by investigating these serious allegations.

c. R.C. 4731.224 Reporting Misconduct,

This proposal amends the statute to bolster the obligations of health care entities and licensees to timely report sexual misconduct and criminal conduct of licensees to the Medical Board. Specifically, a health care facility must report to the Medical Board any investigation of a

licensee for criminal conduct or sexual misconduct as defined in OAC 4731-26-01 within 30 days of the commencement of the investigation. Also, individual licensees are required to report within 30 days to the Medical Board any incidents that they reasonably believe to have occurred that involve: (1) sexual misconduct by a licensee involving a patient or key third party or (2) fraudulent prescribing, drug diversion, or theft of controlled substances by a licensee. Timely reporting by health care entities and licensees protects the public because it facilitates swift Board investigations to collect and evaluate evidence closer in time to the incident at issue.

4. Disciplinary and Patient Notification Statutes

R.C. 4731.22 Disciplinary actions

Proposed R.C. 4731.22(P) authorizes the Board to enter an emergency order suspending a license for a felony indictment under state or federal law in which the conduct charged would be a violation of R.C. 4731.22(B). Other proposed amendments include: (1) affirmatively authorizing Board staff to provide an investigative status update to a complainant upon request and verification of the complainant's identity in division (F)(4) and (2) prohibiting the disclosure of confidential investigatory information in division (F)(5).

R.C. 4731.99 Penalty

Proposed R.C. 4731.99(E) differentiates the penalties for failure to report sexual misconduct and criminal conduct (violations of R.C. 4731.224(A)(2) and (B)(3)) as misdemeanors of the fourth degree from the minor misdemeanor penalties for violations of other divisions of R.C. 4731.224. This is consistent with the penalties for R.C.2921.22(F)(1). In addition, new division (G) adds a misdemeanor of the first-degree penalty for violation of R.C. 4731.22(F)(5) for knowingly accessing, using, or disclosing Medical Board confidential investigatory information in a manner prohibited by law.

4731.991 Patient Notification of Licensee's Probation

This is a new statutory proposal that will provide valuable information to patients about licensees who have been placed on probation by the Medical Board for specific types of offenses involving harm to a patient. This applies to licensees placed on probation for sexual misconduct, drug or alcohol abuse that resulted in patient harm or impairs the ability of the licensee to practice safely, criminal conviction directly involving harm to patient health, or inappropriate prescribing resulting in harm to a patient. Licensees would be required to provide a written signed disclosure to the patient, obtain a signed copy from the patient confirming the disclosure, and keep that patient signed copy in the patient's medical record. The Medical Board would be required to provide current information about the probation on its website.

Legislative Drafts related to Sexual Misconduct and Reporting Requirements

R.C. 2907.01 Sex Offenses general definitions.

As used in sections [2907.01](#) to [2907.38](#) and 2917.211 of the Revised Code:

(A) "Sexual conduct" means vaginal intercourse between a male and female; anal intercourse, fellatio, and cunnilingus between persons regardless of sex; and, without privilege to do so, the insertion, however slight, of any part of the body or any instrument, apparatus, or other object into the vaginal or anal opening of another. Penetration, however slight, is sufficient to complete vaginal or anal intercourse.

(B) "Sexual contact" means any touching of an erogenous zone of another, including without limitation the thigh, genitals, buttock, pubic region, or, if the person is a female, a breast, for the purpose of sexually arousing or gratifying either person.

(C) "Sexual activity" means sexual conduct or sexual contact, or both.

(D) "Prostitute" means a male or female who promiscuously engages in sexual activity for hire, regardless of whether the hire is paid to the prostitute or to another.

(E) "Harmful to juveniles" means that quality of any material or performance describing or representing nudity, sexual conduct, sexual excitement, or sado-masochistic abuse in any form to which all of the following apply:

(1) The material or performance, when considered as a whole, appeals to the prurient interest of juveniles in sex.

(2) The material or performance is patently offensive to prevailing standards in the adult community as a whole with respect to what is suitable for juveniles.

(3) The material or performance, when considered as a whole, lacks serious literary, artistic, political, and scientific value for juveniles.

(F) When considered as a whole, and judged with reference to ordinary adults or, if it is designed for sexual deviates or other specially susceptible group, judged with reference to that group, any material or performance is "obscene" if any of the following apply:

(1) Its dominant appeal is to prurient interest;

(2) Its dominant tendency is to arouse lust by displaying or depicting sexual activity, masturbation, sexual excitement, or nudity in a way that tends to represent human beings as mere objects of sexual appetite;

(3) Its dominant tendency is to arouse lust by displaying or depicting bestiality or extreme or bizarre violence, cruelty, or brutality;

(4) Its dominant tendency is to appeal to scatological interest by displaying or depicting human bodily functions of elimination in a way that inspires disgust or revulsion in persons with ordinary sensibilities, without serving any genuine scientific, educational, sociological, moral, or artistic purpose;

(5) It contains a series of displays or descriptions of sexual activity, masturbation, sexual excitement, nudity, bestiality, extreme or bizarre violence, cruelty, or brutality, or human bodily functions of elimination, the cumulative effect of which is a dominant tendency to appeal to prurient or scatological interest, when the appeal to such an interest is primarily for its own sake or for commercial exploitation, rather than primarily for a genuine scientific, educational, sociological, moral, or artistic purpose.

(G) "Sexual excitement" means the condition of human male or female genitals when in a state of sexual stimulation or arousal.

(H) "Nudity" means the showing, representation, or depiction of human male or female genitals, pubic area, or buttocks with less than a full, opaque covering, or of a female breast with less than a full, opaque covering of any portion thereof below the top of the nipple, or of covered male genitals in a discernibly turgid state.

(I) "Juvenile" means an unmarried person under the age of eighteen.

(J) "Material" means any book, magazine, newspaper, pamphlet, poster, print, picture, figure, image, description, motion picture film, phonographic record, or tape, or other tangible thing capable of arousing interest through sight, sound, or touch and includes an image or text appearing on a computer monitor, television screen, liquid crystal display, or similar display device or an image or text recorded on a computer hard disk, computer floppy disk, compact disk, magnetic tape, or similar data storage device.

(K) "Performance" means any motion picture, preview, trailer, play, show, skit, dance, or other exhibition performed before an audience.

(L) "Spouse" means a person married to an offender at the time of an alleged offense, except that such person shall not be considered the spouse when any of the following apply:

(1) When the parties have entered into a written separation agreement authorized by section [3103.06](#) of the Revised Code;

(2) During the pendency of an action between the parties for annulment, divorce, dissolution of marriage, or legal separation;

(3) In the case of an action for legal separation, after the effective date of the judgment for legal separation.

(M) "Minor" means a person under the age of eighteen.

(N) "Mental health client or patient" has the same meaning as in section [2305.51](#) of the Revised Code.

(O) "Mental health professional" has the same meaning as in section [2305.115](#) of the Revised Code.

(P) "Sado-masochistic abuse" means flagellation or torture by or upon a person or the condition of being fettered, bound, or otherwise physically restrained.

(Q) "Licensed medical professional" means any of the following medical professionals:

(1) a physician assistant licensed under Chapter 4730. of the Revised Code;

(2) a physician licensed or authorized by training certificate under Chapter 4731. of the Revised to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery;

(3) a massage therapist licensed under Chapter 4731. of the Revised Code.

2907.03 Sexual Battery

(A) No person shall engage in **sexual conduct activity** with another, not the spouse of the offender, when any of the following apply:

(1) The offender knowingly coerces the other person to submit by any means that would prevent resistance by a person of ordinary resolution.

(2) The offender knows that the other person's ability to appraise the nature of or control the other person's own conduct is substantially impaired.

(3) The offender knows that the other person submits because the other person is unaware that the act is being committed.

(4) The offender knows that the other person submits because the other person mistakenly identifies the offender as the other person's spouse.

(5) The offender is the other person's natural or adoptive parent, or a stepparent, or guardian, custodian, or person in loco parentis of the other person.

(6) The other person is in custody of law or a patient in a hospital or other institution, and the offender has supervisory or disciplinary authority over the other person.

(7) The offender is a teacher, administrator, coach, or other person in authority employed by or serving in a school for which the state board of education prescribes minimum standards pursuant to division (D) of section [3301.07](#) of the Revised Code, the other person is enrolled in or attends that school, and the offender is not enrolled in and does not attend that school.

(8) The other person is a minor, the offender is a teacher, administrator, coach, or other person in authority employed by or serving in an institution of higher education, and the other person is enrolled in or attends that institution.

(9) The other person is a minor, and the offender is the other person's athletic or other type of coach, is the other person's instructor, is the leader of a scouting troop of which the other person is a member, or is a person with temporary or occasional disciplinary control over the other person.

(10) The offender is a mental health professional, the other person is a mental health client or patient of the offender, and the offender induces the other person to submit by falsely representing to the other person that the sexual conduct is necessary for mental health treatment purposes.

(11) The offender is a licensed medical professional, the other person is a patient of the offender, and the sexual activity occurs in the course of medical treatment.

~~(11)~~ **(12)** The other person is confined in a detention facility, and the offender is an employee of that detention facility.

~~(12)~~ **(13)** The other person is a minor, the offender is a cleric, and the other person is a member of, or attends, the church or congregation served by the cleric.

~~(13)~~ **(14)** The other person is a minor, the offender is a peace officer, and the offender is more than two years older than the other person.

(B) Whoever violates this section is guilty of sexual battery.

(1) When the sexual activity is sexual conduct, Except as otherwise provided in this division, sexual battery is a felony of the third degree. If the other person is less than thirteen eighteen years of age, sexual battery is a felony of the second degree, and the court shall impose upon the offender a mandatory prison term equal to one of the definite prison terms prescribed in division (A)(2)(b) of section 2929.14 of the Revised Code for a felony of the second degree, except that if the violation is committed on or after the effective date of this amendment, the court shall impose as the minimum prison term for the offense a mandatory prison term that is one of the minimum terms prescribed in division (A)(2)(a) of that section for a felony of the second degree.

(2) When the sexual activity is sexual contact, except as otherwise provided in this division, sexual battery is a felony of the fifth degree. If the other person is less than eighteen years of age, sexual battery is a felony of the fourth degree.

(C) As used in this section:

(1) "Cleric" has the same meaning as in section [2317.02](#) of the Revised Code.

(2) "Detention facility" has the same meaning as in section [2921.01](#) of the Revised Code.

(3) "Institution of higher education" means a state institution of higher education defined in section [3345.011](#) of the Revised Code, a private nonprofit college or university located in this state that possesses a certificate of authorization issued by the Ohio board of regents pursuant to Chapter 1713. of the Revised Code, or a school certified under Chapter 3332. of the Revised Code.

(4) "Peace officer" has the same meaning as in section [2935.01](#) of the Revised Code.

(5) "Medical treatment" includes in-person examination, consultation, health care, treatment, procedure, surgery or other in-person services provided by a licensed medical professional under the legal authority conferred by a license or certificate.

2907.17 Notice of indictment of mental health professional or licensed medical professional sent to regulatory or licensing board or agency

If a mental health professional **or licensed medical professional** is indicted or charged and bound over to the court of common pleas for trial for an alleged violation of division (A)(10) **or (11)** of section [2907.03](#) or division (A)(5) of section [2907.06](#) of the Revised Code, the prosecuting attorney handling the case shall send written notice of the indictment or the charge and bind over to the regulatory or licensing board or agency, if any, that has the administrative authority to suspend or revoke the mental health **professional or licensed medical** professional's professional license, certification, registration, or authorization.

2907.18 Notice of conviction of mental health professional or licensed medical professional sent to regulatory or licensing board or agency.

If a mental health professional **or licensed medical professional** is convicted of or pleads guilty to a violation of division (A)(10) **or (11)** of section 2907.03 or division (A)(5) of section [2907.06](#) of the Revised Code, the court shall transmit a certified copy of the judgment entry of conviction to the regulatory or licensing board or agency, if any, that has the administrative authority to suspend or revoke the mental health **professional or licensed medical** professional's professional license, certification, registration, or authorization.

R.C. 2929.42 Notice of conviction sent to licensing board.

(A) The prosecutor in any case against any person licensed, certified, registered, or otherwise authorized to practice under Chapter 3719., 4715., 4723., 4729., 4730., 4731., 4734., ~~or 4741.~~, **4759., 4760., 4761., 4762., 4774., or 4778.** of the Revised Code shall notify the appropriate licensing board, on forms provided by the board, of any of the following regarding the person:

- (1) A plea of guilty to, or a conviction of, a felony, or a court order dismissing a felony charge on technical or procedural grounds;
- (2) A plea of guilty to, or a conviction of, a misdemeanor committed in the course of practice or in the course of business, or a court order dismissing such a misdemeanor charge on technical or procedural grounds;
- (3) A plea of guilty to, or a conviction of, a misdemeanor involving moral turpitude, or a court order dismissing such a charge on technical or procedural grounds.

(B) The report required by division (A) of this section shall include the name and address of the person, the nature of the offense, and certified copies of court entries in the action.

R.C. 2921.22 Failure to report a crime or knowledge of a death or burn injury.

(A)

(1) Except as provided in division (A)(2) of this section, no person, knowing that a felony has been or is being committed, shall knowingly fail to report such information to law enforcement authorities.

(2) No person, knowing that a violation of division (B) of section [2913.04](#) of the Revised Code has been, or is being committed or that the person has received information derived from such a violation, shall knowingly fail to report the violation to law enforcement authorities.

(B) Except for conditions that are within the scope of division (E) of this section, no person giving aid to a sick or injured person shall negligently fail to report to law enforcement authorities any gunshot or stab wound treated or observed by the person, or any serious physical harm to persons that the person knows or has reasonable cause to believe resulted from an offense of violence.

(C) No person who discovers the body or acquires the first knowledge of the death of a person shall fail to report the death immediately to a physician or advanced practice registered nurse whom the person knows to be treating the deceased for a condition from which death at such time would not be unexpected, or to a law enforcement officer, an ambulance service, an emergency squad, or the coroner in a political subdivision in which the body is discovered, the death is believed to have occurred, or knowledge concerning the death is obtained. For purposes of this division, "advanced practice registered nurse" does not include a certified registered nurse anesthetist.

(D) No person shall fail to provide upon request of the person to whom a report required by division (C) of this section was made, or to any law enforcement officer who has reasonable cause to assert the authority to investigate the circumstances surrounding the death, any facts within the person's knowledge that may have a bearing on the investigation of the death.

(E)

(1) As used in this division, "burn injury" means any of the following:

(a) Second or third degree burns;

(b) Any burns to the upper respiratory tract or laryngeal edema due to the inhalation of superheated air;

(c) Any burn injury or wound that may result in death;

(d) Any physical harm to persons caused by or as the result of the use of fireworks, novelties and trick noisemakers, and wire sparklers, as each is defined by section [3743.01](#) of the Revised Code.

(2) No physician, nurse, physician assistant, or limited practitioner who, outside a hospital, sanitarium, or other medical facility, attends or treats a person who has sustained a burn injury that is inflicted by an explosion or other incendiary device or that shows evidence of having been inflicted in a violent, malicious, or criminal manner shall fail to report the burn injury immediately to the local arson, or fire and explosion investigation, bureau, if there is a bureau of

this type in the jurisdiction in which the person is attended or treated, or otherwise to local law enforcement authorities.

(3) No manager, superintendent, or other person in charge of a hospital, sanitarium, or other medical facility in which a person is attended or treated for any burn injury that is inflicted by an explosion or other incendiary device or that shows evidence of having been inflicted in a violent, malicious, or criminal manner shall fail to report the burn injury immediately to the local arson, or fire and explosion investigation, bureau, if there is a bureau of this type in the jurisdiction in which the person is attended or treated, or otherwise to local law enforcement authorities.

(4) No person who is required to report any burn injury under division (E)(2) or (3) of this section shall fail to file, within three working days after attending or treating the victim, a written report of the burn injury with the office of the state fire marshal. The report shall comply with the uniform standard developed by the state fire marshal pursuant to division (A)(15) of section [3737.22](#) of the Revised Code.

(5) Anyone participating in the making of reports under division (E) of this section or anyone participating in a judicial proceeding resulting from the reports is immune from any civil or criminal liability that otherwise might be incurred or imposed as a result of such actions. Notwithstanding section [4731.22](#) of the Revised Code, the physician-patient relationship or advanced practice registered nurse-patient relationship is not a ground for excluding evidence regarding a person's burn injury or the cause of the burn injury in any judicial proceeding resulting from a report submitted under division (E) of this section.

(F)

(1) Any person who knows or has reasonable cause to suspect based on facts that would cause a reasonable person in a similar position to suspect that a licensed medical professional, as defined in division (Q) of section 2907.01 of the Revised Code, has committed a violation of a law within Chapter 2907. of the Revised Code against a patient or key third party of the patient shall report such knowledge or belief to local law enforcement authorities within seven days of obtaining this knowledge or belief.

(2) With the exception of a self-report or participation in the violation of law being reported, anyone making a timely report under division (F)(1) of this section or anyone participating in a judicial proceeding resulting from such reports is immune from any civil or criminal liability that otherwise might be incurred or imposed as a result of such actions so long as the individual is acting in good faith without fraud or malice.

(3) Notwithstanding section 4731.22(B)(4) of the Revised Code, the physician-patient relationship or physician assistant-patient relationship is not a ground for excluding evidence regarding the person's knowledge or belief of a violation of law within Chapter 2907. of the Revised Code against a licensed medical professional in any judicial proceeding resulting from a report submitted under division (F)(1) of this section.

(G)

(1) Any doctor of medicine or osteopathic medicine, hospital intern or resident, nurse, psychologist, social worker, independent social worker, social work assistant, licensed

professional clinical counselor, licensed professional counselor, independent marriage and family therapist, or marriage and family therapist who knows or has reasonable cause to believe that a patient or client has been the victim of domestic violence, as defined in section [3113.31](#) of the Revised Code, shall note that knowledge or belief and the basis for it in the patient's or client's records.

(2) Notwithstanding section [4731.22](#) of the Revised Code, the physician-patient privilege or advanced practice registered nurse-patient privilege shall not be a ground for excluding any information regarding the report containing the knowledge or belief noted under division (F)(1) of this section, and the information may be admitted as evidence in accordance with the Rules of Evidence.

~~(G)~~ (H) Divisions (A) and (D) of this section do not require disclosure of information, when any of the following applies:

(1) The information is privileged by reason of the relationship between attorney and client; physician and patient; advanced practice registered nurse and patient; licensed psychologist or licensed school psychologist and client; licensed professional clinical counselor, licensed professional counselor, independent social worker, social worker, independent marriage and family therapist, or marriage and family therapist and client; member of the clergy, rabbi, minister, or priest and any person communicating information confidentially to the member of the clergy, rabbi, minister, or priest for a religious counseling purpose of a professional character; husband and wife; or a communications assistant and those who are a party to a telecommunications relay service call.

(2) The information would tend to incriminate a member of the actor's immediate family.

(3) Disclosure of the information would amount to revealing a news source, privileged under section [2739.04](#) or [2739.12](#) of the Revised Code.

(4) Disclosure of the information would amount to disclosure by a member of the ordained clergy of an organized religious body of a confidential communication made to that member of the clergy in that member's capacity as a member of the clergy by a person seeking the aid or counsel of that member of the clergy.

(5) Disclosure would amount to revealing information acquired by the actor in the course of the actor's duties in connection with a bona fide program of treatment or services for drug dependent persons or persons in danger of drug dependence, which program is maintained or conducted by a hospital, clinic, person, agency, or community addiction services provider whose alcohol and drug addiction services are certified pursuant to section [5119.36](#) of the Revised Code.

(6) Disclosure would amount to revealing information acquired by the actor in the course of the actor's duties in connection with a bona fide program for providing counseling services to victims of crimes that are violations of section [2907.02](#) or [2907.05](#) of the Revised Code or to victims of felonious sexual penetration in violation of former section [2907.12](#) of the Revised Code. As used in this division, "counseling services" include services provided in an informal setting by a person who, by education or experience, is competent to provide those services.

~~(H)~~ (I) No disclosure of information pursuant to this section gives rise to any liability or recrimination for a breach of privilege or confidence.

~~(H)~~ (J) Whoever violates division (A), ~~or (B), or (F)(1)~~ of this section is guilty of failure to report a crime. Violation of division (A)(1) or (F)(1) of this section is a misdemeanor of the fourth degree. Violation of division (A)(2) or (B) of this section is a misdemeanor of the second degree.

~~(J)~~ (K) Whoever violates division (C) or (D) of this section is guilty of failure to report knowledge of a death, a misdemeanor of the fourth degree.

~~(K)~~ (L)

(1) Whoever negligently violates division (E) of this section is guilty of a minor misdemeanor.

(2) Whoever knowingly violates division (E) of this section is guilty of a misdemeanor of the second degree.

~~(L)~~ (M) As used in this section,

(1) "Nurse" includes an advanced practice registered nurse, registered nurse, and licensed practical nurse.

(2) . **"Key third party" means an individual closely involved in the patient's decision-making regarding health care services, including but not limited to, the patient's spouse or partner, parents, child, sibling, or guardian. An individual's status as a key third party ceases upon the termination of the licensee-patient relationship or upon termination of the individual's relationship with the patient.**

R.C. 2305.252 Confidentiality of proceedings and records within scope of peer review committee of health care entity.

(A) Except as required to comply with a subpoena issued under division (F)(3) of section 4731.22 of the Revised Code from the state medical board, ~~P~~proceedings and records within the scope of a peer review committee of a health care entity shall be held in confidence and shall not be subject to discovery or introduction in evidence in any civil action against a health care entity or health care provider, including both individuals who provide health care and entities that provide health care, arising out of matters that are the subject of evaluation and review by the peer review committee. No individual who attends a meeting of a peer review committee, serves as a member of a peer review committee, works for or on behalf of a peer review committee, or provides information to a peer review committee shall be permitted or required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the peer review committee or as to any finding, recommendation, evaluation, opinion, or other action of the committee or a member thereof.

Information, documents, or records otherwise available from original sources are not to be construed as being unavailable for discovery or for use in any civil action merely because they were produced or presented during proceedings of a peer review committee, but the information, documents, or records are available only from the original sources and cannot be obtained from the peer review committee's proceedings or records.

The release of any information, documents, or records that were produced or presented during proceedings of a peer review committee or created to document the proceedings does not affect the confidentiality of any other information, documents, or records produced or presented during those proceedings or created to document them. Only the information, documents, or records actually released cease to be privileged under this section.

Nothing in this section precludes health care entities from sharing information, documents, or records that were produced or presented during proceedings of a peer review committee or created to document them as long as the information, documents, or records are used only for peer review purposes.

Health care entities shall provide information, documents, or records related to allegations of sexual misconduct or criminal conduct of individuals licensed by the state medical board of Ohio that were produced or presented during proceedings of a peer review committee or created to document them to the state medical board of Ohio pursuant to a subpoena issued under division (F)(3) of section 4731.22 of the Revised Code.

An individual who testifies before a peer review committee, serves as a representative of a peer review committee, serves as a member of a peer review committee, works for or on behalf of a peer review committee, or provides information to a peer review committee shall not be prevented from testifying as to matters within the individual's knowledge, but the individual cannot be asked about the individual's testimony before the peer review committee, information the individual provided to the peer review committee, or any opinion the individual formed as a result of the peer review committee's activities.

An order by a court to produce for discovery or for use at trial the proceedings or records described in this section is a final order.

(B) Division (A) of this section applies to a peer review committee of the bureau of workers' compensation that is responsible for reviewing the professional qualifications and the performance of providers certified by the bureau to participate in the health partnership program created under sections 4121.44 and 4121.441 of the Revised Code, except that the proceedings and records within the scope of the peer review committee are subject to discovery or court subpoena and may be admitted into evidence in any criminal action or administrative or civil action initiated, prosecuted, or adjudicated by the bureau involving an alleged violation of applicable statutes or administrative rules. The bureau may share proceedings and records within the scope of the peer review committee, including claimant records and claim file information, with law enforcement agencies, licensing boards, and other governmental agencies that are prosecuting, adjudicating, or investigating alleged violations of applicable statutes or administrative rules. If the bureau shares proceedings or records with a law enforcement agency, licensing board, or another governmental agency pursuant to this division, that sharing does not affect the confidentiality of the record. Recipients of claimant records and claim file information provided by the bureau pursuant to this division shall take appropriate measures to maintain the confidentiality of the information.

R.C. 4731.22 Disciplinary actions.

(A) The state medical board, by an affirmative vote of not fewer than six of its members, may limit, revoke, or suspend a license or certificate to practice or certificate to recommend, refuse to grant a license or certificate, refuse to renew a license or certificate, refuse to reinstate a license or certificate, or reprimand or place on probation the holder of a license or certificate if the individual applying for or holding the license or certificate is found by the board to have committed fraud during the administration of the examination for a license or certificate to practice or to have committed fraud, misrepresentation, or deception in applying for, renewing, or securing any license or certificate to practice or certificate to recommend issued by the board.

(B) The board, by an affirmative vote of not fewer than six members, shall, to the extent permitted by law, limit, revoke, or suspend a license or certificate to practice or certificate to recommend, refuse to issue a license or certificate, refuse to renew a license or certificate, refuse to reinstate a license or certificate, or reprimand or place on probation the holder of a license or certificate for one or more of the following reasons:

- (1) Permitting one's name or one's license or certificate to practice to be used by a person, group, or corporation when the individual concerned is not actually directing the treatment given;
- (2) Failure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease;
- (3) Except as provided in section [4731.97](#) of the Revised Code, selling, giving away, personally furnishing, prescribing, or administering drugs for other than legal and legitimate therapeutic purposes or a plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction of, a violation of any federal or state law regulating the possession, distribution, or use of any drug;
- (4) Willfully betraying a professional confidence.

For purposes of this division, "willfully betraying a professional confidence" does not include providing any information, documents, or reports under sections [307.621](#) to [307.629](#) of the Revised Code to a child fatality review board; does not include providing any information, documents, or reports to the director of health pursuant to guidelines established under section [3701.70](#) of the Revised Code; does not include written notice to a mental health professional under section [4731.62](#) of the Revised Code; and does not include the making of a report of an employee's use of a drug of abuse, or a report of a condition of an employee other than one involving the use of a drug of abuse, to the employer of the employee as described in division (B) of section [2305.33](#) of the Revised Code. Nothing in this division affects the immunity from civil liability conferred by section [2305.33](#) or [4731.62](#) of the Revised Code upon a physician who makes a report in accordance with section [2305.33](#) or notifies a mental health professional in accordance with section [4731.62](#) of the Revised Code. As used in this division, "employee," "employer," and "physician" have the same meanings as in section [2305.33](#) of the Revised Code.

- (5) Making a false, fraudulent, deceptive, or misleading statement in the solicitation of or advertising for patients; in relation to the practice of medicine and surgery, osteopathic medicine

and surgery, podiatric medicine and surgery, or a limited branch of medicine; or in securing or attempting to secure any license or certificate to practice issued by the board.

As used in this division, "false, fraudulent, deceptive, or misleading statement" means a statement that includes a misrepresentation of fact, is likely to mislead or deceive because of a failure to disclose material facts, is intended or is likely to create false or unjustified expectations of favorable results, or includes representations or implications that in reasonable probability will cause an ordinarily prudent person to misunderstand or be deceived.

(6) A departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established;

(7) Representing, with the purpose of obtaining compensation or other advantage as personal gain or for any other person, that an incurable disease or injury, or other incurable condition, can be permanently cured;

(8) The obtaining of, or attempting to obtain, money or anything of value by fraudulent misrepresentations in the course of practice;

(9) A plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction for, a felony;

(10) Commission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed;

(11) A plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction for, a misdemeanor committed in the course of practice;

(12) Commission of an act in the course of practice that constitutes a misdemeanor in this state, regardless of the jurisdiction in which the act was committed;

(13) A plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction for, a misdemeanor involving moral turpitude;

(14) Commission of an act involving moral turpitude that constitutes a misdemeanor in this state, regardless of the jurisdiction in which the act was committed;

(15) Violation of the conditions of limitation placed by the board upon a license or certificate to practice;

(16) Failure to pay license renewal fees specified in this chapter;

(17) Except as authorized in section [4731.31](#) of the Revised Code, engaging in the division of fees for referral of patients, or the receiving of a thing of value in return for a specific referral of a patient to utilize a particular service or business;

(18) Subject to section [4731.226](#) of the Revised Code, violation of any provision of a code of ethics of the American medical association, the American osteopathic association, the American podiatric medical association, or any other national professional organizations that the board specifies by rule. The state medical board shall obtain and keep on file current copies of the codes of ethics of the various national professional organizations. The individual whose license

or certificate is being suspended or revoked shall not be found to have violated any provision of a code of ethics of an organization not appropriate to the individual's profession.

For purposes of this division, a "provision of a code of ethics of a national professional organization" does not include any provision that would preclude the making of a report by a physician of an employee's use of a drug of abuse, or of a condition of an employee other than one involving the use of a drug of abuse, to the employer of the employee as described in division (B) of section [2305.33](#) of the Revised Code. Nothing in this division affects the immunity from civil liability conferred by that section upon a physician who makes either type of report in accordance with division (B) of that section. As used in this division, "employee," "employer," and "physician" have the same meanings as in section [2305.33](#) of the Revised Code.

(19) Inability to practice according to acceptable and prevailing standards of care by reason of mental illness or physical illness, including, but not limited to, physical deterioration that adversely affects cognitive, motor, or perceptive skills.

In enforcing this division, the board, upon a showing of a possible violation, may compel any individual authorized to practice by this chapter or who has submitted an application pursuant to this chapter to submit to a mental examination, physical examination, including an HIV test, or both a mental and a physical examination. The expense of the examination is the responsibility of the individual compelled to be examined. Failure to submit to a mental or physical examination or consent to an HIV test ordered by the board constitutes an admission of the allegations against the individual unless the failure is due to circumstances beyond the individual's control, and a default and final order may be entered without the taking of testimony or presentation of evidence. If the board finds an individual unable to practice because of the reasons set forth in this division, the board shall require the individual to submit to care, counseling, or treatment by physicians approved or designated by the board, as a condition for initial, continued, reinstated, or renewed authority to practice. An individual affected under this division shall be afforded an opportunity to demonstrate to the board the ability to resume practice in compliance with acceptable and prevailing standards under the provisions of the individual's license or certificate. For the purpose of this division, any individual who applies for or receives a license or certificate to practice under this chapter accepts the privilege of practicing in this state and, by so doing, shall be deemed to have given consent to submit to a mental or physical examination when directed to do so in writing by the board, and to have waived all objections to the admissibility of testimony or examination reports that constitute a privileged communication.

(20) Except as provided in division (F)(1)(b) of section [4731.282](#) of the Revised Code or when civil penalties are imposed under section [4731.225](#) of the Revised Code, and subject to section [4731.226](#) of the Revised Code, violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board.

This division does not apply to a violation or attempted violation of, assisting in or abetting the violation of, or a conspiracy to violate, any provision of this chapter or any rule adopted by the board that would preclude the making of a report by a physician of an employee's use of a drug of abuse, or of a condition of an employee other than one involving the use of a drug of abuse, to the employer of the employee as described in division (B) of section [2305.33](#) of the Revised Code. Nothing in this division affects the immunity from civil liability conferred by that section

upon a physician who makes either type of report in accordance with division (B) of that section. As used in this division, "employee," "employer," and "physician" have the same meanings as in section [2305.33](#) of the Revised Code.

(21) The violation of section [3701.79](#) of the Revised Code or of any abortion rule adopted by the director of health pursuant to section [3701.341](#) of the Revised Code;

(22) Any of the following actions taken by an agency responsible for authorizing, certifying, or regulating an individual to practice a health care occupation or provide health care services in this state or another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand;

(23) The violation of section [2919.12](#) of the Revised Code or the performance or inducement of an abortion upon a pregnant woman with actual knowledge that the conditions specified in division (B) of section [2317.56](#) of the Revised Code have not been satisfied or with a heedless indifference as to whether those conditions have been satisfied, unless an affirmative defense as specified in division (H)(2) of that section would apply in a civil action authorized by division (H)(1) of that section;

(24) The revocation, suspension, restriction, reduction, or termination of clinical privileges by the United States department of defense or department of veterans affairs or the termination or suspension of a certificate of registration to prescribe drugs by the drug enforcement administration of the United States department of justice;

(25) Termination or suspension from participation in the medicare or medicaid programs by the department of health and human services or other responsible agency;

(26) Impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability to practice.

For the purposes of this division, any individual authorized to practice by this chapter accepts the privilege of practicing in this state subject to supervision by the board. By filing an application for or holding a license or certificate to practice under this chapter, an individual shall be deemed to have given consent to submit to a mental or physical examination when ordered to do so by the board in writing, and to have waived all objections to the admissibility of testimony or examination reports that constitute privileged communications.

If it has reason to believe that any individual authorized to practice by this chapter or any applicant for licensure or certification to practice suffers such impairment, the board may compel the individual to submit to a mental or physical examination, or both. The expense of the examination is the responsibility of the individual compelled to be examined. Any mental or physical examination required under this division shall be undertaken by a treatment provider or physician who is qualified to conduct the examination and who is chosen by the board.

Failure to submit to a mental or physical examination ordered by the board constitutes an admission of the allegations against the individual unless the failure is due to circumstances beyond the individual's control, and a default and final order may be entered without the taking of testimony or presentation of evidence. If the board determines that the individual's ability to

practice is impaired, the board shall suspend the individual's license or certificate or deny the individual's application and shall require the individual, as a condition for initial, continued, reinstated, or renewed licensure or certification to practice, to submit to treatment.

Before being eligible to apply for reinstatement of a license or certificate suspended under this division, the impaired practitioner shall demonstrate to the board the ability to resume practice in compliance with acceptable and prevailing standards of care under the provisions of the practitioner's license or certificate. The demonstration shall include, but shall not be limited to, the following:

- (a) Certification from a treatment provider approved under section [4731.25](#) of the Revised Code that the individual has successfully completed any required inpatient treatment;
- (b) Evidence of continuing full compliance with an aftercare contract or consent agreement;
- (c) Two written reports indicating that the individual's ability to practice has been assessed and that the individual has been found capable of practicing according to acceptable and prevailing standards of care. The reports shall be made by individuals or providers approved by the board for making the assessments and shall describe the basis for their determination.

The board may reinstate a license or certificate suspended under this division after that demonstration and after the individual has entered into a written consent agreement.

When the impaired practitioner resumes practice, the board shall require continued monitoring of the individual. The monitoring shall include, but not be limited to, compliance with the written consent agreement entered into before reinstatement or with conditions imposed by board order after a hearing, and, upon termination of the consent agreement, submission to the board for at least two years of annual written progress reports made under penalty of perjury stating whether the individual has maintained sobriety.

(27) A second or subsequent violation of section [4731.66](#) or [4731.69](#) of the Revised Code;

(28) Except as provided in division (N) of this section:

(a) Waiving the payment of all or any part of a deductible or copayment that a patient, pursuant to a health insurance or health care policy, contract, or plan that covers the individual's services, otherwise would be required to pay if the waiver is used as an enticement to a patient or group of patients to receive health care services from that individual;

(b) Advertising that the individual will waive the payment of all or any part of a deductible or copayment that a patient, pursuant to a health insurance or health care policy, contract, or plan that covers the individual's services, otherwise would be required to pay.

(29) Failure to use universal blood and body fluid precautions established by rules adopted under section [4731.051](#) of the Revised Code;

(30) Failure to provide notice to, and receive acknowledgment of the notice from, a patient when required by section [4731.143](#) of the Revised Code prior to providing nonemergency professional services, or failure to maintain that notice in the patient's medical record;

- (31) Failure of a physician supervising a physician assistant to maintain supervision in accordance with the requirements of Chapter 4730. of the Revised Code and the rules adopted under that chapter;
- (32) Failure of a physician or podiatrist to enter into a standard care arrangement with a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner with whom the physician or podiatrist is in collaboration pursuant to section [4731.27](#) of the Revised Code or failure to fulfill the responsibilities of collaboration after entering into a standard care arrangement;
- (33) Failure to comply with the terms of a consult agreement entered into with a pharmacist pursuant to section [4729.39](#) of the Revised Code;
- (34) Failure to cooperate in an investigation conducted by the board under division (F) of this section, including failure to comply with a subpoena or order issued by the board or failure to answer truthfully a question presented by the board in an investigative interview, an investigative office conference, at a deposition, or in written interrogatories, except that failure to cooperate with an investigation shall not constitute grounds for discipline under this section if a court of competent jurisdiction has issued an order that either quashes a subpoena or permits the individual to withhold the testimony or evidence in issue;
- (35) Failure to supervise an oriental medicine practitioner or acupuncturist in accordance with Chapter 4762. of the Revised Code and the board's rules for providing that supervision;
- (36) Failure to supervise an anesthesiologist assistant in accordance with Chapter 4760. of the Revised Code and the board's rules for supervision of an anesthesiologist assistant;
- (37) Assisting suicide, as defined in section [3795.01](#) of the Revised Code;
- (38) Failure to comply with the requirements of section [2317.561](#) of the Revised Code;
- (39) Failure to supervise a radiologist assistant in accordance with Chapter 4774. of the Revised Code and the board's rules for supervision of radiologist assistants;
- (40) Performing or inducing an abortion at an office or facility with knowledge that the office or facility fails to post the notice required under section [3701.791](#) of the Revised Code;
- (41) Failure to comply with the standards and procedures established in rules under section [4731.054](#) of the Revised Code for the operation of or the provision of care at a pain management clinic;
- (42) Failure to comply with the standards and procedures established in rules under section [4731.054](#) of the Revised Code for providing supervision, direction, and control of individuals at a pain management clinic;
- (43) Failure to comply with the requirements of section [4729.79](#) or [4731.055](#) of the Revised Code, unless the state board of pharmacy no longer maintains a drug database pursuant to section [4729.75](#) of the Revised Code;
- (44) Failure to comply with the requirements of section [2919.171](#), [2919.202](#), or [2919.203](#) of the Revised Code or failure to submit to the department of health in accordance with a court order a complete report as described in section [2919.171](#) or [2919.202](#) of the Revised Code;

(45) Practicing at a facility that is subject to licensure as a category III terminal distributor of dangerous drugs with a pain management clinic classification unless the person operating the facility has obtained and maintains the license with the classification;

(46) Owning a facility that is subject to licensure as a category III terminal distributor of dangerous drugs with a pain management clinic classification unless the facility is licensed with the classification;

(47) Failure to comply with any of the requirements regarding making or maintaining medical records or documents described in division (A) of section [2919.192](#), division (C) of section [2919.193](#), division (B) of section 2919.195, or division (A) of section 2919.196 of the Revised Code ;

(48) Failure to comply with the requirements in section [3719.061](#) of the Revised Code before issuing for a minor a prescription for an opioid analgesic, as defined in section [3719.01](#) of the Revised Code;

(49) Failure to comply with the requirements of section [4731.30](#) of the Revised Code or rules adopted under section [4731.301](#) of the Revised Code when recommending treatment with medical marijuana;

(50) Practicing at a facility, clinic, or other location that is subject to licensure as a category III terminal distributor of dangerous drugs with an office-based opioid treatment classification unless the person operating that place has obtained and maintains the license with the classification;

(51) Owning a facility, clinic, or other location that is subject to licensure as a category III terminal distributor of dangerous drugs with an office-based opioid treatment classification unless that place is licensed with the classification;

(52) A pattern of continuous or repeated violations of division (E)(2) or (3) of section [3963.02](#) of the Revised Code.

(C) Disciplinary actions taken by the board under divisions (A) and (B) of this section shall be taken pursuant to an adjudication under Chapter 119. of the Revised Code, except that in lieu of an adjudication, the board may enter into a consent agreement with an individual to resolve an allegation of a violation of this chapter or any rule adopted under it. A consent agreement, when ratified by an affirmative vote of not fewer than six members of the board, shall constitute the findings and order of the board with respect to the matter addressed in the agreement. If the board refuses to ratify a consent agreement, the admissions and findings contained in the consent agreement shall be of no force or effect.

A telephone conference call may be utilized for ratification of a consent agreement that revokes or suspends an individual's license or certificate to practice or certificate to recommend. The telephone conference call shall be considered a special meeting under division (F) of section [121.22](#) of the Revised Code.

If the board takes disciplinary action against an individual under division (B) of this section for a second or subsequent plea of guilty to, or judicial finding of guilt of, a violation of section [2919.123](#) of the Revised Code, the disciplinary action shall consist of a suspension of the individual's license or certificate to practice for a period of at least one year or, if determined

appropriate by the board, a more serious sanction involving the individual's license or certificate to practice. Any consent agreement entered into under this division with an individual that pertains to a second or subsequent plea of guilty to, or judicial finding of guilt of, a violation of that section shall provide for a suspension of the individual's license or certificate to practice for a period of at least one year or, if determined appropriate by the board, a more serious sanction involving the individual's license or certificate to practice.

(D) For purposes of divisions (B)(10), (12), and (14) of this section, the commission of the act may be established by a finding by the board, pursuant to an adjudication under Chapter 119. of the Revised Code, that the individual committed the act. The board does not have jurisdiction under those divisions if the trial court renders a final judgment in the individual's favor and that judgment is based upon an adjudication on the merits. The board has jurisdiction under those divisions if the trial court issues an order of dismissal upon technical or procedural grounds.

(E) The sealing of conviction records by any court shall have no effect upon a prior board order entered under this section or upon the board's jurisdiction to take action under this section if, based upon a plea of guilty, a judicial finding of guilt, or a judicial finding of eligibility for intervention in lieu of conviction, the board issued a notice of opportunity for a hearing prior to the court's order to seal the records. The board shall not be required to seal, destroy, redact, or otherwise modify its records to reflect the court's sealing of conviction records.

(F)

(1) The board shall investigate evidence that appears to show that a person has violated any provision of this chapter or any rule adopted under it. Any person may report to the board in a signed writing any information that the person may have that appears to show a violation of any provision of this chapter or any rule adopted under it. In the absence of bad faith, any person who reports information of that nature or who testifies before the board in any adjudication conducted under Chapter 119. of the Revised Code shall not be liable in damages in a civil action as a result of the report or testimony. Each complaint or allegation of a violation received by the board shall be assigned a case number and shall be recorded by the board.

(2) Investigations of alleged violations of this chapter or any rule adopted under it shall be supervised by the supervising member elected by the board in accordance with section [4731.02](#) of the Revised Code and by the secretary as provided in section [4731.39](#) of the Revised Code. The president may designate another member of the board to supervise the investigation in place of the supervising member. No member of the board who supervises the investigation of a case shall participate in further adjudication of the case.

(3) In investigating a possible violation of this chapter or any rule adopted under this chapter, or in conducting an inspection under division (E) of section [4731.054](#) of the Revised Code, the board may question witnesses, conduct interviews, administer oaths, order the taking of depositions, inspect and copy any books, accounts, papers, records, or documents, issue subpoenas, and compel the attendance of witnesses and production of books, accounts, papers, records, documents, and testimony, except that a subpoena for patient record information **or information, documents, and records from a peer review committee of a health care entity related to sexual misconduct or criminal conduct** shall not be issued without consultation with the attorney general's office and approval of the secretary and supervising member of the board.

(a) Before issuance of a subpoena for patient record information or information, documents, or records from a peer review committee of a health care entity related to sexual misconduct or criminal conduct, the secretary and supervising member shall determine whether there is probable cause to believe that the complaint filed alleges a violation of this chapter or any rule adopted under it and that the records sought are relevant to the alleged violation and material to the investigation. The subpoena may apply only to records that cover a reasonable period of time surrounding the alleged violation.

(b) On failure to comply with any subpoena issued by the board and after reasonable notice to the person being subpoenaed, the board may move for an order compelling the production of persons or records pursuant to the Rules of Civil Procedure.

(c) A subpoena issued by the board may be served by a sheriff, the sheriff's deputy, or a board employee or agent designated by the board. Service of a subpoena issued by the board may be made by delivering a copy of the subpoena to the person named therein, reading it to the person, or leaving it at the person's usual place of residence, usual place of business, or address on file with the board. When serving a subpoena to an applicant for or the holder of a license or certificate issued under this chapter, service of the subpoena may be made by certified mail, return receipt requested, and the subpoena shall be deemed served on the date delivery is made or the date the person refuses to accept delivery. If the person being served refuses to accept the subpoena or is not located, service may be made to an attorney who notifies the board that the attorney is representing the person.

(d) A sheriff's deputy who serves a subpoena shall receive the same fees as a sheriff. Each witness who appears before the board in obedience to a subpoena shall receive the fees and mileage provided for under section [119.094](#) of the Revised Code.

(4) ~~All hearings, investigations, and inspections of the board shall be considered civil actions for the purposes of section [2305.252](#) of the Revised Code. The Board may provide an investigative status update to a complainant upon request and verification of complainant's identity.~~

(5) A report required to be submitted to the board under this chapter, a complaint, or information received by the board pursuant to an investigation or pursuant to an inspection under division (E) of section [4731.054](#) of the Revised Code is confidential and not subject to discovery in any civil action.

The board shall conduct all investigations or inspections and proceedings in a manner that protects the confidentiality of patients and persons who file complaints with the board. The board shall not make public the names or any other identifying information about patients or complainants unless proper consent is given or, in the case of a patient, a waiver of the patient privilege exists under division (B) of section [2317.02](#) of the Revised Code, except that consent or a waiver of that nature is not required if the board possesses reliable and substantial evidence that no bona fide physician-patient relationship exists.

The board may share any information it receives pursuant to an investigation or inspection, including patient records and patient record information, with law enforcement agencies, other licensing boards, and other governmental agencies that are prosecuting, adjudicating, or

investigating alleged violations of statutes or administrative rules. An agency or board that receives the information shall comply with the same requirements regarding confidentiality as those with which the state medical board must comply, notwithstanding any conflicting provision of the Revised Code or procedure of the agency or board that applies when it is dealing with other information in its possession. In a judicial proceeding, the information may be admitted into evidence only in accordance with the Rules of Evidence, but the court shall require that appropriate measures are taken to ensure that confidentiality is maintained with respect to any part of the information that contains names or other identifying information about patients or complainants whose confidentiality was protected by the state medical board when the information was in the board's possession. Measures to ensure confidentiality that may be taken by the court include sealing its records or deleting specific information from its records.

No person shall knowingly access, use or disclose the confidential investigatory information in a manner prohibited by law.

(6) On a quarterly basis, the board shall prepare a report that documents the disposition of all cases during the preceding three months. The report shall contain the following information for each case with which the board has completed its activities:

- (a) The case number assigned to the complaint or alleged violation;
- (b) The type of license or certificate to practice, if any, held by the individual against whom the complaint is directed;
- (c) A description of the allegations contained in the complaint;

(d) Whether witnesses were interviewed;

(e) Whether there are open complaints pending against the individual;

~~(d)~~ (f) The disposition of the case.

The report shall state how many cases are still pending and shall be prepared in a manner that protects the identity of each person involved in each case. The report shall be a public record under section [149.43](#) of the Revised Code.

(G) If the secretary and supervising member determine both of the following, they may recommend that the board suspend an individual's license or certificate to practice or certificate to recommend without a prior hearing:

- (1) That there is clear and convincing evidence that an individual has violated division (B) of this section;
- (2) That the individual's continued practice presents a danger of immediate and serious harm to the public.

Written allegations shall be prepared for consideration by the board. The board, upon review of those allegations and by an affirmative vote of not fewer than six of its members, excluding the secretary and supervising member, may suspend a license or certificate without a prior hearing. A telephone conference call may be utilized for reviewing the allegations and taking the vote on the summary suspension.

The board shall issue a written order of suspension by certified mail or in person in accordance with section [119.07](#) of the Revised Code. The order shall not be subject to suspension by the court during pendency of any appeal filed under section [119.12](#) of the Revised Code. If the individual subject to the summary suspension requests an adjudicatory hearing by the board, the date set for the hearing shall be within fifteen days, but not earlier than seven days, after the individual requests the hearing, unless otherwise agreed to by both the board and the individual.

Any summary suspension imposed under this division shall remain in effect, unless reversed on appeal, until a final adjudicative order issued by the board pursuant to this section and Chapter 119. of the Revised Code becomes effective. The board shall issue its final adjudicative order within seventy-five days after completion of its hearing. A failure to issue the order within seventy-five days shall result in dissolution of the summary suspension order but shall not invalidate any subsequent, final adjudicative order.

(H) If the board takes action under division (B)(9), (11), or (13) of this section and the judicial finding of guilt, guilty plea, or judicial finding of eligibility for intervention in lieu of conviction is overturned on appeal, upon exhaustion of the criminal appeal, a petition for reconsideration of the order may be filed with the board along with appropriate court documents. Upon receipt of a petition of that nature and supporting court documents, the board shall reinstate the individual's license or certificate to practice. The board may then hold an adjudication under Chapter 119. of the Revised Code to determine whether the individual committed the act in question. Notice of an opportunity for a hearing shall be given in accordance with Chapter 119. of the Revised Code. If the board finds, pursuant to an adjudication held under this division, that the individual committed the act or if no hearing is requested, the board may order any of the sanctions identified under division (B) of this section.

(I) The license or certificate to practice issued to an individual under this chapter and the individual's practice in this state are automatically suspended as of the date of the individual's second or subsequent plea of guilty to, or judicial finding of guilt of, a violation of section [2919.123](#) of the Revised Code. In addition, the license or certificate to practice or certificate to recommend issued to an individual under this chapter and the individual's practice in this state are automatically suspended as of the date the individual pleads guilty to, is found by a judge or jury to be guilty of, or is subject to a judicial finding of eligibility for intervention in lieu of conviction in this state or treatment or intervention in lieu of conviction in another jurisdiction for any of the following criminal offenses in this state or a substantially equivalent criminal offense in another jurisdiction: aggravated murder, murder, voluntary manslaughter, felonious assault, kidnapping, rape, sexual battery, gross sexual imposition, aggravated arson, aggravated robbery, or aggravated burglary. Continued practice after suspension shall be considered practicing without a license or certificate.

The board shall notify the individual subject to the suspension by certified mail or in person in accordance with section [119.07](#) of the Revised Code. If an individual whose license or certificate is automatically suspended under this division fails to make a timely request for an adjudication under Chapter 119. of the Revised Code, the board shall do whichever of the following is applicable:

(1) If the automatic suspension under this division is for a second or subsequent plea of guilty to, or judicial finding of guilt of, a violation of section [2919.123](#) of the Revised Code, the board shall enter an order suspending the individual's license or certificate to practice for a period of at

least one year or, if determined appropriate by the board, imposing a more serious sanction involving the individual's license or certificate to practice.

(2) In all circumstances in which division (I)(1) of this section does not apply, enter a final order permanently revoking the individual's license or certificate to practice.

(J) If the board is required by Chapter 119. of the Revised Code to give notice of an opportunity for a hearing and if the individual subject to the notice does not timely request a hearing in accordance with section [119.07](#) of the Revised Code, the board is not required to hold a hearing, but may adopt, by an affirmative vote of not fewer than six of its members, a final order that contains the board's findings. In that final order, the board may order any of the sanctions identified under division (A) or (B) of this section.

(K) Any action taken by the board under division (B) of this section resulting in a suspension from practice shall be accompanied by a written statement of the conditions under which the individual's license or certificate to practice may be reinstated. The board shall adopt rules governing conditions to be imposed for reinstatement. Reinstatement of a license or certificate suspended pursuant to division (B) of this section requires an affirmative vote of not fewer than six members of the board.

(L) When the board refuses to grant or issue a license or certificate to practice to an applicant, revokes an individual's license or certificate to practice, refuses to renew an individual's license or certificate to practice, or refuses to reinstate an individual's license or certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a license or certificate to practice and the board shall not accept an application for reinstatement of the license or certificate or for issuance of a new license or certificate.

(M) Notwithstanding any other provision of the Revised Code, all of the following apply:

(1) The surrender of a license or certificate issued under this chapter shall not be effective unless or until accepted by the board. A telephone conference call may be utilized for acceptance of the surrender of an individual's license or certificate to practice. The telephone conference call shall be considered a special meeting under division (F) of section [121.22](#) of the Revised Code. Reinstatement of a license or certificate surrendered to the board requires an affirmative vote of not fewer than six members of the board.

(2) An application for a license or certificate made under the provisions of this chapter may not be withdrawn without approval of the board.

(3) Failure by an individual to renew a license or certificate to practice in accordance with this chapter or a certificate to recommend in accordance with rules adopted under section [4731.301](#) of the Revised Code shall not remove or limit the board's jurisdiction to take any disciplinary action under this section against the individual.

(4) At the request of the board, a license or certificate holder shall immediately surrender to the board a license or certificate that the board has suspended, revoked, or permanently revoked.

(N) Sanctions shall not be imposed under division (B)(28) of this section against any person who waives deductibles and copayments as follows:

(1) In compliance with the health benefit plan that expressly allows such a practice. Waiver of the deductibles or copayments shall be made only with the full knowledge and consent of the plan purchaser, payer, and third-party administrator. Documentation of the consent shall be made available to the board upon request.

(2) For professional services rendered to any other person authorized to practice pursuant to this chapter, to the extent allowed by this chapter and rules adopted by the board.

(O) Under the board's investigative duties described in this section and subject to division (F) of this section, the board shall develop and implement a quality intervention program designed to improve through remedial education the clinical and communication skills of individuals authorized under this chapter to practice medicine and surgery, osteopathic medicine and surgery, and podiatric medicine and surgery. In developing and implementing the quality intervention program, the board may do all of the following:

(1) Offer in appropriate cases as determined by the board an educational and assessment program pursuant to an investigation the board conducts under this section;

(2) Select providers of educational and assessment services, including a quality intervention program panel of case reviewers;

(3) Make referrals to educational and assessment service providers and approve individual educational programs recommended by those providers. The board shall monitor the progress of each individual undertaking a recommended individual educational program.

(4) Determine what constitutes successful completion of an individual educational program and require further monitoring of the individual who completed the program or other action that the board determines to be appropriate;

(5) Adopt rules in accordance with Chapter 119. of the Revised Code to further implement the quality intervention program.

An individual who participates in an individual educational program pursuant to this division shall pay the financial obligations arising from that educational program.

(P) If a licensee is charged in any state or federal court for a crime classified as a felony under that state's law or federal law and the conduct charged would be a violation of division (B) of this section, the licensee's practice shall be considered an immediate and serious harm to the public.

(1) If the board receives verifiable information that a licensee has been charged in any state or federal court for a crime classified as a felony under that state's law or federal law and the conduct charged would constitute a violation of division (B) of this section, written allegations shall be prepared for consideration by the board. The board, upon review of those allegations and by an affirmative vote of not fewer than six of its members, excluding the secretary and supervising member, may suspend a license without a prior hearing. A telephone conference call may be utilized for reviewing the allegations and taking the vote on the emergency suspension.

(2) The emergency order of suspension shall remain in effect until:

(a) The criminal charges are finally resolved, and the board issues a final order after receipt of the court documents resolving the criminal charges; or

(b) The board issues an order revoking or modifying the emergency order after an adjudicatory hearing.

(3) A licensee required to comply with an emergency order may request an adjudicatory hearing for the determination as to whether the findings of fact providing the bases for the emergency order are supported by substantial evidence and if so, constitute one or more violations of division (B) of this section. If the licensee subject to the emergency order requests an adjudicatory hearing by the board, the date set for the hearing shall be within fifteen days, but not earlier than seven days, after the individual requests the hearing, unless otherwise agreed to by both the board and individual.

(4) Any emergency order shall remain in effect, unless reversed on appeal, until a final adjudicative order issued by the board pursuant to this section and Chapter 119. of the Revised Code becomes effective.

R.C. 4731.224 Reporting misconduct.

(A)(1) Within ~~sixty~~ **thirty** days after the imposition of any formal disciplinary action taken by any health care facility, including a hospital, health care facility operated by a health insuring corporation, ambulatory surgical center, or similar facility, against any individual holding a valid license or certificate to practice issued pursuant to this chapter, the chief administrator or executive officer of the facility shall report to the state medical board the name of the individual, the action taken by the facility, and a summary of the underlying facts leading to the action taken. Upon request, the board shall be provided certified copies of the patient records that were the basis for the facility's action. Prior to release to the board, the summary shall be approved by the peer review committee that reviewed the case or by the governing board of the facility. As used in this division, "formal disciplinary action" means any action resulting in the revocation, restriction, reduction, or termination of clinical privileges for violations of professional ethics, or for reasons of medical incompetence or medical malpractice . "Formal disciplinary action" includes a summary action, an action that takes effect notwithstanding any appeal rights that may exist, and an action that results in an individual surrendering clinical privileges while under investigation and during proceedings regarding the action being taken or in return for not being investigated or having proceedings held. "Formal disciplinary action" does not include any action taken for the sole reason of failure to maintain records on a timely basis or failure to attend staff or section meetings.

The filing or nonfiling of a report with the board, investigation by the board, or any disciplinary action taken by the board, shall not preclude any action by a health care facility to suspend, restrict, or revoke the individual's clinical privileges.

In the absence of fraud or bad faith, no individual or entity that provides patient records to the board shall be liable in damages to any person as a result of providing the records.

(2) Within thirty days of the commencement of the investigation, a health care facility, including a hospital, health care facility operated by a health insuring corporation, ambulatory surgical center, or similar facility, shall report to the state medical board any investigation regarding any individual holding a valid license or certificate to practice issued pursuant to this chapter for criminal conduct or sexual misconduct as defined in Rule 4731-26-01 of the Administrative Code.

(B)

(1) Except as provided in division (B)(2) of this section, if any individual authorized to practice under this chapter or any professional association or society of such individuals believes that a violation of any provision of this chapter, Chapter 4730., 4759., 4760., 4761., 4762., 4774., or 4778. of the Revised Code, or any rule of the board has occurred, the individual, association, or society shall report to the board the information upon which the belief is based.

(2) If any individual authorized to practice under this chapter or any professional association or society of such individuals believes that a violation of division (B)(26) of section [4731.22](#) of the Revised Code has occurred, the individual, association, or society shall report the information upon which the belief is based to the monitoring organization conducting the program established by the board under section 4731.251 of the Revised Code. If any such report is made to the board, it shall be referred to the monitoring organization unless the board is aware that the individual who is the subject of the report does not meet the program eligibility requirements of section 4731.252 of the Revised Code.

(3) Any individual authorized to practice under this chapter or any professional association or society of such individuals shall report to the Board within 30 days any incidents that the individual reasonably believes to have occurred involving any of the following:

(a) Sexual misconduct involving a patient or key third party by any person authorized to practice under this chapter. Sexual misconduct as defined in Rule 4731-26-01 of the Administrative Code means conduct that exploits the licensee-patient relationship in a sexual way, whether verbal or physical, and may include the expression of thoughts, feelings, or gestures that are sexual or that reasonably may be construed by a patient as sexual. Key third party means an individual closely involved in the patient's decision-making regarding health care services, including but not limited to, the patient's spouse or partner, parents, child, sibling, or guardian. An individual's status as a key third party ceases upon the termination of the licensee-patient relationship or upon termination of the individual's relationship with the patient.

(b) Fraudulent prescribing, drug diversion, or theft of any controlled substances by another individual authorized to practice under this chapter. For purposes of this section, "drug diversion" means transferring controlled substances or prescriptions for controlled substances to (i) the licensee for personal use; (ii) a licensee's immediate family member, as defined in rule 4731-11-08 of the Administrative Code; (iii) any other person living in the same residence as the licensee; (iv) any person with whom the

licensee is having a sexual relationship; or (v) any individual unless for a legitimate medical purpose by an individual practitioner acting in the usual course of professional practice.

(C) Any professional association or society composed primarily of doctors of medicine and surgery, doctors of osteopathic medicine and surgery, doctors of podiatric medicine and surgery, or practitioners of limited branches of medicine that suspends or revokes an individual's membership for violations of professional ethics, or for reasons of professional incompetence or professional malpractice, within sixty days after a final decision shall report to the board, on forms prescribed and provided by the board, the name of the individual, the action taken by the professional organization, and a summary of the underlying facts leading to the action taken.

The filing of a report with the board or decision not to file a report, investigation by the board, or any disciplinary action taken by the board, does not preclude a professional organization from taking disciplinary action against an individual.

(D) Any insurer providing professional liability insurance to an individual authorized to practice under this chapter, or any other entity that seeks to indemnify the professional liability of such an individual, shall notify the board within thirty days after the final disposition of any written claim for damages where such disposition results in a payment exceeding twenty-five thousand dollars. The notice shall contain the following information:

- (1) The name and address of the person submitting the notification;
- (2) The name and address of the insured who is the subject of the claim;
- (3) The name of the person filing the written claim;
- (4) The date of final disposition;
- (5) If applicable, the identity of the court in which the final disposition of the claim took place.

(E) The board may investigate possible violations of this chapter or the rules adopted under it that are brought to its attention as a result of the reporting requirements of this section, except that the board shall conduct an investigation if a possible violation involves repeated malpractice. As used in this division, "repeated malpractice" means three or more claims for medical malpractice within the previous five-year period, each resulting in a judgment or settlement in excess of twenty-five thousand dollars in favor of the claimant, and each involving negligent conduct by the practicing individual.

(F) All summaries, reports, and records received and maintained by the board pursuant to this section shall be confidential held in confidence pursuant to section 4731.22(F)(5) of the Revised Code and shall not be subject to discovery or introduction in evidence in any federal or state civil action involving a health care professional or facility arising out of matters that are the subject of the reporting required by this section. The board may use the information obtained only as the basis for an investigation, as evidence in a disciplinary hearing against an individual whose practice is regulated under this chapter, or in any subsequent trial or appeal of a board action or order.

~~The board may disclose the summaries and reports it receives under this section only to health care facility committees within or outside this state that are involved in credentialing or recredentialing the individual or in reviewing the individual's clinical~~

~~privileges. The board shall indicate whether or not the information has been verified. Information transmitted by the board shall be subject to the same confidentiality provisions as when maintained by the board.~~

(G) Except for reports filed by an individual pursuant to **divisions (A)(2) or (B)** of this section, the board shall send a copy of any reports or summaries it receives pursuant to this section to the individual who is the subject of the reports or summaries. The individual shall have the right to file a statement with the board concerning the correctness or relevance of the information. The statement shall at all times accompany that part of the record in contention.

(H) An individual or entity that, pursuant to this section, reports to the board, reports to the monitoring organization described in section 4731.251 of the Revised Code, or refers an impaired practitioner to a treatment provider approved by the board under section [4731.25](#) of the Revised Code shall not be subject to suit for civil damages as a result of the report, referral, or provision of the information.

(I) In the absence of fraud or bad faith, no professional association or society of individuals authorized to practice under this chapter that sponsors a committee or program to provide peer assistance to practitioners with substance abuse problems, no representative or agent of such a committee or program, no representative or agent of the monitoring organization described in section 4731.251 of the Revised Code, and no member of the state medical board shall be held liable in damages to any person by reason of actions taken to refer a practitioner to a treatment provider approved under section [4731.25](#) of the Revised Code for examination or treatment.

R.C. 4731.99 Penalty.

(A) Whoever violates section [4731.41](#), [4731.43](#), or [4731.60](#) of the Revised Code is guilty of a felony of the fifth degree on a first offense and a felony of the fourth degree on each subsequent offense.

(B) Whoever violates section [4731.49](#), [4731.50](#), or [4731.81](#) of the Revised Code is guilty of a misdemeanor of the fourth degree on a first offense and a misdemeanor of the first degree on each subsequent offense.

(C) Whoever violates section [4731.46](#) or [4731.47](#) of the Revised Code is guilty of a felony of the fifth degree.

(D) Whoever violates section [4731.48](#) of the Revised Code is guilty of a misdemeanor of the fourth degree.

(E) (1)Whoever violates divisions (A)(2) or (B)(3) of section 4731.224 of the Revised Code is guilty of a misdemeanor of the fourth degree.

(2) Whoever violates **divisions (A)(1), (B)(1), (B)(2),** (C), or (D) of section [4731.224](#) of the Revised Code is guilty of a minor misdemeanor on a first offense and a misdemeanor of the fourth degree on each subsequent offense, except that an individual guilty of a subsequent offense shall not be subject to imprisonment, but to a fine alone of up to one thousand dollars for each offense.

(F) Whoever violates section [4731.481](#) of the Revised Code is guilty of a misdemeanor of the first degree.

(G) Whoever violates section 4731.22(F)(5) of the Revised Code is guilty of a misdemeanor of the first degree.

R.C. 4731.991 Patient Notification of Licensee's Probation (new statute proposal)

(A) On or after January 1, 2021, except as otherwise provided in division (C), the board shall require a licensee to provide a written disclosure signed by the licensee that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient, the patient's guardian, or key third party before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after January 1, 2021, in any of the following circumstances:

(1) A final board order, final adjudicative order under Chapter 119. of the Revised Code, or a consent agreement when ratified by an affirmative vote of not fewer than six members of the board establishing any of the following:

(a) The commission of any act of sexual misconduct with a patient or key third party. "Key third party" means an individual closely involved in the patient's decision-making regarding health care services, including but not limited to, the patient's spouse or partner, parents, child, sibling, or guardian. An individual's status as a key third party ceases upon the termination of the licensee-patient relationship or upon termination of the individual's relationship with the patient.

(b) Drug or alcohol abuse directly resulting in harm to patient or the extent that such use impairs the ability of the licensee to practice safely.

(c) Criminal conviction directly involving harm to patient health.

(d) Inappropriate prescribing resulting in harm to patient.

(2) A statement of issues alleged that the licensee committed any of the acts described in division (1)(a), (b), (c), or (d), and a consent agreement, ratified by an affirmative vote of not fewer than six members of the board, that does not involve an admission of guilt, but includes an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

(B) A licensee required to provide a written disclosure pursuant to division (A) shall obtain from the patient, the patient's guardian, or key third party a separate copy of that disclosure signed by the patient, the patient's guardian, or key third party. This signed copy shall be kept in the patient's medical record maintained by the licensee and shall be immediately available to the board on request.

(C) A licensee shall not be required to provide a disclosure pursuant to division (A) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to division (B) and a guardian or key third party is unavailable to comprehend the disclosure and sign the copy.

(2) The direct patient interaction occurs in an emergency room or otherwise occurs as an immediate result of a medical emergency.

(D) On and after January 1, 2021, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) The formal action documents detailing the citation, reports and recommendations, board order, and/or consent agreement applicable to the licensee.

(2) The length of the probation and end date.

(3) All practice restrictions placed on the license by the board.



MEMORANDUM

TO: Amol Soin, M.D., Chair
Policy Committee Members

FROM: Nathan T. Smith, Senior Legal and Policy Counsel

DATE: November 5, 2020

RE: Additions to OAC 4731-11-09 Frequently Asked Questions

Medical Board staff have received questions regarding telehealth prescribing pursuant to OAC rule 4731-11-09 and the associated Frequently Asked Questions (“FAQs”). These questions and the corresponding suggested answers have been added as new FAQs numbered 8, 9, 15, 16, and 25. For ease of reference, they appear in red font. The addition of new FAQs required some numbering changes to existing FAQs, but there are no substantive changes to the existing FAQs.

Action Requested: Approve new FAQs for addition to existing FAQs and send to full Board for approval.



Rule 4731-11-09 – Frequently Asked Questions

Please note: During the COVID-19 state emergency, the board has adopted temporary changes to its telemedicine rules. [Click here](#) to view the current telemedicine guidance.

Medical Board Rule 4731-11-09 describes the circumstances under which a physician or physician assistant can prescribe medication to a patient whom the physician or physician assistant has never personally examined when the patient is at a different location from the prescriber. Although most frequently referred to as the “telemedicine prescribing” rule, 4731-11-09 applies in all situations where the physician or physician assistant is in one location and the patient is in another and the physician or physician assistant has never personally examined the patient.

Q1: Why does this FAQ include physician assistants in the questions and answers when the language of the rule only states “physician?”

A: The rule is applicable to physician assistants because Rule 4730-1-06, Ohio Administrative Code, states that all rules in Chapter 4731-11 of the Ohio Administrative Code are applicable to physician assistants. In addition, Section 4730.42, Ohio Revised Code, provides that a supervising physician shall not grant physician-delegated prescriptive authority to a physician assistant in a manner that exceeds the supervising physician's prescriptive authority.

Q2: What is meant by the term “health care provider?”

A: “Health care provider” is a licensed individual acting within the scope of their professional license. The term includes advanced practice nurses and physician assistants who hold prescriptive authority.

Q3: When the patient is remote from the physician or physician assistant, does an “evaluation” require the use of devices that allow there to be a visual connection with the patient?

A: Rule 4731-11-09 is silent as to the requirements for the equipment. However, for prescribing a controlled substance in compliance with Paragraph (D) of the rule, federal law requires that telemedicine practice occur via use of a telecommunication system that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner. Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system. However, asynchronous store and forward technologies may be used for photographs specific to the patient’s medical condition when adequate for furnishing or confirming a diagnosis and treatment plan. 42 CFR 410.78(a).

Q4: Is there a difference between prescribing controlled medications versus non-controlled medications to a patient under Rule 4731-11-09?

A: Yes, controlled substance (or Drug Enforcement Administration [DEA] scheduled) medications can only be prescribed via the procedures outlined in Rule 4731-11-09(D). Non-controlled medications can only be prescribed by following the procedures in Rule 4731-11-09(C).

Q5: Are there any situations in which the physician or physician assistant can prescribe a controlled substance medication to a patient who is not in the same location as the physician or physician assistant, even though the physician or physician assistant has never conducted a physical examination of the patient?

A: Yes, paragraph (D) of the rule lists the situations in federal law that authorize an Ohio prescriber to prescribe a controlled substance to a patient whom they have not personally examined and who is at a different location than the prescriber, as follows:

- When providing on-call or cross coverage for a physician or other appropriately licensed health care practitioner who has the patient as an active patient and all of the requirements of 4731-11-09(C) for non-controlled medication prescriptions are met. The on-call or cross coverage must be per an agreement between the on-call/cross covering physician and the health care provider.
- The patient is in a hospital or clinic that is registered with the DEA and the patient is being treated by a healthcare provider who has a DEA certificate of registration.
- The patient is in the physical presence of a health care provider who has a DEA certificate of registration and the patient is being treated by that healthcare provider.
- The physician or physician assistant has obtained from the DEA administrator a special DEA certificate of registration. (NOTE: At this time the special DEA certificate of registration is not available although it may be in the future.)

Q6: Does Rule 4731-11-09 recognize the unique prescribing needs presented by patients enrolled in state licensed hospice programs?

A: Yes, Rule 4731-11-09(D)(5) authorizes the medical director, hospice physician, or attending physician for a licensed hospice program to prescribe a controlled substance to a remote patient whom they have not personally examined, when all of the following are met:

- The controlled substance medication is being provided to a patient enrolled in the hospice program **and**
- The prescription is transmitted to the pharmacy by a means that is compliant with Ohio Board of Pharmacy rules.

Q7: Does Rule 4731-11-09 recognize the unique prescribing needs of patients in institutional settings?

A: Yes, Rule 4731-11-09 authorizes a medical director or attending physician at an institutional facility as defined by Pharmacy Board Rule 4729-17-01 (see <http://codes.ohio.gov/oac/4729-17-01>), to prescribe a controlled substance to a patient who is remote from the physician and whom the physician has never conducted a physical examination when the following conditions are met:

- The controlled substance medication is being provided to a person who has been admitted as an inpatient or is a resident of that institutional facility **and**
- The prescription is transmitted to the pharmacy by a means that is compliant with Ohio Board of Pharmacy rules.

Q8: When prescribing controlled substances for nursing home patients, does the exception for medical directors in OAC 4731-11-09 (D)(6) extend to their physician assistant if the medical director is unavailable or prefers that the PA care for the patient if that PA has never conducted a physical examination of the patient?

A: 4731-11-09 (D)(6) states the “The physician is the medical director of, or attending physician at, an institutional facility, as that term is defined in rule 4729-17-01 of the Administrative Code, and both of the following conditions are met:

- (a) The controlled substance is being provided to a person who has been admitted as an inpatient to or is a resident of an institutional facility, and
- (b) The prescription is transmitted to the pharmacy by a means that is compliant with Ohio board of pharmacy rules.

The requirements are less stringent for a medical director than a physician in a cross-coverage arrangement in division (D)(1). The requirements are less demanding because of the unique position of the medical director in the patient setting of a nursing home. Consequently, these requirements cannot be extended to a provider that does not hold this unique position in the institutional facility.

Q9: When prescribing controlled substances for nursing home patients, if the covering on-call physician or the medical director’s physician assistant is required to comply with 4731-11-09(D)(1) due to a cross-coverage agreement, is personal interaction between the prescriber and the nursing home patient necessary?

A: When prescribing controlled substances under 4731-11-09(D)(1), a prescriber is required to comply with all steps of paragraph (C) including (C)(4) which requires that the prescriber “shall, through interaction with the patient, complete a medical evaluation that is appropriate for the patient and the condition with which the patient presents and that meets the minimal standards of care, which may include portions of the evaluation having been conducted by other Ohio licensed healthcare providers acting within the scope of their professional license.” Also, see the answer to #14.

Q10: What types of facilities are included in the definition of “institutional facility?”

A: As defined in Pharmacy Board rule, an “institutional facility” means a hospital as defined in Section 3727.01 of the Ohio Revised Code, or a facility licensed by the Ohio State Board of Pharmacy and the Ohio Department of Health, Ohio Department of Rehabilitation and Correction, Ohio Department of Development Disabilities, or the Ohio Department of Mental Health and Addiction Services at which medical care is provided on site and a medical record documenting episodes of care, including medications ordered and administered, is maintained.

The following facilities are examples of institutional facilities:

- Hospitals registered with the Ohio Department of Health
- Convalescent homes
- Developmental facilities
- Long term care facilities
- Nursing homes
- Psychiatric facilities
- Rehabilitation facilities
- Developmental disability facilities
- Level III sub-acute detoxification facilities

Q11: I am a gastroenterologist and routinely prescribe non-controlled laxatives to patients prior to providing screening colonoscopies. Am I required to interact with the patient prior to prescribing these non-controlled substances?

A: If the patient has been referred for a screening colonoscopy by a healthcare provider who has prescriptive authority, the information contained in the referral, including patient history and physical examination notes, are sufficient for the gastroenterologist to rely upon in prescribing the non-controlled substances for preparation for the colonoscopy. The evaluation by the referring health care provider with prescriptive authority would meet the requirements of 4731-11-09(C)(4).

Q12: I am a psychiatrist. Am I able to prescribe Schedule II controlled substance stimulants such as Vyvanse or Adderall to a patient who is remote when I have never conducted an in-person examination of the patient?

A: In general, no. However, if the prescribing situation meets one of the exceptions listed in Paragraph (D) of the rule then the answer is yes. But see the answer to #3, above, for important information concerning the requirements for the telecommunications system when prescribing a controlled substance via the practice of telemedicine.

Q13: I am a psychiatrist. Am I able to prescribe Schedule II controlled substance stimulants such as Vyvanse or Adderall to a patient in a cross-coverage arrangement with an advanced practice nurse who can only prescribe Schedule II medications for a seventy-two hour period?

A: It depends. "Cross-coverage" under Rule 4731-11-09 and federal law is defined as a practitioner who conducts a medical evaluation at the request of another practitioner who conducted a medical evaluation of the patient within the previous twenty-four months and is temporarily unavailable to conduct a current evaluation. Under a September 2018 interpretation by the U.S. Department of Health and Human Services, the remote psychiatrist would be able to rely upon the examination conducted by the advanced practice registered nurse who is registered with the DEA, when the patient is in the presence of the advanced practice registered nurse and the physician communicates with the patient via an appropriately safeguarded interactive telecommunication system to determine whether the prescription is appropriate. See the answer to #3, above, for important information concerning the requirements for the telecommunication system.

Q14: I am a physician who has a collaboration agreement with an advanced practice registered nurse or a supervision agreement with a physician assistant. Can I rely solely on the assessment conducted by the advanced practice registered nurse or physician assistant for the evaluation aspect before prescribing a controlled substance to the patient?

A: No, not solely on the assessment of the advanced practice registered nurse or physician assistant. Federal law recognizes that some of the evaluation may be conducted by the advanced practice registered nurse or physician assistant who holds DEA registration, however, federal law still requires that the collaborating or supervising physician must communicate with the patient, who is in the presence of the advanced practice registered nurse or physician assistant, via an appropriately safeguarded interactive telecommunication system to determine whether the prescription is appropriate. See the answer to #3, above, for important information concerning the requirements for the telecommunication systems.

Q15: In a group practice where one or more of the group practice physicians or physician assistants have examined the patient, can any of the physicians and PAs that have examined the patient within the past 24 months prescribe controlled or non-controlled substances for the existing practice patient without having to follow OAC 4731-11-09?

A: To fall outside of the requirements of OAC rule 4731-11-09, a physician or physician assistant must have sufficient familiarity with the patient such that the physician or PA must have examined the patient previously and become familiar with the patient's specific condition for which the medication is being prescribed. If the physician or PA has examined the patient previously for a different problem or condition than the specific condition for which the medication is being prescribed, that prescriber would have to comply with the requirements of 4731-11-09.

Q16: I am a physician assistant providing care to a discharged, post-operative patient under a supervision agreement with the surgeon. This patient needs adjusted/additional controlled substance pain medication when the surgeon is not available or prefers that I address prescription requests. I have never conducted a physical examination of the patient. Am I required to interact with the patient prior to prescribing controlled substances?

A: Yes, no exception applies to this situation because it involves a controlled substance.

Q17: In a cross-coverage or on-call situation, I am considering prescribing a non-controlled substance to a patient who I have never physically examined. Can I rely on a nurse's assessment of the patient to comply with 4731-11-09(C)(4)?

A: Yes, in a cross-coverage situation the interaction with the patient required by Paragraph (C)(4) of the rule may be coordinated through another licensed health care provider acting within the scope of their professional license. Examples of licensed health care providers include a nurse, pharmacist, or physician assistant. "Cross-coverage" is defined in Rule 4731-11-01 to include "on call coverage."

Q18: Before prescribing a non-controlled substance to a new patient via a telemedicine encounter, am I required to personally perform all of the steps in 4731-11-09 (C)(1) through (C)(9)?

A: The physician or physician assistant must interact with the patient to complete a medical evaluation, as required by 4731-11-09(C)(4), and to establish or confirm a diagnosis and treatment plan, to include the utilization of any prescription drug, as required by 4731-11-09(C)(5). However, all documentation and other requirements may be delegated to appropriate personnel.

Q19: I am in a cross-coverage arrangement with another health care provider and I am covering for that health care provider who is on vacation. What do I need to do if I am considering prescribing a controlled substance medication to a patient of the vacationing health care provider?

A: The prescribing of controlled substances must comply with 4731-11-09(D):

- Under (D)(1), you must comply with the requirements of paragraph (C) of the rule. See Questions 15 and 16 for information concerning compliance with paragraph (C) requirements.
- Under (D)(2) – (6), you must have sufficient information to prescribe within the minimal standards of care.

Q20: I am in a cross-coverage arrangement as described above. What do I need to do if I am considering prescribing a non-controlled substance medication to the same patient?

A: You must comply with the requirements of 4731-11-09(C) regardless of whether or not the patient is in an in-patient setting. However, the interaction with the patient required by Paragraph (C)(4) may be coordinated through another licensed health care professional working within the scope of their professional license.

Q21: I am a hospice medical director. May I prescribe a controlled substance medication to a hospice patient I have never personally examined?

A: Yes, 4731-11-09(D)(5) permits you to do so when you comply with the requirements of that paragraph.

Q22: I am the medical director of a hospice. May I prescribe a non-controlled substance medication to a hospice patient I have never personally examined?

A: Yes, but you must follow all of the requirements in 4731-11-09(C). However, the interaction with the patient required by Paragraph (C)(4) of the rule may be coordinated through another licensed health care provider acting within the scope of their professional license.

Q23: I am an attending physician of a hospice program. I am considering prescribing a non-controlled substance to a hospice patient whom I have never examined. Do I need to follow all of the requirements in 4731-11-09(C) if the patient is in a home care setting?

A: Yes. However, the interaction with the patient required by Paragraph (C)(4) of the rule may be coordinated through another licensed health care provider acting within the scope of their professional license.

Q24: What if the patient is in an in-patient setting? Do I still have to follow all of the requirements in 4731-11-09(C) in a cross-coverage situation?

A: Yes. However, the interaction with the patient required by Paragraph (C)(4) of the rule may be coordinated through another licensed health care provider acting within the scope of their professional license.

Q25: I am a physician assistant, providing care to a non-hospice oncology patient or a non-hospice palliative care patient under a supervision agreement when the physician is not available or prefers that I address controlled substance prescription requests. The patient may need controlled substance medication adjustments and I have never conducted a physical examination of the patient. Am I required to interact with the patient prior to prescribing controlled substances?

A: Yes, no exception applies to this situation because it involves a controlled substance.

Q26: I am the physician for a home health program. I am the collaborating physician for advanced practice registered nurses and supervising physician for physician assistants who make the home visits. Many of the patients require Schedule II controlled substances, however, the situation is not one in which the advanced practice registered nurse or physician assistant is authorized by the Ohio Revised Code to prescribe a Schedule II drug. Even though I have never personally examined the patient, may I prescribe a Schedule II medication to the patient based upon the physical examinations and assessments performed by the advanced practice registered nurse or physician assistant?

A: See the answers to #13 and #14, above.

Q27: The medical license of a physician who practices as a sole practitioner was suspended by the Medical Board. Some of the physician's patients have called my office seeking new prescriptions for the controlled substances that had been prescribed to them by the now suspended physician. It will be several days before the patients will be able to be seen by me. Does it constitute cross-coverage or on-call when the previous prescribing physician is not available due to license suspension or revocation?

A: The suspension of a physician's medical license does not create a cross-coverage or on-call situation with a subsequent physician for the purpose of prescribing controlled substances. "Cross-coverage" under Rule 4731-11-09 and federal law is defined as a practitioner who conducts a medical evaluation at the request of another practitioner who conducted a medical evaluation of the patient within the previous twenty-four months and is temporarily unavailable to conduct a current evaluation. While the suspended physician is certainly "unavailable," patient safety requires that the subsequent physician establish a physician-patient relationship with the patient by conducting an in-person examination of the patient to determine appropriate medical care before prescribing a controlled substance.

Q28: In a cross-covering situation is the cross-covering physician or physician assistant required to have interaction with the patient who seeks a new prescription for a maintenance drug that is not a controlled substance?

A: Perhaps. The cross-covering physician or physician assistant does not need to personally interact with the patient if all of the following conditions are met:

1. It is a cross-coverage situation as defined in Rule 4731-11-01, Ohio Administrative Code. That is, the care is being delivered by agreement between an Ohio-licensed physician or physician assistant and another Ohio licensed physician or health care provider who is temporarily unavailable to conduct an evaluation of the patient.
2. The patient is an active patient of the other physician or healthcare provider. An active patient is one that within the previous twenty-four months the physician or other healthcare provider being cross-covered conducted at least one in-person medical evaluation of the patient or an evaluation of the patient through the practice of telemedicine.
3. The drug requested is a non-controlled maintenance drug for a chronic condition.
4. The cross-covering physician or physician assistant has access to the patient's medical record and reviews the record as part of the prescriptive decision-making.
5. The cross-covering physician or physician assistant authorizes the issuance of a new prescription.



Legislative Update: November 10, 2020

Bills of high interest or with significant activity since the last board meeting:

SB 246 – Occupational Licensing (Sen. Roegner, McColley) Companion HB432

To require an occupational licensing authority to issue a license or government certification to an applicant who holds a license, government certification, or private certification or has satisfactory work experience in another state under certain circumstances.

Areas of Interest:

- Amendments requested by the policy team have been drafted by the Legislative Service Commission and are expected to be adopted at the next committee hearing
- The requested amendments would allow the board to include language regarding “fitness to practice” which would allow the Board the ability to make a determination on whether or not an applicant has adequately met Ohio’s qualifications for licensure.

Board Position: Neutral

Status: 7/21/2020 Senate General Government and Agency Review, (Sixth Hearing)

- There are no currently scheduled hearings.

SB 364 – Join Interstate Medical Licensure Compact (Sen. Roegner)

To enter into the Interstate Medical Licensure Compact.

Areas of Interest:

- Requires entrance into the interstate medical licensing compact
- Model compact language must be adopted as written and cannot be amended
- The policy team met with OSMA and we’re advised that they will likely support this language
- The policy, legal and licensing team are currently researching this issue. Several other states with introduced legislation and passed legislation have been contacted as well as the IMLC Executive Director Marschall Smith.
- The policy attended an interested party meeting with the bill sponsor and several stakeholders
- The policy team also held a meeting with the bill sponsor to discuss concerns.

Board Position: Opposed

Status: 9/16/2020 Introduced in the Senate. Referred to Senate Health, Human Services and Medicaid - There are no currently scheduled hearings.

HB 263 – Occupational Licensing (Rep. Koehler)

To revise the initial occupational licensing restrictions applicable to individuals convicted of criminal offenses

Areas of interest: Limited look back period for criminal convictions check of five years. Removal of references to good moral character and "moral turpitude"

- Requires state licensing authorities to provide a list of disqualifying offenses that would bar an individual from licensure.
- The licensing authority may only consider the listed disqualifying offenses when deciding whether to license an individual and for no more than five years preceding the application for licensure.
- The five-year lookback limitation does not apply to offenses that are violent or sexual in nature.
- Prohibits a state licensing authority from refusing to issue an initial license to an individual based solely on being charged with or convicted of a criminal offense or a nonspecific qualification such as "moral turpitude" or lack of "moral character."
- If an individual is denied licensure, the licensing authority must provide a reason for the refusal along with the earliest date that the individual may reapply and the individual's ability to offer evidence of rehabilitation upon reapplication.
- In conjunction with the boards of pharmacy, nursing, chiropractic and dental, amendments have been requested to the language to create a new ORC section to apply to healthcare licensing agencies. Those requested amendments were included in the House passed version of the bill.
- The addition of the amendments specify that licensing authorities can consider disciplinary actions taken against an individual who has already been licensed with no lookback limitation.
- The policy team has contacted the Governor's office and the sponsor to express concern for this language.
- The policy team attended a meeting with Rep. Koehler and several other healthcare boards on 9/28/2020.
- The policy team attended an interested party meeting with the Professional Certification Coalition and other healthcare boards. The coalition expressed opposition to the language and suggested alternative language passed in another state.

Board Position: Opposed

Status: Second hearing held in Senate Transportation, Commerce and Workforce held 9/23/2020

HB 492 – Physicians Assistants (Rep. Wiggam, Rep. Joe Miller)

To modify the laws regarding physician assistants.

Areas of Interest: Decouples national accreditation from licensure. Renames the PA/physician "supervision agreement" to "collaborative agreement" to more accurately represent the relationship between practitioners. Eliminates physician liability for the actions of a physician assistant. Allows a physician assistant to "pink-slip" a patient. Allows physician assistants to perform fluoroscopy. Permits a physician assistant to perform rapid intubation and procedural sedation, order fluoroscopy. Permits a physician assistant to perform rapid intubation and procedural sedation, order rapid intubation and procedural sedation, and order drugs needed to perform rapid intubation and procedural sedation in a health care facility

- Met with the lobbyist representing the PAs. This bill is unlikely to proceed through the entire legislative process. Alternatively, an amendment around procedural sedation is likely to be pursued.

- A statement of opposition was sent to the bill sponsor, the physician assistant association and the Governor's office.

Board Position: Opposed

Status: First hearing is scheduled to be held 11/10/2020 in House Health

HB 679 – Telehealth (Rep Fraizer, Holmes)

To establish and modify requirements regarding the provision of telehealth services and to declare an emergency.

- The ad-hoc committee continues to discuss the bill provisions. Changes around initial visits, consistency in standard of care, Medical Board rulemaking authority and synchronous technology are proposed based on the last discussions with the committee.
- The legal team has drafted changes based on those discussions
- The policy team presented the amendments to the bill sponsor, the committee chair and the vice chair to be added to the bill which were in turn drafted by the Legislative Service Commission.
- The amendments are expected to be adopted at the next Senate Insurance committee meeting.

Board Position: Support- closely monitoring

Status: 6/09/2020 House Insurance, (Third Hearing) Reported

6/10/2020 House Vote, Passed 91/3

6/12/2020 Senate, Introduced

9/23/2020 Referred to Senate Insurance

Bills that continue to be monitored but have not seen significant activity since the last board meeting:

SB 1 – Reduce the number of regulatory restrictions

To require certain agencies to reduce the number of regulatory restrictions in their administrative rules, to require the approval of the Joint Committee on Agency Rule Review for Department of Health orders to be effective for more than fourteen days, and to modify the Department's rulemaking authority.

Areas of interest: Requires state agencies to reduce regulatory restrictions in rules by 30% by 2022. Prohibits agencies from adopting rules that would increase the percentage of regulatory restrictions contained in its rules. Requires an agency to produce a base inventory of rules by 12/31/2019.

Board Position: Interested Party - the rule reductions only apply to cabinet level agencies

Status: Senate did not agree to House Amendments 5/28/2020 – Awaiting Conference Committee

SB 31 – Exempt EMS telecommunicator from public records law (Sen.Roegner)

To include emergency service telecommunicators, certain Ohio National Guard members, federal judges, regional physician advisory board members, and first responders as individuals whose residential and familial information is exempt from disclosure under the Public Records Law, to address matters related to contact tracing, and to require the Bureau of Workers' Compensation or Industrial Commission to disclose a claimant's name to a journalist upon written request.

Areas of interest: Exempts emergency medical service workers' personal records such as addresses from being made public, the House added an amendment requiring a signed consent before someone undergoes contact tracing, an important way to stem the spread of the coronavirus.

Board Position: Interested Party

Status: Senate did not agree to House Amendments 5/28/2020 – Awaiting Conference Committee

SB 105 – Massage Therapy Licensing (companion HB 374) (Sen.Brenner)

To make changes to the massage therapy licensing law.

Areas of interest: Requires any individual practicing massage within the state to obtain the current massage therapy license issued by the State Medical Board.

Board Position: Interested Party

Status: Awaiting third hearing in Senate Health and Human Services – Second hearing was held 9/18/2019

SB 156 – Prohibits Defrauding an Alcohol, Drug and Urine Screening Test (Sen.Gavarone)

To enact section 2925.15 of the Revised Code to prohibit defrauding an alcohol, drug, or urine screening test.

Areas of interest: Prohibits defrauding a drug or urine screening test, and bans the sale and use of fake urine for that purpose. Fake urine could be synthetic, the urine of another person, or the person's own urine if it was collected before the screening.

Board Position: Interested Party

Status: Awaiting third hearing in House Criminal Justice Committee. Second hearing was held 5/28/2020

SB 178- Podiatrists authority to administer the flu vaccine (Sen.Schuring)

To provide the authority of podiatrists to administer influenza vaccinations.

Areas of interest: Allows a podiatrist to administer a flu vaccine.

Board Position: Support

Status: Third Hearing is schedule to be held 11/10/2020

SB 238- License and regulate art and music therapists (Sen.Yuko)

To license and regulate art therapists and music therapist

Areas of interest: Places music therapists under the purview of the Medical Board. Art therapists would be regulated by the Counselor, Social Worker and Marriage and Family Therapist Board

- The policy team has attempted to contact the Association of Ohio Music Therapists with no response.

Board Position: Interested Party

Status: 2nd hearing held in Senate Transportation, Commerce and Workforce 9/23/2020

SB 293 - Create Court of Claims Procedure for Open Meeting Violations (Sen. Manning)

To create a procedure within the Court of Claims to hear complaints alleging a violation of the Open Meetings Law.

Areas of interest: Creates a procedure within the Court of Claims to hear complaints alleging a violation of the Open Meetings Law

Board Position: Interested Party

Status: Awaiting a first hearing in House Civil Justice. Introduced in the House 6/25/2020

SB 308 Civil Liability - Emergency Services (Sen. Matt Huffman) (Companion HB 606)

To revise the law governing immunity from civil liability for health care providers during disasters, to provide qualified civil immunity to service providers providing services during and after a government-declared disaster or emergency due to COVID-19, and to declare an emergency.

Areas of interest: The requirement of proving gross negligence will make these minimal standard of care professional disciplinary violations, which are intended to protect public health and safety, very difficult to pursue

Board Position: Interested Party

Status: HB 606 passed out of both chambers 9/1/2020.

SB 341 – Nursing Licensure Compact (Sen. Roegner)

To enact sections 4723.11 and 4723.111 of the Revised Code to enter into the Nurse Licensure Compact.

Areas of interest: No current concerns – monitoring due to potential for physician interstate compact language

Board Position: Interested Party

Status: First hearing held in Senate Health and Human Services 9/22/2020

SB 348 – Regards boards of health (Sen. Schaffer, Roegner)

To prohibit local boards of health from using certain threatening words in notifications to the public, to allow local boards of health to reject Department of Health orders during an emergency, to allow health care professionals who serve on a board of health to receive continuing education credit, and to change the makeup of local boards of health.

Areas of interest: Allows up to five hours of CME credit for serving on a local board of health.

Board Position: Interested Party

Status: First hearing held in Senate Health, Human Services and Medicaid 9/1/2020

SB 365– Extend authority to hold meetings by electronic technology (Sen. Fedor)

To extend the authorization for members of a public body to hold and attend meetings or hearings via electronic technology, during the period of the emergency declared by Executive Order 2020-01D on March 9, 2020, until the declared emergency is terminated.

Areas of interest: Extends the authorization to hold virtual meetings

Board Position: Support

Status: Referred to Senate General Government and Agency Review 9/22/2020. Awaiting first hearing.

HB 61 – Public Records (Rep. Lanese, Rep. Liston)

To include forensic mental health providers, mental health evaluation providers, regional psychiatric hospital employees, emergency service telecommunicators, and certain Ohio National Guard members as individuals whose residential and familial information is exempt from disclosure under the Public Records Law and to address matters related to contact tracing.

Areas of interest: Allows exemption to certain healthcare providers from public records law.

Board Position: Support

Status: Passed the Senate with amendments 6/10/2020. House refused to concur 6/11/2020. Conferees named 9/22/2020.

HB 203 – Specifies requirements for mobile dental facility operations (Rep. Lipps)

To specify requirements for the operation of mobile dental facilities and to authorize pharmacists to enter consult agreements with certain physician assistants and advanced practice registered nurses.

Areas of interest:

- Establishes a greater framework for a statewide mobile dental facility database
- Allow the medical records of a mobile dental facility patient to transfer to a dental office so that those patients can receive more effective and efficient follow up services.
- The as passed version of the bill was amended to include language from SB 303 (Pharmacy Consult Agreements).

- Authorizes pharmacists to enter into consult agreements with certain advanced practice registered nurses and physician assistants for the management of patient drug therapies.
- Maintains existing law provisions allowing pharmacists to enter into consult agreements with physicians.
- Authorizes a pharmacist, when managing a patient's drug therapy under a consult agreement, to order and evaluate laboratory and diagnostic tests for the patient, rather than limiting it to blood and urine tests as under current law.
- Requires the board of pharmacy to consult with the medical board to develop rules to be followed by pharmacists.
- Requires the medical board to consult with the board of pharmacy to develop rules to be followed by physicians.
- Requires the board of nursing to consult with both the medical board and the board of pharmacy to develop rules to be followed by clinical nurse specialist, certified nurse-midwives and certified nurse practitioners.

Board Position: Interested Party

Status: Passed and signed. Effective 12/15/2020

HB 323 - Authorize psychologists to prescribe drugs/therapeutic devices (Rep. Don Manning)

To authorize certain psychologists to prescribe drugs and therapeutic devices as part of the practice of psychology

Areas of interest:

Board Position: Strongly Oppose

Status: Awaiting third hearing in House Health. Second hearing was held 1/28/2020

HB 341- Addiction Treatment Drugs (Rep. Ginter)

Regarding the administration of addiction treatment drugs, federal agency access to the Ohio Automated Rx Reporting System, the Board of Pharmacy's exemption from open meetings requirements, the occasional sale of certain drugs at wholesale, and naloxone access and education.

Areas of interest:

- Authorizes a pharmacist to administer by injection any long-acting or extended-release drug prescribed by a physician to treat drug addiction, instead of limiting the pharmacist's authority to the administration of opioid antagonists as under current law.
- Also permits the state's prescription drug monitoring program, The Ohio Automated RX Reporting System (OARRS), to share data with the Defense Health Agencies (DHA) prescription drug monitoring program.
- An amendment was added to authorize certain advanced practice registered nurses and physician assistants to develop protocols to permit individuals and employees of service entities to personally furnish or administer naloxone.

Board Position: Interested Party

Status: Passed and signed. Effective 12/15/2020

HB 374 – Massage Therapy License (Rep. Plummer, Manchester) (companion SB 105)

To make changes to the massage therapy licensing law.

Areas of interest: Requires any individual practicing massage within the state to obtain the current massage therapy license issued by the State Medical Board. SB 105 is more likely to move in the legislative process.

Board Position: Interested Party

Status: First hearing held in House Commerce and Labor 12/11/2019

HB 388 – Out-of-network care (Surprise Billing) (Rep. Holmes)

To enact sections 3902.50, 3902.51, 3902.52, 3902.53, and 3902.54 of the Revised Code regarding out-of-network care.

Areas of interest: Requires hospitals to provide upfront costs for basic items and services

Board Position: Interested Party

Status: Passed the House 5/20/2020. Pending Senate committee assignment

HB 407 – Enact Clinician Integrity and Medical Accuracy Act (Rep. Liston, Rep. Russo)

To enact sections 3902.50, 3902.51, 3902.52, 3902.53, and 3902.54 of the Revised Code regarding out-of-network care.

Areas of interest: Prohibits a state or local government entity from requiring a physician to provide a patient with a medical service or information that is not, in the physician's clinical judgment, medically accurate and appropriate for the patient. Specifies that a state or local government entity cannot prohibit a physician from providing a patient with a medical service or information that is, in the physician's clinical judgment, appropriate for the patient and evidence-based or medically accurate.

Board Position: Interested Party

Status: First hearing in House Health 11/10/2020

HB 455 – Surgical Assistants (Rep. Todd Smith, Rep. Kelly)

To regulate the practice of surgical assistants.

Areas of interest: Requires that all surgical assistants be registered with the State Medical Board - allows for the application of a waiver in areas where there are shortages - grants authority to the Board to create rules.

- Lobbyist that represents the surgical assistants has requested a meeting to discuss. Pending schedule confirmation.

Board Position: Interested Party

Status: Awaiting second hearing in House Health. First hearing held 5/19/2020

HB 484 – Athletic Training (Rep. Abrams, Carfagna)

To amend sections 4755.60 and 4755.62 and to enact section 4755.621 of the Revised Code regarding the practice of athletic training.

Areas of interest: Eliminate language in current law that restricts ATs by only allowing administering of “topical” care”.

Board Position: Interested Party

Status: Passed the House 6/12/2020. Referred to Senate Health, Human Services and Medicaid 9/23/2020. Awaiting first hearing.

HB 486 – Define Crime/ Civil Action – Assisted Reproduction (Rep. Powell)

To create the crime of fraudulent assisted reproduction and civil actions for an assisted reproduction procedure without consent.

Areas of Interest: "Prohibits a health care professional from purposely or knowingly using human reproductive material from a donor while performing an assisted reproduction procedure if the person receiving the procedure has not expressly consented to the use of that donor’s material"

Board Position: Interested Party

Status: Awaiting first hearing in House criminal justice. Referred 2/4/2020

HB 547- Restrict Cost Sharing- Occupational Licensing/ Physical Therapists (Rep.LaRe)

To enact sections 3902.50 and 3902.51 of the Revised Code to restrict cost sharing requirements with regard to occupational and physical therapists.

Areas of Interest: Caps cost-sharing for occupational and physical therapy

Board Position: Interested Party

Status: Awaiting second hearing in House Insurance. First hearing held 5/12/2020

HB 580- Telemedicine (Rep. Liston, Rep. Patton)

To amend section 3902.30 of the Revised Code to require health plan issuers to cover telemedicine services during a state of emergency, and to declare an emergency.

Areas of Interest: Requires health plan insurers to cover telemedicine during a state of emergency

Board Position: Support

Status: Awaiting first hearing in House Insurance. Referred 5/5/2020

HB 598- Authorize EMTs to perform medical services in hospitals (Rep. Blair, Rep. O'Brien)

To temporarily authorize emergency medical technicians to perform certain medical services in hospitals and to declare an emergency.

Areas of Interest: Temporarily authorizes emergency medical technicians to perform certain medical services in hospitals and to declare an emergency. An emergency medical technician-basic, emergency medical technician-intermediate, and emergency medical technician paramedic may perform medical services in any area of a hospital if the services are performed under the direction and supervision of a physician; a physician assistant designated by a physician; a registered nurse designated by a physician.

Board Position: Opposed

Status: Awaiting first hearing in House Health. Referred 5/5/2020

HB 606- Grant Immunity to essential workers who transmit COVID-19 (Rep. Grendell)

To make temporary changes related to qualified civil immunity for health care and emergency services provided during a government-declared disaster or emergency and for exposure to or transmission or contraction of certain coronaviruses.

Areas of Interest:

- Grants temporary qualified immunity to specified health care providers who provide health care services or emergency services during a declared disaster or emergency;
- Grants immunity from tort liability and professional discipline for such services provided as a result of, and in response to, a disaster or emergency that results in injury, death, or loss allegedly resulting from (1) actions or omissions in the provision, withholding, or withdrawal of those services, (2) decisions related to the provision, withholding, or withdrawal of those services, and (3) compliance with an executive order or director's order;
- Grants immunity from tort liability and professional discipline for injury, death, or loss that allegedly resulted because a health care provider was unable to treat a person, including the inability to perform any elective procedure, due to an executive or director's order or a local health order issued in relation to an epidemic or pandemic disease or other public health emergency;
- Excludes from immunity in tort actions conduct that constitutes a reckless disregard of the consequences or intentional or willful or wanton misconduct on the part of the person against whom the action is brought.
- The legislation does not grant an immunity from tort or other civil liability or a professional disciplinary action to a health care provider for actions that are outside the skills, education, and training of the health care provider, unless the health care provider undertakes the action in good faith and in response to a lack of resources caused by a disaster or emergency.
- The legislation does not affect any legal responsibility of a health care provider to comply with any applicable law of this state or rule of an agency of this state.

Board Position: Support

Status: Passed and signed. Effective 12/16/2020

HB 629 – Staffing/Employment Conditions for Registered Nurses (Rep. Skindell)

To amend sections 3727.50, 3727.51, 3727.52, and 3727.53 and to enact sections 3727.80 to 3727.88 of the Revised Code regarding staffing ratios and other employment conditions for registered nurses employed by hospitals.

Areas of Interest: Addresses the staffing ratios of registered nurses in hospitals

Board Position: Interested Party

Status: Awaiting first hearing in House Commerce and Labor. Referred 5/19/2020

HB 641 – Medical Marijuana – Autism Spectrum Disorder (Rep. Brent)

To amend section 3796.01 of the Revised Code to authorize the use of medical marijuana for autism spectrum disorder.

Areas of Interest: Authorize medical marijuana for autism spectrum disorder

Board Position: Oppose - the Board has already declared positions on these allowed conditions

Status: Awaiting first hearing in House Health. Referred 5/27/2020

HB 650 – Medical Marijuana – Anxiety, Opioid Use Disorder (Rep. Upchurch)

To amend section 3796.01 of the Revised Code to authorize the use of medical marijuana for anxiety, autism spectrum disorder, and opioid use disorder.

Areas of Interest: Authorize medical marijuana for anxiety, opioid use disorder

Board Position: Oppose - the Board has already declared positions on these allowed conditions

Status: Awaiting first hearing in House Health. Referred 5/27/2020

HB 673 – Regards business, professions, education during COVID-19 (Rep. Roemer)

Regarding the operation of businesses, practice of certain professions, and completion of education as it relates to COVID-19.

Areas of Interest: Authorizes pharmacists to administer Covid-19 vaccines and order COVID-19 diagnostic tests.

Board Position: Interested Party

Status: Passed out of the House 6/10/2020. Awaiting first hearing in Senate General Government and Agency Review.

HB 747 – Prescribing and Dispensing Drugs for off-label use (Rep. Grendell, Cutrona)

To enact sections 4723.283, 4729.261, 4730.253, and 4731.201 of the Revised Code regarding the prescribing and dispensing of drugs for off-label uses.

Areas of Interest: Prohibits the Board of Nursing and State Medical Board from taking actions on a license solely for issuing a prescription for a drug to be used in a manner other than the use approved by the U.S. FDA , except when the issuance of such a prescription conflicts with acceptable and prevailing standards of safe care.

- Applies to the following license types: Certified Nurse Practitioner, Clinical Nurse Specialist, Physician Assistant, Licensees practicing medicine in accordance with chapter 4731 of the Ohio revised code
- Feedback from the board is needed

Board Position: Interested Party

Status: Awaiting first hearing in House Health. Referred 8/31/2020



TO: Stephanie Loucka, Executive Director of the State of Ohio Medical Board

FROM: Chelsea Wonski, Director of Legislative Affairs

SUBJECT: HB 606 – To grant immunity to essential workers who transmit COVID-19 and its effect on professional discipline

DATE: 10/29/2020

Bill Number/ Sponsor(s): House Bill 606 (Rep.Grendell)

Date Introduced: 4/10/2020

Date Passed: 9/2/2020

Date Signed: 9/14/2020

Effective Date: 12/13/2020

Summary:

- Temporary law that grants immunity from tort liability and professional discipline for injury, death, or loss that allegedly resulted because a health care provider was unable to treat a person, including the inability to perform any elective procedure, due to an executive or director's order or a local health order issued in relation to an epidemic or pandemic disease or other public health emergency;
- Excludes from immunity in tort actions conduct that constitutes a reckless disregard of the consequences or intentional or willful or wanton misconduct on the part of the health care professional
 - The duty to prove "reckless disregard or intentional misconduct or willful or wanton misconduct" is left to the Board.
- The final version of the bill extended the protections through September 2021
- Grants immunity to the following entities:
 - Advanced practice registered nurses, registered nurses, and licensed practical nurses
 - Respiratory care professionals
 - Pharmacist Direct support professionals for individuals with developmental disabilities
 - Dentists and dental hygienists
 - Behavioral health providers

- Optometrists Emergency medical technicians (EMTs-basic, (EMTs-I, and paramedics)
- Physicians Home health agencies
- Physician assistants Hospice care programs
- Chiropractors Medicaid home and community-based services providers
- Physical therapists, occupational therapists, and athletic trainers
- Other health care workers who provide healthcare related services to an individual under the direction of a health care professional with the authority to direct that worker's activities, including medical technicians, medical assistants, dental assistants, occupational therapy assistants, physical therapist assistants, orderlies, nurse aides, and any other similar individual
- Speech language-pathologists and audiologists Facilities that provide health care services, including a variety of facilities the act specifies
- Laboratory workers Agents, board members, committee members, employees, employers, officers, or volunteers of a home health agency, hospice care program, Medicaid home and community based services provider, or facility
- Massage therapists

Board Actions:

- A memorandum was sent to the sponsor addressing the concerns that the would only allow professional disciplinary action if the “health care provider’s action, omission, decision, or compliance constitutes gross negligence.” The requirement of proving gross negligence (defined as “a lack of care so great that it appears to be a conscious indifference to the rights of others”) will make these minimal standard of care professional disciplinary violations, which are intended to protect public health and safety, very difficult to pursue.

Bill Number/ Link	Name	Current Bill Status	Committee Assignment	Board Position	Bill Sponsor(s)	Date Introduced	Areas of Interest	Action Taken	Action Needed
SB 1	Reduce Regulatory Restrictions	Passed Senate and House with amendments 5/6/2020 - awaiting conference committee	Conference Committee for concurrence of House amendment	Interested party- the rule reductions only apply to cabinet level agencies	Sen. Rob McColley (R-17) Sen. Christina Roegner (R-27)	2/12/2019	Requires state agencies to reduce regulatory restrictions in rules by 30% by 2022. Prohibits agencies from adopting rules that would increase the percentage of regulatory restrictions contained in it's rules. Requires an agency to produce a base inventory of rules by 12/31/2020	None	The policy team will continue to monitor this bill throughout the legislative process
SB 31	Exempt EMS telecommunicator info from Public Records Law	Passed Senate and House with amendments 5/28/2020 - awaiting conference committee	Conference Committee for concurrence of House amendment	Interested party	Sen. Kristina Roegner (R-27)	2/12/2019	Exempts emergency medical service workers' personal records such as addresses from being made public, the House added an amendment requiring a signed consent before someone undergoes contact tracing, an important way to stem the spread of the coronavirus.	None	The policy team will continue to monitor this bill throughout the legislative process
SB 105	Massage Therapy Licensing (companion HB 374)	Awaiting third hearing 2nd hearing held 9/18/2019	Senate Health and Human Services 3/21/2019	Interested Party	Sen. Andrew Brenner (R-19)	3/13/2019	Requires any individual practicing massage within the state to obtain the current massage therapy license issued by the State Medical Board.	The lobbyist that represents the massage therapists has advised that the bill language will be proposed to be added as an amendment to another bill during the lame duck session	The policy team will continue to monitor this bill throughout the legislative process
SB 156	Prohibits Defrauding an Alcohol, Drug or Urine Screening Test	Passed Senate 2/12/2020 Referred to House Committee 5/12/2020 Awaiting third hearing	House Criminal Justice - 2nd Hearing 5/28/2020	Interested Party	Sen. Theresa Gavarone (R-2)	5/28/2020	Prohibits defrauding a drug or urine screening test, and bans the sale and use of fake urine for that purpose. Fake urine could be synthetic, the urine of another person, or the person's own urine if it was collected before the screening.	None	The policy team will continue to monitor this bill throughout the legislative process
SB 178	Podiatrists authority to administer the flu vaccine	Passed the Senate 2/12/2020 Third hearing 11/10/2020	House Health 5/12/2020 Second hearing held 6/9/2020	Support	Sen. Kirk Schuring (R-29)	7/17/2020	Allows a podiatrist to administer a flu vaccine	None	The policy team will continue to monitor this bill throughout the legislative process
SB 238	License and regulate art and music therapists	Introduced 11/13/2019	Referred to House Transportation, Commerce and Workforce 12/4/2019	Interested party - concerns	Sen. Yuko (D-25)	11/13/2019	Requires music therapists to be licensed under the medical board. Creates an advisory committee. Art therapists would be regulated by the Counselor, Social Worker and Marriage and Family Therapist Board	Attempts have been made to contact the Association of Ohio Music Therapists. No response. Met with CSWM&F Board. They advised that this legislation has been seen before.	The policy team will continue to monitor this bill throughout the legislative process

SB 246	Occupational licensing - reciprocity	Pending 7th Hearing – Vote is expected – No meeting scheduled	Senate General Government and Agency Review	Neutral	Sen. Kristina Roegner (R-27); Senator Rob McColley (R-1)	11/26/2019	Ability of the Board to adequately assess applicants would be greatly reduced as written. The proposed amendments would remedy this issue.	Policy team has met with bill sponsors and committee chair to discuss concerns - -A sub bill will be introduced which includes the requested amendments -the amendments would allow the board to retain current standards of review but if the bill passes, reciprocity would still be granted to out of state license holders -the Policy team will continue to advocate for an unlimited lookback period when considering criminal convictions - currently there is A five year limitation - The policy team has re-submitted amendment requests to the sponsors and committee chair - awaiting adoption of requested amendments	-Awaiting draft amendments from LSC – staff will review upon receipt
SB 293	Create Court of Claims Procedure for Open Meeting Violations	Passed Senate 6/10/2020 Introduced in the House 6/25/2020	Civil Justice 8/31/2020	Interested party	Sen. Nathan Manning (R-13) Sen. Louis Blessing (R-8)	3/17/2020	Creates a procedure within the Court of Claims to hear complaints alleging a violation of the Open Meetings Law	None	The policy team will continue to monitor this bill throughout the legislative process
SB 303	Pharmacist Consult Agreements - added as an amendment to HB 203	Amended into HB 203	House Health - First hearing 6/9/2020	Interested party-major concerns	Sen. Stephen Huffman (R-5) Sen. Nathan Manning (R-13)	4/20/2020	Establishes policies and protocols for pharmacist consult agreements	None	The policy team will continue to monitor this bill throughout the legislative process
SB 308	Civil Liability - Emergency Services	Passed the Senate 6/3/2020 Awaitng first House committee hearing	House Civil Justice 6/10/2020	Interested Party	Sen. Matt Huffman (R-12)	5/5/2020	Revise the law governing immunity from civil liability for health care providers during disasters, to provide qualified civil immunity to service providers providing services during and after a government-declared disaster or emergency due to COVID-19	None	The policy team will continue to monitor this bill throughout the legislative process
SB 341	Nursing Licensure Compact	First Senate hearing held 9/22/2020	Senate Health and Human Services 9/1/2020	Neutral	Sen. Kristina Roegner (R-27)	7/21/2020	No current concerns – monitoring due to potential for physician interstate compact language	-Policy analysis complete	The policy team will continue to monitor this bill as it progresses through the legislative process
SB 348	Local Boards of Health	First hearing 9/1/2020	Senate Health, Human Services and Medicaid	Neutral	Sen. Tim Schaffer(R-20)– Sen. Kristina Roegner (R-27)	8/4/2020	Requires licensing boards of health care providers to allow up to five CME credits for serving on a local board of health	-Policy analysis complete -licensing has determined that implementation is not a problem -awaiting legal feedback	-Determination on whether allowing CME credit for hours served on a local board of health is appropriate

SB 364	Join Interstate Medical Licensure Compact	Introduced in the Senate 9/16/2020	Health, Human Services and Medicaid 9/22/2020	Opposed	Sen. Kristina Roegner (R-27)	9/16/2020	Requires entrance into the interstate medical licensing compact	Policy, legal and licensing review is in progress - Met with OSMA, they will likely support after review - the original language came from the AMA - Met with Commission Executive Director, several states and will be attending an IP meeting. - Policy team met with the sponsor and were advised that the bill will not likely see movement this GA	The policy team will continue to monitor this bill throughout the legislative process
SB 365	Extend authority to hold meetings by electronic technology	Introduced in the Senate 9/16/2020	General Government and Agency Review 9/22/2020	Support	Sen. Teresa Fedor (D-11)	9/16/2020	Extends the authority to hold meetings electronically through the end of the declared emergency	Policy and legal review is in progress	The policy team is currently reviewing the passed language for impact on the board
HB 61	Health Provider Residential Info	Passed the Senate with amendments 6/10/2020 - House refused to concur 6/11/2020	Conference Committee for concurrence of Senate Amendment - Conferees names 9/22/2020	Support	Rep. Laura Lanese (R-23)	2/12/2019	To include forensic mental health providers, mental health evaluation providers, and regional psychiatric hospital employees as individuals whose residential and familial information is exempt from disclosure under the Public Records Law.	None	The policy team will continue to monitor this bill throughout the legislative process
HB 177	standard care arrangements and prescribing requirements	Sixth hearing in House Health 1/28/2020	House Health 4/2/2019	Neutral	Rep. Brinkman (R-27)	3/28/2019	Allows an advanced practice registered nurse (APRN) who is a certified nurse practitioner, clinical nurse specialist, or certified nurse-midwife to practice without a collaborating physician or podiatrist. - Eliminates the requirement that the APRN enter into a standard care arrangement with one or more collaborating physicians or podiatrists and practice in accordance with the agreement. - Makes conforming changes to the laws governing APRNs and other health professionals. - Prohibits a physician from issuing a schedule II controlled substance prescription from a convenience care clinic. - Allows a school district or youth sports organization to authorize any licensed health	Met with OSMA - They have expressed strong opposition to this language	The policy team will continue to monitor this bill throughout the legislative process
HB 203	Requirements for mobile dental facility operations	Concurrence with Senate Amendments passed 9/1/2020	N/A	Opposed to the amendments regarding pharmacy consult agreements	Rep. Scott Lipps (R-62)	4/16/2019	Allows the services provided by Mobile Dental Facilities more effective in order to allow greater access to proper oral health care. AMENDED to include SB 303 language regarding pharmacy consult agreements	None	The policy team is currently reviewing the passed language for impact on the board

HB 263	Occupational Licensing - criminal convictions	Passed out of the House 6/9/2020- Introduced in the Senate 6/10/20	House Transportation, Commerce and Workforce 6/24/2020 1st Hearing - 9/2/2020	Strongly oppose	Rep. Kyle Koehler (R-79)	5/28/2019	Limited look back period for criminal convictions check of five years. Removal of references to good moral character and "moral turpitude"	In conjunction with the boards of pharmacy, nursing, chiropractic and dental, amendments have been requested to the language to create a new ORC section to apply to healthcare licensing agencies. - Discussed with Governor's office and sent concerns Currently under review	The policy team will continue to monitor this bill as it progresses through the legislative process
HB 323	Authorize psychologists to prescribe drugs/therapeutic devices	Awaiting third hearing - Second hearing was held 1/28/2020	House Health 9/24/2019	Strongly oppose	Rep. Don Manning	8/28/2019	Allows psychologists to prescribe drugs/therapeutic devices as part of the practice of psychology		The policy team will continue to monitor this bill throughout the legislative process
HB 341	Addiction Treatment Drugs	Enacted 9/16/2020 Effective in 90 days - 12/15/2020	N/A	Interested Party	Rep. Tim Ginter (R- 5)	9/23/2019	Authorizes a pharmacist to administer by injection any long-acting or extended-release drug prescribed by a physician to treat drug addiction, instead of limiting the pharmacist's authority to the administration of opioid antagonists as under current law Also permits the state's prescription drug monitoring program, The Ohio Automated RX Reporting System (OARRS), to share data with the Defense Health Agencies (DHA) prescription drug monitoring program. AMENDED - Authorizes certain advanced practice registered nurses and physician assistants to develop protocols to permit individuals and employees of service entities to personally furnish or administer naloxone.	None	The policy team will continue to monitor this bill as it progresses through the legislative process
HB 374	Massage Therapy License (companion SB 105)	1st hearing in the House held 12/11/2020	House Commerce and Labor	Interested Party	Rep.Phil Plummer (R-40) Rep. Susan Manchester (R-84)	10/23/2019	Requires any individual practicing massage within the state to obtain the current massage therapy license issued by the State Medical Board.	None	The policy team will continue to monitor this bill as it progresses through the legislative process
HB 388	Out-of-network care	Passed the House 5/20/2020 Introduced in the Senate 5/25/2020	Pending assignment	Interested Party	Rep. Adam Holmes (R-97)	11/5/2019	Addresses surprise billing Requires hospitals to provide upfront costs for basic items and services	None	

HB 407	Enact Clinician Integrity and Medical Accuracy Act	First hearing in House Health 11/10/2020	House Health 11/18/2019	Interested Party	Rep. Beth Liston (D-21) Rep. Allison Russo (D-24)	11/12/2019	Prohibits a state or local government entity from requiring a physician to provide a patient with a medical service or information that is not, in the physician's clinical judgment, medically accurate and appropriate for the patient. Specifies that a state or local government entity cannot prohibit a physician from providing a patient with a medical service or information that is, in the physician's clinical judgment, appropriate for the patient and evidence-based or medically accurate	None	The policy team will continue to monitor this bill as it progresses through the legislative process
HB 455	Surgical Assistants	First Hearing 5/19/2020	House Health 1/28/2020	Following closely - currently have concerns	Rep. Todd Smith (R- 43) Rep. Bridgid Kelly (D-31)	12/17/2020	Requires that all surgical assistants be registered with the State Medical Board - allows for the application of a waiver in areas where there are shortages - grants authority to the Board to create rules	Lobbyist representing the surgical assistants asked to discuss this legislation - pending schedule confirmation	The policy team will continue to monitor this bill as it progresses through the legislative process
HB 484	Athletic Training	Passed the House 6/10/2020 Introduced in the Senate 6/12/2020	Referred to Senate Health, Human Services and Medicaid 9/23/2020	Interested Party	Rep. Cindy Abrams (R-29) Rep. Rick Carfagna (R-68)	1/28/2020	Allow ATs to work under a collaboration agreement with physicians. Eliminate language in current law that restricts ATs by only allowing administering of "topical" care	None	The policy team will continue to monitor this bill as it progresses through the legislative process
HB 486	Define Crime/ Civil Action - Assisted Reproduction	Awaiting first hearing	House Criminal Justice 2/4/2020	Interested Party	Rep. Jena Powell (R-80)	1/29/2020	Prohibits a health care professional from purposely or knowingly using human reproductive material from a donor while performing an assisted reproduction procedure if the person receiving the procedure has not expressly consented to the use of that donor's material	None	The policy team will continue to monitor this bill as it progresses through the legislative process
HB 492	Physician Assistants	First hearing 11/10/2020	House Health 2/11/2020	Strongly oppose	Rep. Scott Wiggam (R-1) Rep. Joe Miller (D-56)	2/4/2020	Decouples national accreditation from licensure. Renames the PA/physician "supervision agreement" to "collaborative agreement" to more accurately represent the relationship between practitioners. Eliminates physician liability for the actions of a physician assistant. Allows a physician assistant to "pink-slip" a patient. Allows physician assistant's to perform fluoroscopy. Permits a physician assistant to perform rapid intubation and procedural sedation, order rapid intubation and procedural sedation, and order drugs needed to perform rapid intubation and procedural sedation in a health care facility. Other technical corrections.	Sent letter of opposition to the PA association lobbyist, the bill sponsor, the committee chair, Association of Anesthesiologists and OSMA	The policy team will continue to monitor this bill as it progresses through the legislative process
HB 547	Restrict Cost Sharing - Occupational/Physical Therapists	1st House hearing held 5/12/2020	House Insurance	Interested Party	Rep. Jeff LaRe (R-77)	3/10/2020	Caps cost-sharing for occupational and physical therapy	None	The policy team will continue to monitor this bill as it progresses through the legislative process

HB 580	Telemedicine	First hearing 9/23/2020	House Insurance	Support	Rep. Beth Liston (D-21) Rep. Patton (R-7)	3/23/2020	Require health plan issuers cover telemedicine in emergency Show Long Title	None	The policy team will continue to monitor this bill as it progresses through the legislative process
HB 598	Authorize EMTs to perform medical services in hospitals	First hearing 11/10/2020	House Health 5/5/2020		Rep. Gil Blair (D-63) Rep. Michael O'Brien (D-64)	4/6/2020	Temporarily authorizes emergency medical technicians to perform certain medical services in hospitals and to declare an emergency An emergency medical technician-basic, emergency medical technician-intermediate, and emergency medical technicianparamedic may perform medical services in any area of a hospital if the services are performed under the direction and supervision of a physician; a physician assistant designated by a physician; a registered nurse designated by a physician	None	The policy team will continue to monitor this bill as it progresses through the legislative process
HB 606	Grant immunity to essential workers who transmit COVID-19	Enacted 9/14/2020 - Effective in 90 days 12/13/2020	N/A	Interested Party	Rep. Diane Grendell (R-76)	4/10/2020	Grants immunity from tort liability and professional discipline for injury, death, or loss that allegedly resulted because a health care provider was unable to treat a person, including the inability to perform any elective procedure, due to an executive or director's order or a local health order issued in relation to an epidemic or pandemic disease or other public health emergency; Excludes from immunity in tort actions conduct that constitutes a reckless disregard of the consequences or intentional or willful or wanton misconduct on the part of the person against whom the action is brought The final version of the bill extended the	Memo drafted with concerns and sent to the bill sponsor	None -passed
HB 629	Staffing/Employment Conditions for Registered Nurses	Awaiting first hearing	House Commerce and Labor 5/19/2020	Interested Party	Rep. Michael Skindell (D-13)	5/12/2020	Addresses the staffing ratios of registered nurses in hospitals	None	The policy team will continue to monitor this bill as it progresses through the legislative process
HB 641	Medical Marijuana - Autism Spectrum Disorder	Awaiting first hearing	House Health 5/27/2020	Oppose - the Board has already declared positions on these allowed conditions	Rep. Juanita Brent (D-12)	5/19/2020	Authorize medical marijuana for autism spectrum disorder	None	The policy team will continue to monitor this bill as it progresses through the legislative process
HB 650	Medical Marijuana - Anxiety, Opioid Use Disorder	Awaiting first hearing	House Health 5/27/2020	Oppose - the Board has already declared positions on these allowed conditions	Rep. Terrence Upchurch (D-10)	5/19/2020	Authorize the use of medical marijuana for anxiety, autism spectrum disorder, and opioid use disorder	None	The policy team will continue to monitor this bill as it progresses through the legislative process

HB 673	Regards business, professions, education during COVID-19	Passed out of the House 6/10/2020	Referred to Senate General Government and Agency Review 6/24/2020	Interested Party	Rep. Bill Roemer (R-38)	5/26/2020	Authorizes pharmacists to administer Covid-19 vaccines and order COVID-19 diagnostic tests.	None	The policy team will continue to monitor this bill as it progresses through the legislative process
Sub. HB 679	Telehealth	Passed out of the House 6/10/2020 Awaitng first Senate Hearing	Referred to Senate Insurance & Financial Institutions 9/23/2020	Support - following closely	Rep. Mark Fraizer (R-71) Rep. Adam Holmes (R-97)	5/26/2020	<ul style="list-style-type: none"> -Initial visits -Consistency in standard of care -Medical Board rulemaking authority -Synchronous technology 	<ul style="list-style-type: none"> -Legal is drafting amendments based on discussion with the Ad-hoc telehealth committee Sent comments to Medicaid regarding thier expansion rules - Amendments from the ad hoc commitee have been drafted. Awaiting adoption in next committee meeting 	<ul style="list-style-type: none"> -Approval of amendments for submission to the bill sponsors
HB 747	Prescribing and Dispensing Drugs for Off-label Use	Introduced	House Health 8/31/2020	Interested Party	Rep. Diane Grendell (R-76) Rep. Alessandro Cutrona (R-59)	8/11/2020	<ul style="list-style-type: none"> -Prohibits the Board of Nursing and State Medical Board from taking actions on a license solely for issuing a prescription for a drug to be used in a manner other than the use approved by the U.S. FDA , except when the issuance of such a prescription conflicts with acceptable and prevailing standards of safe care. <p>Applies to the following license types: Certified Nurse Practitioner, Clinical Nurse Specialist, Physician Assistant, Licensees practicing medicine in accordance with chapter 4731 of the Ohio revised code</p>	<ul style="list-style-type: none"> -Policy Analysis complete -Awaiting feedback from legal and licensing 	<ul style="list-style-type: none"> -Determination on whether the board is concerned about the prohibitions set forth in the language

Key
Monitoring - currently no impact on the Board
Monitoring - potential impact on the Board
Passed both Chambers or is enacted
Requires immediate action
Enacted
No Longer Active



Ohio 2020 General Election Results

Overview as of November 4, 2020:

- Ohio Senate Republicans continue to hold their super majority of 24-9 seats and could pick up another seat pending the outcome of a Franklin county race that is still undecided. Six new Senators will be welcomed in the 134th General Assembly next year. Four of the six new Senators are currently members of the Ohio House.
- The Ohio House also remains in Republican control as they were able to pick up four new seats while only losing one seat. The Republican majority holds 64 of the 99 House seats. A total of 22 new members will join the House next year.
- All 16 congressional incumbents retained their seats through re-election.
- One supreme court seat was flipped from Republican to Democrat changing the Republican majority to 4-3.

Ohio Legislature Results:

Ohio Senate				
Dist.	Incumbent	Democrat	Republican	Third Party
2	T. Gavarone	Joel O'Dorisio	X Theresa Gavarone	
4	B. Coley	Kathy Wyenandt	X George Lang	Kent Keller (WI)
6	P. Lehner	Mark Fogel	X Niraj Antani	
8	L. Blessing	Daniel Brown	X Louis Blessing III	
10	R. Hackett	Charlie Ballard	X Robert Hackett	
12	M. Huffman	Ken Poling	X Matt Huffman	
14	T. Johnson	Ryan Ottney	X Terry Johnson	
16	S. Kunze	Crystal Lett	Stephanie Kunze TCTC	
18	J. Eklund	Betsy Rader	X Jerry Cirino	
20	T. Schaffer	Christian Johnson	X Tim Schaffer	
22	L. Obhof	Ryan Hunger	X Mark Romanchuk	
24	M. Dolan	Tom Jackson	X Matt Dolan	
26	D. Burke	Craig Swartz	X Bill Reineke	Robert Taylor (WI)
28	V. Sykes	X Vern Sykes	Michael Downey	
30	F. Hoagland	Michael Fletcher	X Frank Hoagland	
32	S. O'Brien	Sean O'Brien	X Sandra O'Brien	

Ohio House

Dist.	Incumbent	Democrat	Republican	Third Party
1	S. Wiggam	Alison Theiss	X Scott Wiggam	
2	M. Romanchuk	Sam Grady	X Marilyn John	
3	H. Ghanbari	Laurel Johnson	X Haraz Ghanbari	
4	R. Cupp		X Robert Cupp	
5	T. Ginter	Daniel Winston	X Tim Ginter	
6	P. Robinson	X Phil Robinson	Shay Hawkins	
7	T. Patton	Joan Sweeny	X Tom Patton	
8	K. Smith	X Kent Smith		
9	J. Boyd	X Janine Boyd	Dustin Russell	
10	T. Upchurch	X Terrence Upchurch		
11	S. Howse	X Stephanie Howse		
12	J. Brent	X Juanita Brent	Jerry Powell	
13	M. Skindell	X Mike Skindell	Daniel Harrington	
14	B. Sweeney	X Bride Rose Sweeney	Lynn McMahan	
15	J. Crossman	X Jeffrey Crossman	Kevin C. Kusmaul	
16	D. Greenspan	X Monique T. Smith	Dave Greenspan	
17	A. Miller	X Adam Miller	Timothy D. Haske	
18	K. Boggs	X Kristin Boggs	Kayla Anne Packard	
19	M. Lightbody	X Mary Lightbody	Meredith Freedhoff	
20	R. Brown	X Richard Brown	Christopher J. Baer	
21	B. Liston	X Beth Liston	Mehek Cooke	
22	D. Leland	X David Leland		
23	L. Lanese	Nancy Day-Achauer	X Laura Lanese	
24	A. Russo	X Allison Russo	Patrick Manley	
25	B. Kent	X Dontavius Jarrells	James E. Burgess	
26	E. Crawley	X Erica Crawley		
27	T. Brinkman	Sara Bitter	X Tom Brinkman	
28	J. Miranda	X Jessica Miranda	Chris Monzel	
29	C. Abrams		X Cindy Abrams	Harrison Stanley (WI)
30	B. Seitz		X William Seitz	Tom Roll
31	B. Kelly	X Brigid Kelly		
32	C. Ingram	X Catherine Ingram		
33	S. Denson	X Sedrick Denson	Mary L. Hill	
34	E. Sykes	X Emilia Sykes	Henry Morgan Todd	
35	T. Galonski	X Tavia Galonski	Jodi Sarver	
36	A. DeVitis	Matt Shaughnessy	X Bob Young	
37	C. Weinstein	X Casey Weinstein	Beth Bigham	
38	B. Roemer	Joe Campbell	X Bill Roemer	
39	F. Strahorn	X Willis Blackshear Jr.	John Ferrell Mullins III	
40	P. Plummer	Leronda F. Jackson	X Phil Plummer	
41	J. Butler	Cate Berger	X Andrea White	
42	N. Antani		X Tom Young	
43	J. Smith	Amy Cox	X Rodney Creech	

44	P. Hicks-Hudson	X Paula Hicks-Hudson	Robert McMahon	
45	L. Sobecki	X Lisa Sobecki	Shane Logan	
46	M. Sheehy	X Michael Sheehy	Steven Salander	
47	D. Merrin	Nancy Larson	X Derek Merrin	
48	S. Oelslager		X Scott Oelslager	Jean Mastin (WI)
49	T. West	X Thomas West	James Haavisto	
50	R. Stoltzfus	Brian K. Simeone	X Reginald Stoltzfus	
51	S. Carruthers	Johnny Hamilton (WI)	X Sara Carruthers	
52	G. Lang	Chuck Horn	X Jennifer Gross	
53	C. Keller	Michelle E. Novak	X Thomas Hall	
54	P. Zeltwanger	Morgan Showen	X Paul Zeltwanger	
55	G. Manning	Zach Stepp	X Gayle Manning	Dale Stein (WI)
56	J. Miller	X Joe Miller	Bradley A. Lacko	
57	D. Stein	Dara Adkison	X Dick Stein	
58	M. Lepore-Hagan	X Michele Lepore-Hagan	David T. Simon	
59	D. Manning	Chris Stanley	X Al Cutrona	
60	J. Rogers	X Dan Troy	George Phillips	
61	J. Callender	Adam Dudziak	X Jamie Callender	
62	S. Lipps	Erin Rosiello	X Scott Lipps	
63	G. Blair	Gil Blair	X Mike Loychik	
64	M. O'Brien	X Michael O'Brien	Martha Yoder	Jim Lewis (WI)
65	J. Becker	Alan Darnowsky	X Jean Schmidt	
66	D. Green		X Adam Bird	Alicia Gee (WI)
67	K. Jordan	Rachael Morocco	X Kris Jordan	
68	R. Carfagna	Steve Mount	X Rick Carfagna	
69	S. Hambley	Donna Beheydt	X Sharon Ray	
70	D. Kick	Kevin Barnet	X Darrell Kick	
71	M. Fraizer	Mark Carr	X Mark Fraizer	
72	L. Householder	Marci McCaulay (WI)	X Larry Householder	Kaitlyn Clark (WI) Jay Conrad (WI) Robert Leist (WI)
73	R. Perales	Kim McCarthy	X Brian Lampton	
74	B. Dean		X Bill Dean	
75	R. Clites	Randi Clites	X Gail Pavliga	
76	D. Grendell	Garrett Westhoven	X Diane Grendell	
77	J. LaRe	Melissa Wilde	X Jeff LaRe	
78	R. Hood	Charlotte Owens	X Brian Stewart	
79	K. Koehler	Cynthia Richards	X Kyle Koehler	
80	J. Powell	Ted Jones	X Jena Powell	
81	J. Hoops		X Jim Hoops	Janet Breneman (WI)
82	C. Riedel		X Craig Riedel	
83	J. Cross	Mary Harshfield (WI)	X Jon Cross	
84	S. Manchester	Joseph Monbeck	X Susan Manchester	
85	N. Vitale		X Nino Vitale	Ted Greek (WI)
86	T. Richardson	Tiffanie Roberts	X Tracy Richardson	
87	R. McClain	Nicholas Barnes	X Riordan McClain	
88	B. Reineke	Chris Liebold	X Gary Click	
89	D. Swearingen	Alexis Miller	X Douglas Swearingen	
90	B. Baldrige		X Brian Baldrige	
91	S. Wilkin	Scott Dailey	X Shane Wilkin	
92	G. Scherer	Beth Workman	X Mark Johnson	
93	J. Stephens		X Jason Stephens	Ted Saunders (WI)
94	J. Edwards	Katie O'Neill	X Jay Edwards	
95	D. Jones		X Don Jones	
96	J. Cera	Rich Olivito	X Ron Ferguson	Oscar Herrera (L)



MEMORANDUM

TO: Amol Soin, M.D., Chair, Policy Committee
Members, Policy Committee

FROM: Stephanie Loucka, Executive Director

RE: Informational update on letter received re: Department of Mental Health and Addiction Services Rule

DATE: November 7, 2020

This memo serves to make you aware of a letter the Board received from a group of physicians at the Department of Mental Health and Addiction Services (MHAS). **Staff does not recommend any further action from the Board, other than to send a letter of acknowledgment and explanation of the role of the Board.**

The letter

On November 5th, 2020, the Board, through Dr. Schottenstein, received a letter from a group of physicians who work for MHAS (attached). The letter expresses concern about a recently proposed Ohio Administrative Code rule change (attached). Specifically, the physicians are concerned the rule will allow non-physician “licensed practitioners” (e.g., physician assistants and nurse practitioners) to order seclusion and/or restraint at the state run hospitals. Per conversation with MHAS senior staff, MHAS does not currently employ physician assistants.

The proposed rule

The MHAS rule is in the JCARR process; the hearing is November 16th, 2020. The rule is applicable to practices in state run hospitals. MHAS staff shared that other major hospital systems have similar policies to allow non-physician licensed practitioners to order seclusion and restraint. Additionally, the Joint Commission adopted standards in March 2020 using the “licensed practitioner” language (attached).

The role of the SMBO

SMBO rules and laws do not currently prohibit physician assistants from ordering seclusion and restraint. Further, the scope of practice of the physician assistant can only be modified by the legislature (or through the board if given rule making authority). SMBO staff reminded MHAS that, regardless of the MHAS rule, if physician assistants want to order seclusion and/or restraint, it must be done in accordance with a supervision agreement. SMBO staff also encouraged MHAS to consider adding reference to supervision agreements in the proposed rule.

Ohio Department of Mental Health and Addiction Services
Lori Criss, Director
Justin Trevino M.D., Medical Director
Jamie Carmichael, Deputy Director for Public Affairs
30 East Broad Street, 36th Floor
Columbus, Ohio 43125

Re: Rule 5122-2-17

November 2, 2020

Dear Ms. Criss and Dr. Trevino,

We, the undersigned physicians at the Ohio Department of Mental Health and Addiction Services (ODMHAS), oppose the proposed changes to rule 5122-2-17. The Regional Psychiatric Hospitals provide care for the most ill psychiatric patients in the state of Ohio. The patients being cared for at the RPHs require a higher level of care than those admitted to other psychiatric units/facilities. The surrounding community, university, and stand-alone psychiatric hospitals send their most complicated and ill patients to the RPHs for care.

We do not believe any “licensed practitioner” working at the RPHs should have the authority to order seclusion and restraints for these vulnerable patients and that only “licensed physicians” should have this authority per the previous rule. In addition, we do not support any plan that removes the requirement for a face to face evaluation of a patient in restraints by a physician. These rule changes are a patient safety issue. Nurse practitioners and physician assistants are an important and valuable part of patient care. However, their education represents a different purpose in healthcare that was never intended to become a replacement for the critical decision making that is needed by a physician.

Medical illnesses can be easily confused with psychiatric illnesses and distinguishing between the two requires a high level of decision making. Failure to identify and treat medical emergencies can lead to patient harm or death. It is our duty as physicians to advocate for our most vulnerable patients in order to provide them with the best care possible. While nurse practitioners and physician assistants are valued members of the team, their education and training it is not comprehensive enough to make these critical decisions. Nurse practitioners and physician assistants should not be ordering seclusion or restraints on patients admitted to the RPHs, and no one should be ordering seclusion or restraints on a patient without promptly reviewing the data and examining the patient for underlying medical disturbances.

We are deeply concerned by the prospect of allowing patients to be secluded or restrained without a face to face assessment by a physician. The potential for misidentifying a life-threatening emergency is much too great a risk. Nursing staff are not trained to diagnose and treat such grave conditions.

We strongly oppose any effort to leave the state’s most vulnerable and severely mentally ill patients without physician care in an emergency. This is a medically unsound practice, and it falls below the standard of care. It is being imposed on patients whose rights have been abridged, who have been compelled into treatment, and who cannot object to non-physician care.

We urge ODHMAS to maintain the current requirement for a prompt face to face evaluation of a patient in seclusion or restraints by a physician, to abandon the replacement of the word physician with “provider” in rule 5122-2-17, and to eliminate the proposed definition of “provider” in the rule.

Sincerely yours,

Ellen Hott, M.D.
Cortney A. Kohberger, M.D.
Jyoti Anjela, M.D.
Olufunke Fajobi, M.D.
Jera A. Barret, M.D., J.D.
Vamshi K. Myneni, M.D.
Alex McCormick, D.O.
Irina Korobkova, M.D.
Selena Magalotti, M.D.
Vikram Vaka, M.D.
Nita Bhatt, M.D., M.P.H, F.A.P.A.
Ann Browning-Shaw, M.D.
Muhammad Awais Aftab, M.D.
Mahboob Ahmed, M.D.
Sujan Barua, M.D.
Florence Kimbo, M.D.
William Miller, D.O.
Virginia Woodrow, M.D.
Tetyana Bodnar, M.D.
Assadulla Khaishgi, M.D.
Vanessa Doyle, M.D.
Adrienne Saxton, M.D.
Adelaida Fernandez, M.D.

cc:

Janet Shaw, Executive Director, Ohio Psychiatric Physicians Association
Todd Baker, Chief Executive Officer, Ohio State Medical Association
Michael Schottenstein, M.D., President, State Medical Board of Ohio

5122-2-17

Seclusion and restraint use in regional psychiatric hospitals.

- (A) The provision of a physically and psychologically safe environment is a basic ~~foundation and~~ requirement for effective mental health treatment. Treatment environments free of coercive interventions and violence promote positive, trusting relationships and facilitate treatment and recovery.

~~Seclusion and physical~~ Physical restraint and seclusion are emergency interventions intended to prevent patient and staff injury. They are not a form of therapy and may ~~actually~~ be traumatizing to a patient. We ~~thus~~ strive continually to ~~reduce and~~ minimize the use of seclusion and restraint. We recognize that these emergency interventions are to be used only by trained and competent staff and as a last resort in order to eliminate dangerous and potentially harmful behaviors and to preserve safety and dignity. All patients should be assessed for any past exposure to these emergency interventions along with possible alternative interventions based on patient preference and experience.

The fundamental goal of inpatient care is to facilitate recovery from serious mental illness, especially from acute exacerbation of illness that may affect judgment, perception, ~~and emotion, and~~ behavior. Quality inpatient care includes a physically and psychologically safe environment for both patients and staff. The ~~policy and~~ preference of the department is for ~~more the use of~~ positive, supportive and less intrusive measures to engage patients in treatment, including the use of counseling, positive relationships, and ~~creating~~ a therapeutic environment that facilitates treatment and recovery.

To reduce incidents that may lead to injuries, staff should employ a multi-modal approach and an interdisciplinary, trauma-informed, proactive intervention perspective ~~interdisciplinary, trauma-informed, proactive intervention treatment perspective~~. ODMH policy MD-19 "Proactive Positive Interventions" describes ~~appropriate early staff intervention to maximize safety; recommended actions when symptoms of aggression erupt; and necessary debriefing, communication and medication reevaluation after an episode of aggression. In the final section, the policy outlines a staged process for the clinician role in the treatment paradigm for safe and quality care, including psychotropic medication specifics.~~

~~Best practices include careful early assessment and documentation of a person's history with a particular emphasis on past trauma or abuse. Seclusion and restraint are extremely intrusive measures to control potentially harmful behavior and to preserve safety. At times, restraint is experienced by patients as a recapitulation of past experience(s) of abuse. Special attention must be given to anticipate, and prevent if possible, or minimize restraint in such cases. The experience of seclusion and restraint is stressful for both staff and patients, requiring debriefing and support for these individuals. The purpose of this rule shall be to define and establish uniform~~

procedures governing the safe, humane, and appropriate use of seclusion and restraint consistent with this philosophy, standards of quality treatment and respect for the rights of patients.

(B) The provisions of this rule shall be applicable to all regional psychiatric hospital inpatient settings operated by the department of mental health and addiction services (OhioMHAS).

(C) The following definitions apply to this rule in addition to or in place of those appearing in rule 5122-1-01 of the Administrative Code:

(1) "Chief clinical officer (CCO)" means the medical director of a regional psychiatric hospital (RPH) as defined in division (K) of section 5122.01 of the Revised Code.

(2) "Clear treatment reasons" means that permitting the patient to participate will present a substantial risk of physical harm to the patient or others or will substantially preclude effective treatment of the patient. If a restriction is imposed for clear treatment reasons, the patient's written treatment plan shall specify the treatment designed to eliminate the restriction at the earliest possible time.

(3) "Direct care personnel" means personnel with special training, competency and experience in assessing and treating persons with mental illness and whose primary responsibility is for such functions.

(4) "Emergency" means an impending or crisis situation which demands immediate action for preservation of life or prevention of serious bodily harm to the person or others as determined by a licensed physician, licensed practitioner, or registered nurse (RN).

(5) "Hospital services security personnel" means special police as defined in section ~~5119.14~~5119.08 of the Revised Code and security officers of the regional psychiatric hospital.

(6) Licensed practitioner" means an individual who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with state law and specifically refers to advanced practice nurses (APN) and physician assistants.

~~(6)~~(7) "Mechanical supports" means items used for the purpose of achieving proper body alignment, position and balance. Mechanical supports shall not be considered restraints under this rule when used in this manner. Examples include orthopedic-prescribed devices, surgical dressings or bandages,

protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm.

~~(7)~~(8) "Physical restraint" means any method, or device that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. For purposes of this rule, physical restraint refers to:

(a) "Manual restraint" means physically holding an individual to restrict an individual's ability to move his or her legs, arms, head, or body, freely.

(b) "Physical restraint with devices" means any method of restricting a person's freedom of movement, physical activity, or normal use of his or her body, using an appliance or device manufactured for this purpose.

(c) "Prone restraint" means ~~all items or~~ measures used to limit or control the movement ~~or normal functioning of any portion, or all~~ of an individual's body while the individual is in a face-down position for an extended period of time. Prone restraint includes manual or physical restraint with devices.

(d) "Transitional hold" means a restraint involving a brief physical positioning of an individual face-down for the purpose of quickly and effectively gaining physical control of that individual in order to prevent harm to self and others, ~~or prior to transport to~~ and enable the individual to be transported safely.

~~(8)~~(9) "PRN order" means a practitioner's written order for a medication, treatment, or procedure which is only carried out when an individual patient manifests a specific clinical condition.

~~(9)~~(10) "Quiet time" means a voluntary procedure through which a patient removes him/herself to an unlocked area from a situation which is too stimulating, in an effort to regain self-control.

~~(10)~~(11) "Seclusion" means confinement of a patient alone in a room, locked or unlocked, in which that patient is physically prevented from leaving for any period of time.

~~(11)~~(12) "Treatment plan" means a written statement of specific, reasonable and measurable goals and objectives for an individual established by the treatment team, in conjunction with the patient, with specific criteria to evaluate progress towards achieving those objectives.

~~(12)~~(13) "Treatment team" means a team comprised of the patient, patient's family as defined and authorized by the patient, psychiatrist, licensed practitioner, or physician so privileged by the facility, ~~registered nurse~~RN, social worker, and other appropriate personnel (such as activity therapist, CPST worker, interpreter, ~~reader~~, dietitian, occupational therapist, pharmacist, psychologist, counselors, and others as appropriate) based on patient needs and requests, and standard-setting agency requirements.

(D) It is the policy of the department that seclusion and restraint shall be applied in a safe and humane manner as measures of last resort. The goal of seclusion and restraint use is to assist the patient in regaining ~~self control~~self-control and maintaining dignity while reducing the risk of injury to patients and staff. The use of seclusion and restraint shall be consistent with nationally recognized standards for quality treatment and applicable laws.

(1) ~~Regional psychiatric hospital (RPH)~~RPH policies for seclusion or restraint must require that these measures shall:

- (a) Only be imposed to ensure the immediate physical safety of the patient, a staff member, or others, and must be discontinued at the earliest possible time;
- (b) Not employ a drug or medication when it is used as a restriction to manage the patient's behavior, or restrict the patient's freedom of movement, and is not a standard treatment or dosage for the patient's condition;
- (c) Be employed as a last resort when lesser restrictive measures aimed at assisting a patient to control his or her behavior have failed;
- (d) Not be used as coercion, discipline, or punishment; for the convenience of staff; or longer than clinically necessary;
- (e) Be employed using the least restrictive form of restraint or seclusion that protects the physical safety of the patient, staff or others.
- (f) Not cause injury to the patient;
- (g) Not be used in place of more appropriate treatment interventions;
- (h) Be used in a manner that best protects and maintains the dignity and individuality of each patient, and considers:
 - (i) Gender;

- (ii) Age;
- (iii) Developmental issues;
- (iv) Ethnicity;
- (v) History of physical or sexual abuse, or other trauma;
- (vi) Medical conditions;
- (vii) Physical disabilities; and
- (viii) If individual is deaf, hard-of-hearing, or ~~whose~~ has a primary spoken language is other than English.

- (i) Be ordered only by physicians or a licensed practitioner;
- (j) Be used in a manner to ~~allow~~ provide for the greatest possible comfort of the patient; and
- (k) Be vigorously supervised and monitored using individual medical record reviews and aggregate data reviews as part of an ongoing and systematic quality improvement program.

(2) Position in restraint. RPH policies and procedures shall ensure that:

- (a) The use of prone restraint is prohibited.
- (b) A patient shall be placed in a position that allows airway access and does not compromise respiration, regardless of the method of restraint utilized.
- (c) The use of a transitional hold shall be ~~subject to all of the following requirements:~~
 - ~~(i) Applied only by staff who have current training on the safe use of this procedure, including how to recognize and respond to signs of distress in the patient.~~
 - ~~(ii)(i) Applied only in a manner that does not compromise breathing; including, but not limited to the following:; and,~~
 - ~~(a) The weight of the staff shall be placed to the side, rather than on top of the patient. No transitional hold technique shall allow staff to straddle, or bear pressure or weight on, the patient's~~

~~back while applying the restraint, i.e. no downward pressure may be applied.~~

~~(b) No soft device, such as a pillow, blanket or other item, shall be placed under the patient's head or upper body; and~~

~~(c) No transitional hold technique shall allow placing the patient's or staff's arms under the patient's head, face, or upper body.~~

(ii) Only for the brief amount of time necessary to bring the patient under control and ensure safe patient transport.

~~(iii) All staff involved in the procedure must constantly observe the patient's respiration, coloring, and other signs of distress, listen for any complaints of breathing problems, and immediately respond to any observed concerns with the intent to ensure that the patient is safe and suffers no harm.~~

~~(iv) Transitional hold may be applied only for the reasonable amount of time necessary to safely bring the patient or situation under control and to ensure the safety of the individuals involved; and~~

~~(v) After conclusion of the transitional hold, the patient shall be assessed at least every fifteen minutes, for two hours, to assure that the patient is not in need of medical attention. The results of each assessment shall be documented.~~

(3) RPH restraint and seclusion policies shall incorporate the following:

(a) Restraint shall be applied with concern for good body alignment and comfort of the patient, and recognition of any medical conditions;

(b) Seclusion may be employed only in rooms which contain proper temperature control, ventilation and lighting; a visual panel of safety glass for staff to make observations; a safe and sanitary environment ~~void of~~ with no wall/ceiling fixtures and sharp edges; or electrical outlets; ~~and~~. The room must include a bed, mattress, bed sheets, and pillow unless the patient's condition warrants their removal. Removal of these items requires a physician's or licensed practitioner's written order and documentation of rationale for removal, however, a nurse may initiate their removal and then obtain the physician's or licensed practitioner's order within sixty minutes after the removal.

- (4) Steel cuffs or other restraining devices ~~may be~~ used by security staff for custody, detention, and public safety reasons ~~and~~ are not considered behavioral restraints. The use of steel cuffs to restrain a patient on a unit is prohibited.

(E) Standards

- (1) RPHs may distinguish between manual or physical restraint with devices in policy consistent with regulating and accrediting authorities and this rule.

- (2) Approved restraints are indicated below and are to be used in accordance with the limitations stated in this rule.

(a) Physical restraints with devices:

- (i) Padded leather cuffs, vinyl flexicuffs, waist/wrist cuffs (pads), and two- and four-point belts and cuffs;

- (ii) Mittens securely fastened around the wrist with a tie;

- ~~(iii) Any item which inhibits bending of the elbow, wrist, or fingers that was devised by clinical staff to prevent patients who engage in chronic self-mutilation from inflicting injury to themselves and cannot be readily removed by the patient. These items must be approved prior to use by the CCO and the team designated to review behavioral therapy at the RPH;~~

- ~~(iv)~~(iii) Helmets only if the helmets are of an approved type and affixed in such a manner that removal or choking cannot be easily accomplished by patients;

- ~~(v)~~(iv) Mechanical supports used for restraint rather than support purposes (e.g., soft ties, geri chairs, and tie jackets) shall be considered physical restraint devices under this rule.

- ~~(vi)~~(v) Items used for medical, surgical or dental procedures shall not be considered restraints under this rule.

- (b) Manual restraint. ~~A patient may~~ May be physically held by staff ~~utilized~~ in either an emergency situation to prevent injury to the patient or others until appropriate physical restraint devices may be applied, or to control for transporting/~~transferring~~. Manual restraint is typically applied for only a brief ~~period of time~~ time period (less than ~~five~~ ten minutes).

- (3) Quiet time shall not be considered restraint or seclusion.

- ~~(a) Quiet time may be initiated by either a staff person or the patient;~~
 - ~~(b) The use of quiet time may be part of the plan of care and documented in the patient's medical records;~~
 - ~~(c) The quiet area/room utilized for quiet time may be the patient's room or a special room or area designated for quiet time;~~
 - ~~(d) Special care must be maintained when a suicidal or self-injurious patient is being authorized to use the quiet area/room; and~~
 - ~~(e) Only one patient is allowed in the quiet area/room at a time.~~
- (4) Personnel designated below shall be the only individuals permitted to implement/employ specific seclusion and restraint techniques cited if they have been trained and are competent to do so:
- (a) Direct care and nursing personnel shall be permitted to implement seclusion and restraint ~~only if these employees have successfully completed training programs on minimizing the use of restraint or seclusion and to maximize safety when using seclusion and/or restraint;~~
 - (b) RPH security personnel shall ~~implement seclusion and restraint and~~ assist in the use of these interventions only when requested to do so by a patient's behavior is beyond the control of nursing or other direct care or nursing personnel only if they; and, have
 - (c) Other employees who have successfully completed training programs ~~on minimizing on~~ the use of restraint or seclusion shall be permitted to assist in their application, and maximizing safety when using seclusion and/or restraint; and
 - ~~(e) Any employee who has successfully completed training programs on minimizing the use of restraint or seclusion and maximizing safety when using seclusion and/or restraint shall be permitted to assist in the application of restraints.~~

(F) Procedures

(1) RPH policies shall

- (a) Allow a patient, as part of treatment planning, the opportunity to identify techniques that would help ~~the patient~~ control his or her behavior; and

- (b) Consider a patient's advance directive addressing special safety and treatment if seclusion or restraint is warranted.

(2) Orders

- (a) Any application of seclusion or restraint of a patient shall require ~~a~~an order by a physician ~~physician's order or another licensed practitioner.~~ ~~Physician orders are~~ This order is obtained beforehand, as much as possible, but in emergent situations, a ~~registered nurse (RN)~~ can direct the use of seclusion or restraint (either a physical restraint with devices or a manual restraint) and obtain ~~a physician's~~the order as soon as possible afterward in accordance with paragraph (F)(2)(e) of this rule. ~~The physician must~~ must specify the use of seclusion and restraint separately. Each order shall be documented to include parameters for discontinuation of the intervention (seclusion and/or restraint) and placed in the patient's medical record.
- (b) With the exception of orders for the use of mittens and helmets for patient who exhibit self-injurious behavior, each order for seclusion or restraint shall be in force for no longer than one hour for an initial order, or up to ~~two~~four hours for a renewal. A physician, licensed practitioner, or registered nurse trained in accordance with the requirements specified by CMS shall personally examine ~~the~~a patient being physically restrained and/or placed in seclusion and substantiate the need for continuing the use of seclusion or physical restraint with devices, ~~or seclusion~~ prior to ~~renewing any~~ order.
- ~~(c) The CCO or designee must review any episode of seclusion or restraint which exceeds eight hours before another order may be written.~~
- ~~(d) Orders for restraint devices to prohibit self injury including mittens and helmets shall not exceed four hours, and require a face-to-face evaluation by a physician for renewal in accordance with paragraph (F)(6) of this paragraph.~~
- ~~(e) In situations where, after a series of less restrictive interventions have failed and a seclusion or restraint is needed immediately to control the emergency situation, a patient may be restrained or secluded at the direction of a registered nurse without a written physician's order, if the following requirements are met:~~

- ~~(i) A physician shall be contacted by a registered nurse as soon as possible to obtain a telephone order, but no longer than thirty minutes after the initiation of restraint or seclusion;~~
- ~~(ii) The registered nurse shall explain to the patient the reason for seclusion or restraint and the behaviors of the patient which would indicate sufficient self-control to discontinue the measure;~~
- ~~(iii) The registered nurse shall document the physician's telephone order in the patient's medical record; and~~
- ~~(iv) The physician shall personally examine the patient and document in the chart within one hour after giving/receiving a telephone order to:
 - ~~(a) Substantiate the need for such a measure, including the clinical indications. Documentation should show that the physician considered both the benefits and risks of these measures;~~
 - ~~(b) Perform the medical assessment noted in paragraph (F)(3) of this rule; and~~
 - ~~(c) Countersign, date and time the telephone order.~~~~
- ~~(v) When a nurse initiates seclusion or restraint without a physician's order, and the physician, upon examination, does not substantiate the need for such a measure, the seclusion or restraint shall be terminated immediately.
 - ~~(a) The results of the examination and rationale for not ordering seclusion or restraint shall be documented by the physician.~~
 - ~~(b) The CCO or designee shall review all of the documentation related to the seclusion or restraint.~~~~
- ~~(f) Standing or PRN orders for seclusion or restraint shall not be used.~~

(3) Examinations/assessments

~~The physician shall personally examine the patient who has been secluded or restrained in conjunction with writing orders for these interventions. The patient shall be given an explanation of the reason for the restraint or seclusion, and the behaviors of the patient which would indicate sufficient behavioral control~~

to discontinue the intervention. The examination shall include the following unless clinically contraindicated and documented in the patient's record:

- (a) An assessment of any physical problems or an unstable medical status that might contraindicate the use of seclusion or restraint. If there are none, the evaluator shall document in the patient's medical record that there are no known contraindications to this seclusion or restraint procedure;
 - (b) Vital signs including temperature, pulse, respiration, and blood pressure, or documentation if not done, and why;
 - (c) A review of current medications if the evaluation is conducted by a physician or licensed practitioner;
 - (d) Documentation to substantiate the clinical indication for seclusion or restraint use, and that the evaluator considered both the benefits and risks of these measures; and
 - (e) If the one hour face-to-face evaluation is conducted by a physician other than the attending physician, the attending physician or other licensed ~~independent~~ practitioner responsible for the care of the patient must be consulted as soon as possible.
- (4) Rationale for the release from seclusion or restraint shall be documented by the registered nurse or licensed practical nurse in the patient's medical record.
- (5) The treating physician or licensed practitioner shall be contacted as soon as possible if the restraint or seclusion was ordered by another physician or licensed practitioner.
- (6) Patient care and documentation standards.
- (a) All prior interventions used before seclusion or restraint shall be documented in the patient's medical record.
 - (b) To ensure proper safety, body comfort, and circulation of a patient placed in restraints, checks of the patient's condition shall be made by direct care personnel.
 - (i) Patients placed in restraints or seclusion shall be continuously monitored. Observations of the condition of the patient shall be made and documented in the patient's medical record at least every fifteen minutes or more often if the patient's condition so warrants.

- (ii) Appropriate assessments of a patient in restraint or seclusion shall be conducted every fifteen minutes by trained and competent staff, and documented in the patient's medical record. The fifteen minute assessments shall include, as applicable: signs of any injury; nutrition/hydration; circulation and range of motion in the extremities; vital signs; hygiene and elimination; physical and psychological status and comfort; and readiness for discontinuation of restraint or seclusion.
 - (iii) When a patient is removed from physical restraint with devices, nursing staff shall continue to monitor the progress of the patient and make at least one entry, including vital signs, within two hours in the patient's medical record concerning the patient's status. More frequent monitoring may be necessary if warranted by the patient's condition.
- (c) All patients placed in restraint or seclusion shall be visited by a registered nurse or licensed practical nurse no less than every hour to assess the patient. These visits shall be documented in the patient's medical record. This contact may be modified by a physician's or licensed practitioner's order if the patient's need for reduced stimulus outweighs the need for continued medical assessment.
- (d) A patient placed in restraint or seclusion shall be provided the opportunity for motion and exercise for at least ten minutes during each two hour period in which these devices are employed. This shall be documented in the patient's medical record.
- (e) The patient's medical record shall include documentation of fluids being offered and monitoring for fluid intake and output. Monitoring may be modified by a physician's or licensed practitioner's order if the patient's condition warrants reduced monitoring. The physician's order shall include rationale for the reduction in monitoring of fluid intake and output.
- (f) The rationale for each episode of seclusion or restraint shall be clearly documented in the patient's medical record by the physician or licensed practitioner who examined the patient.
- (g) The physician or licensed practitioner shall specify criteria for discontinuation of seclusion and/or restraint.

- (h) With the patient's consent, the patient's family is notified of the initiation of restraint or seclusion.
- (7) Conduct debriefings after an incident. (See ~~ODMH policy MD-19~~ MHAS policy MED-19 "Proactive Positive Intervention Treatment and Safety").
- (a) The goals of debriefing are to: (1) minimize the negative effects of the incident on all involved individuals; and (2) identify alternatives strategies to prevent or minimize future occurrences.
 - (b) Each patient shall be given the opportunity to debrief each episode of seclusion or restraint, unless specifically contraindicated in the treatment plan for clear treatment reasons. As part of the debriefing, the patient shall be given the opportunity to identify techniques that would assist the patient to control his or her behavior. In addition, patient debriefing provides an opportunity to minimize trauma and reestablish the therapeutic staff-patient relationship. Families may also participate in the debriefings at the patient's request.
 - (c) Each RPH shall develop procedures to debrief staff after an episode of restraint. Conduct a staff debriefing when a physical intervention occurs to:
 - (i) Assess for any injury;
 - (ii) Plan next steps for the patient's care and protection for the remainder of the shift;
 - (iii) Determine how management of the situation could have been handled differently;
 - (iv) Provide information to patient's treatment team to assist in treatment plan revisions;
 - (v) The following are examples of questions that may be included in a staff debriefing:
 - (a) Were there alternative actions that could have been taken to prevent the incident?
 - (b) Could some intervention earlier in the prodrome have prevented the outcome?
 - (c) In the case of restraint, could seclusion have been an alternative?

- (d) Would it be possible to achieve a better outcome if an assist team were called?
- (e) Are we medicating optimally? Is the patient adherent? How do we respond to possible non-adherence?
- (f) What environmental changes might minimize the risk of further dangerous behaviors (e.g., room changes, roommate changes, ambient noise, light, or congestion on the unit, access to exits, response to visitors, etc.)?

(8) Monitoring and quality improvement requirements

- (a) Each unit shall be responsible for preparing a daily log indicating name of patient, patient number, living unit, time of day in, time of day out, for each episode of seclusion or restraint.
- (b) The regional psychiatric hospital CCO or his/her designee and the director of nursing/nurse executive and/or his or her designee shall review, daily, all uses of seclusion or restraint.
- (c) The quality improvement review of restraint and seclusion shall include, at a minimum, the following:
 - (i) A review of the aggregate monthly totals of the use of restraint or seclusion by type, ward, time of day, and other data required in paragraph (F) of this rule;
 - (ii) The review of any major incidents that resulted in the use of seclusion or restraint;
 - (iii) Within one business day, the treatment team shall conduct a review of any patient who required any seclusion or restraint. During this review the current treatment plan shall be assessed and revised as needed to contain specific elements that are aimed at reducing the use of seclusion or restraint. All prior interventions shall be reviewed. If successive treatment plan revisions are not successful in reducing the use of seclusion or physical restraint with devices in a clinically reasonable amount of time, consultation from outside the treatment team must be obtained. The department or regional psychiatric hospital behavior therapy committee, the CCO, other treatment teams, private consultants etc. may be sources utilized to conduct a consultation; and

- (iv) The findings from the activities under paragraph (F) of this rule shall be reviewed monthly. This review shall identify any trends, increases, and problems. The need for additional training, consultations, or corrective action will be noted in the minutes of that review and forwarded to the CCO for possible action.
- (v) The data collected in paragraph (F) of this rule and other related quality improvement review information shall be available to central office.
- (d) Each patient, unless specifically contraindicated in the treatment plan for clear treatment reasons, shall be given the opportunity to debrief each episode of seclusion or restraint. As part of the debriefing, the patient shall be given the opportunity to identify techniques that would assist the patient to control his or her behavior. This shall be documented in the patient's medical record.
- (e) Each regional psychiatric hospital shall develop procedures to debrief staff after an episode of restraint.

(G) Orientation and training

- (1) Each chief executive officer shall be responsible for ensuring that orientation and training programs regarding the use of seclusion and restraint are provided. These programs shall be provided and conducted by appropriate personnel.
- (2) Training shall emphasize the use of non-physical crisis intervention, behavioral and other treatment strategies to prevent exacerbation of aggression, and other techniques that will reduce the use of restraints. Special attention shall be placed on the humane use of any restraint technique.
 - (a) All personnel shall have appropriate training during employee orientation.
 - (b) All new and existing direct care personnel and regional psychiatric hospital security personnel shall receive training in behavioral and other techniques to reduce the use of seclusion or restraint, and the proper use of physical restraint, manual restraint, and seclusion. This training will be conducted at least annually or more often if indicated by quality improvement reviews.
 - (c) Upon successful completion of each orientation or training program, a record of this training shall be documented and maintained in each employee's personnel folder.

(H) Implementation

The chief executive officer of each RPH shall be responsible for implementation of this rule.

Effective:

Five Year Review (FYR) Dates: 9/18/2020

Certification

Date

Promulgated Under: 119.03
Statutory Authority: 5122.33
Rule Amplifies: 5122.33
Prior Effective Dates: 04/24/1978, 07/01/1980, 01/11/1991, 06/01/2000,
07/15/2002, 09/18/2010

- 8. ~~For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides activity services directly or through referral for ambulatory and nonambulatory residents at various functional levels.~~
- 12. ~~For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides 24-hour emergency dental services directly or through arrangement with an external provider.~~
~~Note 4: The hospital may charge a Medicare resident an additional amount for routine and emergency dental services.~~
~~Note 2: The hospital assists residents who are eligible and wish to apply for reimbursement of dental services as an incurred medical expense under the state plan.~~
- 12. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital assists residents who are eligible and wish to apply for reimbursement of dental services as an incurred medical expense under the state plan. The hospital may charge a Medicare resident an additional amount for routine and emergency dental services.**

PC.03.05.05

The hospital initiates restraint or seclusion based on an individual order.

Element(s) of Performance for PC.03.05.05

- 1. ~~A physician, clinical psychologist, or other authorized licensed independent practitioner primarily responsible for the patient's ongoing care orders the use of restraint or seclusion in accordance with hospital policy and law and regulation.~~
~~Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).~~
- 1. A physician or other authorized licensed practitioner responsible for the patient's care orders the use of restraint or seclusion in accordance with hospital policy and law and regulation.**
- 5. ~~Unless state law is more restrictive, every 24 hours, a physician, clinical psychologist, or other authorized licensed independent practitioner primarily responsible for the patient's ongoing care sees and evaluates the patient before writing a new order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others in accordance with hospital policy and law and regulation.~~
~~Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).~~

R
- 5. Unless state law is more restrictive, every 24 hours, a physician or other authorized licensed practitioner responsible for the patient's care sees and evaluates the patient before writing a new order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others in accordance with hospital policy and law and regulation.**

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PC.03.05.07

The hospital monitors patients who are restrained or secluded.

Element(s) of Performance for PC.03.05.07

Key: **(D)** indicates that documentation is required; **(R)** indicates an identified risk area;