Executive Committee Meeting

Virginia Board of Medicine

August 3, 2018

8:30 a.m.

PERIMETER CENTER CONFERENCE CENTER
EMERGENCY EVACUATION OF BOARD AND TRAINING ROOMS
(Script to be read at the beginning of each meeting.)

PLEASE LISTEN TO THE FOLLOWING INSTRUCTIONS ABOUT EXITING THESE PREMISES IN THE EVENT OF AN EMERGENCY.

In the event of a fire or other emergency requiring the evacuation of the building, alarms will sound.

When the alarms sound, leave the room immediately. Follow any instructions given by Security staff

Board Room 4

Exit the room using one of the doors at the back of the room. (**Point**) Upon exiting the room, turn **RIGHT.** Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

Executive Committee

Friday, August 3, 2018 @ 8:30 a.m.
9960 Mayland Drive, Suite 200
Richmond, VA 23230
Board Room 4

Page

Call to Order of the Executive Committee—Kevin O'Connor, MD, President, Chair

Emergency Egress Procedures ..... **i**

Roll Call

Approval of Minutes – April 13, 2018 1-6

Adoption of Agenda

Public Comment on Agenda Items

DHP Director's Report – David Brown, DC

President's Report - Kevin O'Connor, MD

Executive Director's Report – William L. Harp, MD

- New Board Members 7
- Committee Appointments 8
- Letter from Former Board Member 9
- Letter from Virginia Tech Carilion 10

NEW BUSINESS:

1. Regulatory Actions – Ms. Yeatts

    - Chart of Regulatory Actions as of July 17, 2018 11
    - Regulatory Action – Adoption of Exempt Actions to conform to changes in the Code of Virginia 12
    - Regulatory Actions – Emergency Action on regulations for autonomous practice for nurse practitioners 18

2. Consideration of Proposed Statutory Amendments 82

Announcements **95**

Next scheduled meeting: December 7, 2018

Adjournment

VIRGINIA BOARD OF MEDICINE
EXECUTIVE COMMITTEE MINUTES

Friday, April 13, 2018 | Department of Health Professions | Henrico, VA

CALL TO ORDER: The meeting convened at 8:33 AM.

ROLL CALL: Ms. Opher called the roll; a quorum was established.

MEMBERS PRESENT:
Kevin O'Connor, MD, President
Syed Salman Ali, MD
Jane Hickey, JD
Maxine Lee, MD
Nathaniel Tuck, Jr., DC, Vice-President

MEMBERS ABSENT:
Randy Clements, DPM
Lori Conklin, MD, Secretary-Treasurer
Alvin Edwards, MDiv, PhD

STAFF PRESENT:
William L. Harp, MD, Executive Director
Jennifer Deschenes, JD, Deputy Director, Discipline
Alan Heaberlin, Deputy Director, Licensure
Barbara Matusiak, MD, Medical Review Coordinator
Colanthia Morton Opher, Operations Manager
Sherry Gibson, Administrative Assistant
David Brown, DC, DHP Director
Elaine Yeatts, DHP Senior Policy Analyst
Erin Barrett, JD, Assistant Attorney General

OTHERS PRESENT:
Gary Riddle, Indivior
W. Scott Johnson, JD, MSV
Richard Grossman, Vectre Corporation
Ryan LaMura, VHHA
James Pickral, Indivior

EMERGENCY EGRESS INSTRUCTIONS

Dr. Tuck provided the emergency egress instructions.

APPROVAL OF MINUTES OF DECEMBER 1, 2017

Dr. Tuck moved to approve the meeting minutes of December 1, 2017 as presented. The motion was seconded and carried unanimously.

ADOPTION OF AGENDA

Dr. Harp requested that the agenda be amended to include consideration of changes to the FAQ's on the Prescribing of Buprenorphine for Addiction and the timeline for HB 793. Ms. Hickey moved to adopt the agenda as amended. The motion was seconded and carried unanimously.

PUBLIC COMMENT

Gary Riddle of Indivior addressed the Committee and provided a brief description of Sublocade, an injectable buprenorphine formulation that has been approved by the FDA for the treatment of opioid use disorder. He also asked the Committee to consider updating the FAQ's to address prescribing concerns of practitioners.

DHP DIRECTOR'S REPORT

Dr. Brown presented the agency's "to-do-list" from the 2018 Session of the General Assembly. It included:

Is there a need to regulate and certify community health workers? Dr. Allison-Bryan will be heading up the effort to answer this question.

Reporting of dispensing to the PMP by federally-funded clinics. Although the bill did not pass, DHP has been asked to study the current federal laws and regulations and make recommendations to the Clerk of the Senate.

What, if any, legal and technological approaches could capture overdoses in emergency departments and create a report for the practitioner that issued the prescription?

Should there be a regulation prohibiting the practice of "conversion therapy" in minors? DHP will address this by a joint effort of the Boards of Medicine, Nursing and the Behavioral Science.

HB 621 requires the Board of Medicine to adopt regulations to notify practitioners that perform joint replacement surgery to inform patients of the risk of cobalt poisoning. Although the bill did not pass, the Chair of Health, Education and Welfare asked the Board of Medicine to disseminate information about this issue to its licenses.

SB 721 requires practitioners to provide patients of the anticipated cost of procedures at least 3 days in advance of the scheduled date. The bill did not pass, but the Chair of Education and Health asked that the Board of Medicine bring to its licensees' attention the current law regarding transparency about costs.

Dr. Brown spoke about the revamping of space at DHP. He noted that the first phase, moving some of the agency's business practices to the first floor, was complete. The second phase of relocating some boards on the 3rd floor is in full swing. On the issue of building security, he said that Dr. Allison-Bryan and Lisa Hahn would be reviewing DHP's current procedures, as well as what other agencies and boards of medicine do.

Dr. Brown gave a recap of a recent opioid summit he attended at which the common theme was medication-assisted treatment (MAT). Stakeholders are seeking to expand the number of MAT providers who are waivered and able to prescribe buprenorphine. A workgroup will convene to discuss barriers, especially how to ensure those with waivers can feel comfortable integrating MAT into their practice.

Dr. O'Connor stated that only a 1/3 of those with waivers currently prescribe buprenorphine.

Dr. Conklin addressed the issue of reporting to the PMP. She said that currently there is no way for emergency physicians to input information about overdoses into the PMP. Dr. Brown responded that the overdose data may be available from VDH and perhaps could be migrated directly into the PMP.

Dr. Conklin remarked that the number one drug on the streets is mono-product buprenorphine. She said it might be wise to confer with specialist on how the mono-product issue can be addressed in the face of an increasing number of physicians writing the prescriptions.

PRESIDENT'S REPORT

Dr. O'Connor advised the members of a new process for reviewing applications and noted that the members of the Credentials Committee will need to be more involved in the licensing process.

He announced that the Committee of the Joint Boards of Medicine and Nursing will meeting on May 17, 2018 to discuss draft regulations for the implementation of HB 793 which provides for the autonomous practice of nurse practitioners.

Dr. O'Connor noted that he looks forward to working with Susan Jones, MD, child psychiatrist, on the Conversion Therapy workgroup. He added that he and several other Board members will be attending the Federation of State Medical Boards' Annual Meeting in Charlotte, NC. He will provide a report at the full Board meeting in June.

EXECUTIVE DIRECTOR'S REPORT

Revenue and Expenditures

Dr. Harp highlighted several direct and allocated expenditures, pointing out that the Board is 75% of the way through FY18 and is well within budget. He noted that for 2019-2020, 1 new FTE and 1 new P-14 have been requested to help achieve greater speed and accuracy in licensing and provide higher quality customer service.

Dr. Brown commented on the constraints the agency has in filling positions. Even though DHP operates with no general funds, there is still accountability to the General Assembly. However, over the last couple of years, DHP has been successful in obtaining full-time employee positions (FTE's). He said that DHP was successful in getting more staff for the Board of

Pharmacy to register physicians and patients involved with cannabidiol oil or THC-A oil. In the past several years, as DHP's employment level has grown, the majority of FTE's have gone to Enforcement and APD to help deal with the growing numbers of complex opioid cases.

Dr. Brown pointed out that the agency's reliance on contract/temporary employees has increased over the years. However, when these individuals gain valuable experience, they oftentimes move on to full-time jobs. He stated that he would continue to advocate for ways to create full-time positions, and that the Board of Medicine is on the list.

Enforcement, APD, HPMP Reports

Dr. Harp briefly reviewed the Enforcement and APD utilization reports and noted that the increase in investigative and case prep hours is due to the complexity of the cases. He said the number of participants in HPMP has increased to 117.

Dr. Brown informed the Committee that he is working with our HPMP vendor to raise awareness of the program's existence.

NEW BUSINESS

Regulatory Actions

Ms. Yeatts guided the Committee through the Report of the 2018 General Assembly session highlighting **HB 793 Nurse practitioners: practice agreements, HB 1251 CBD oil and THC-A oil: certification for use, dispensing**, **SB 632 Controlled substances: limits on prescriptions containing opioids, SB 983 Prescription Monitoring Program: adds controlled substances included in Schedule V and naloxone,** and **SB 882 Prescriptions refill: protocol.**

Ms. Yeatts informed the Board that after July 1, 2018 it will need to amend regulations in order to be consistent with **HB 1524 Health record retention: practitioners to maintain records for a minimum of six years.**

This report was for informational purposes only.

Chart of Regulatory Actions

Ms. Yeatts reviewed the status of pending regulatory matters.

This report was for informational purposes only.

Final Regulations of Licensure by Endorsement

Ms. Yeatts referred to the proposed regulations for licensure by endorsement in the packet.

She said that a public comment period was open from January 8, 2018 to March 9, 2018 as well as a public hearing conducted on February 15, 2018. No comment has been received.

Ms. Yeatts stated that Mr. Heaberlin has identified a potential issue with 18VAC85-20-141. (3) Licensure by endorsement, which says:

Verify that all licenses held in another United States jurisdiction or in Canada are in good standing, defined as not currently under investigation and if lapsed, eligible for renewal or reinstatement.

Mr. Heaberlin states that other jurisdictions may not divulge pending investigations.

Ms. Hickey asked whether the license application included a question that required the applicant to answer if they were under investigation.

Dr. O'Connor confirmed that there are questions addressing pending/investigations, and the applicant is required to provide that information.

Dr. Harp advised that in order to be eligible for this track, the applicant would have to have had no disciplinary actions in any state regardless of the time span.

Dr. Lee asked if a practitioner practicing in another country with an unrestricted license is eligible for licensure by endorsement.

Dr. O'Connor said that licensure by endorsement is for low-risk applicants, and that out-of-country practitioners would be eligible unless there were questionable actions on their record, then the application would go through the standard licensing process.

After discussion, the members agreed to amend this section as follows:

Verify that all licenses held in another United States jurisdiction or in Canada are in good standing, defined as current and unrestricted, or if lapsed, eligible for reinstatement.

MOTION: Dr. Ali moved to adopt the proposed regulations with the stated amendment. The motion was seconded and carried unanimously.

Consideration of changes to FAQs for Prescribing Buprenorphine for Addiction

Dr. Harp reviewed the current regulations on the treatment with buprenorphine for addiction. To provide greater clarity, he proposed the following amendment to FAQ #1 – **Can I continue to prescribe mono-product for my patients that have a demonstrated intolerance to naloxone-containing products?**

The amended emergency regulations that became effective August 24, 2017 read as follows: *For patients who have a demonstrated intolerance to naloxone; such prescriptions for the mono-product shall not exceed 3% of the total prescriptions for buprenorphine written by the prescriber, and the exception shall be clearly documented in the patient's medical record.* So

3% of buprenorphine prescriptions for off-site administration can be for mono-product, and the rest must be for naloxone-containing products. The proposed change to FAQ #1 would read: The 3% restriction does not apply to injectable formulations of buprenorphine mono-product administered directly to patients in a waivered physician's office, a clinic staffed by a waivered provider, or in a federally licensed opioid treatment program, or to mono-product tablets administered directly to patients in federally licensed opioid treatment programs.

The Committee agreed that the proposed amendment would provide the needed clarification. Board staff will make the necessary changes and have the updated document posted immediately.

Timeline for HB 793

Ms. Yeatts informed the members that the Joint Boards of Medicine and Surgery had already met and discussed HB 793. A general notice outlining the plan for adoption of regulations will be circulated soon. On May 17th the Joint Boards, in conjunction with its Advisory Committee, will function as a Regulatory Advisory Panel to develop draft regulations. The draft regulations will be posted for public comment prior to their going to the Board of Nursing and the Board of Medicine for further review.

The plan is for Nursing to adopt the emergency regulations in July and the Board of Medicine to review for adoption in August. If there is not a consensus between the two Boards, there will be another opportunity to look at any variances and adjust the language.

These regulations must be approved by January 2019.

Dr. Brown stated that this process took up a lot of time and that Ms. Yeatts was called upon to review multiple drafts from the stakeholders. From the technical side, he doesn't think there are any obstacles to implementation.

ANNOUNCEMENTS

The next meeting of the Committee will be August 2, 2018 at 8:30 a.m.

ADJOURNMENT

With no additional business, the meeting adjourned at 9:37 a.m.

Kevin O'Connor, MD
President, Chair

William L. Harp, MD
Executive Director

Colanthia M. Opher
Recording Secretary

Virginia Board of Medicine
Board Members 2018-2019

Syed Salman Ali, MD 2nd Term Expires June 2020 District: 11 – Vienna	**Jacob W. Miller, DO** Unexpired Term – Expires June 2020 Osteopath – Virginia Beach
David Archer, MD 1st Term Expires June 2020 District: 2 - Norfolk	**Kevin O'Connor, MD, President** 2nd Term Expires June 2020 District: 10 –Paeonian Springs
James Arnold, DPM 1st Term Expires June 2022 Podiatrist – Cross Junction	**Karen Ransone, MD** Unexpired Term - Expires June 2020 District 1 – Cobbs Creek
Lori D. Conklin, MD, Secretary-Treasurer 2nd Term Expires June 2021 District: 5 – Charlottesville	**Brenda Stokes, MD** 1st Term Expires June 2022 District: 6 - Lynchburg
Manjit Dhillon, MD Unexpired Term Expires June 2020 District: 4 - Chester	**David Taminger, MD** 1st Term Expires June 2019 District: 4 - Midlothian
Alvin Edwards, PhD 1st Term Expires June 2019 Citizen Member - Charlottesville	**Svinder Toor, MD** 1st Term Expires June 2019 District: 3 – Norfolk
David C. Giammittorio, MD 2nd Term Expires June 2020 District: 8 - Lorton	**Nathaniel Ray Tuck, Jr., DC, Vice-President** 2nd Term Expires June 2021 Chiropractor - Blacksburg
Jane Hickey, JD 1st Term Expires 2019 Citizen Member – Richmond	**Kenneth J. Walker, MD** 2nd Term Expires June 2020 District 9 - Pearisburg
L. Blanton Marchese Unexpired Term Expires 2021 Citizen Member – N. Chesterfield	**Martha S. Wingfield** 1st Term Expires June 2021 Citizen Member - Ashland

VIRGINIA BOARD OF MEDICINE

Committee Appointments

2018-2019

EXECUTIVE COMMITTEE (8)
Kevin O'Connor MD, President, Chair
Syed Salman Ali, MD
David Archer, MD
Lori Conklin, MD, Secretary/Treasurer
Alvin Edwards, PhD
Jane Hickey, JD
Ray Tuck, DC, Vice-President
Kenneth Walker, MD

LEGISLATIVE COMMITTEE (7)
Ray Tuck, Jr., DC, Vice-President, Chair
Alvin Edwards, PhD
David Giammittorio, MD
Jane Hickey, JD
Karen Ransone, MD
David Taminger, MD
Svinder Toor, MD

CREDENTIALS COMMITTEE (9)
Kenneth Walker, MD, Chair
James Arnold, DPM
Manjit Dhillon, MD
Jane Hickey, JD
L. Brandon Marchese
Jacob Miller, DO
Brenda Stokes, MD
David Taminger, MD
Martha Wingfield

FINANCE COMMITTEE
Kevin O'Connor, MD, President
Ray Tuck, Jr., DC, Vice-President
Lori Conklin, MD - Secretary/Treasurer

BOARD BRIEFS COMMITTEE
William L. Harp, M.D., Ex Officio

CHIROPRACTIC COMMITTEE
Ray Tuck, Jr., DC - Secretary/Treasurer

BOARD OF HEALTH PROFESSIONS
Kevin O'Connor, MD

COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
Lori Conklin, MD
Kevin O'Connor, MD
Kenneth Walker, MD

June 8, 2018

William Harp, M.D.
Executive Director
9960 Mayland Drive, Suite 300
Henrico, VA 23233

Dear Bill,
As my final communication with the Board of Medicine, I would appreciate it if you would read the following at the full Board Meeting:

Dear Board Members and staff,
When I joined the Board, I was not planning on living in Florida for half of the year. Now that this will be happening and after consulting Bill Harp, I decided that my resignation would be in the best interest of the BOM. During my time on the BOM I was impressed by the professionalism of the entire staff and the dedication of the Board members. Since joining the Board, I have spoken with medical and non-medical persons and have always emphasized the fact that you work to ensure safe and competent patient care for the citizens of the Commonwealth. It was a pleasure knowing you and I wish you all continued success in your mission.

Sincerely,

VTC | Virginia Tech Carilion School of Medicine

2 Riverside Circle, Suite M140
Roanoke, VA 24016-4962
(540) 526-2500
Fax: (540) 581-0741

William Harp M.D.
Executive Director of Virginia Board of Medicine
Virginia Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

July 5th, 2018

Drs. Carey and Brown,

I would like to thank Drs. Barbara Allison Bryan and Bill Harp for their participation in a recent Medical Grand Rounds at Virginia Tech- Carilion School of Medicine and Carilion Roanoke Memorial Hospital. Both provided lectures that were quite pertinent to the Physicians group and to the incoming resident house staff. The audience found the education on the Opioid crisis and regulations most helpful and clarified many myths that exist regarding the intentions of the regulations. I hope the Commonwealth continues to support this grass roots education.

Thank you for your service to the Commonwealth and continued efforts to make Virginians health a top priority.

J. Randolph Clements, DPM
Institute for Orthopaedics and Neurosciences
Associate Professor of Orthopaedics Surgery
Virginia Tech Carilion School of Medicine
Foot and Ankle, Co-Section Chief
Virginia Tech Carilion School of Medicine
3 Riverside Circle
Roanoke, Virginia 24014
540.526.1006

Agenda Item: **Regulatory Actions - Chart of Regulatory Actions**
As of July 17, 2018

Board	Board of Medicine	
Chapter		**Action / Stage Information**
[18 VAC 85 - 20]	Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic	Supervision and direction for laser hair removal Proposed - *At Governor's Office for 69 days*
[18 VAC 85 - 20]	Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic	Licensure by endorsement Final - *At Governor's Office for 69 days*
[18 VAC 85 - 21]	Regulations Governing Prescribing of Opioids and Buprenorphine	Initial regulations Final - *Register Date: 7/9/18 Effective: 8/8/18*
[18 VAC 85 - 50]	Regulations Governing the Practice of Physician Assistants	Definitions of supervision and weight loss rules Fast-Track - *At Governor's Office for 69 days*
[18 VAC 85 - 130]	Regulations Governing the Practice of Licensed Midwives	Practical experience under supervision Fast-Track - *At Governor's Office for 69 days*
[18 VAC 85 - 170]	Regulations Governing the Practice of Genetic Counselors	Temporary licensure Fast-Track - *DPB Review in progress*

Agenda Item: Regulatory Action – Adoption of Exempt Actions to conform to changes in the Code of Virginia

Enclosed are:

Copy of legislation passed by the 2018 General Assembly, and

Amendments to regulations to conform to changes in the Code for:

1) Students and trainees in polysomnographic technology; and
2) Renewal of registration for surgical assistants

Action: To adopt new sections, 18VAC85-140-45 and 18VAC85-160-60, to conform regulations to the law.

2018 SESSION

CHAPTER 98

An Act to amend and reenact § 54.1-2957.15 of the Code of Virginia, relating to practice of polysomnographic technology; licensure; students or trainees.

[H 854]
Approved March 2, 2018

Be it enacted by the General Assembly of Virginia:

1. That § **54.1-2957.15** of the Code of Virginia is amended and reenacted as follows:

§ **54.1-2957.15**. Unlawful to practice as a polysomnographic technologist without a license.

A. It shall be unlawful for any person not holding a current and valid license from the Board of Medicine to practice as a polysomnographic technologist or to assume the title "licensed polysomnographic technologist," "polysomnographic technologist," or "licensed sleep tech."

B. Nothing in this section shall be construed to prohibit a health care provider licensed pursuant to this title from engaging in the full scope of practice for which he is licensed, including, but not limited to, respiratory care professionals.

C. *Nothing in this section shall be construed to prohibit a student enrolled in an educational program in polysomnographic technology or a person engaged in a traineeship from the practice of polysomnographic technology, provided that such student or trainee is under the direct supervision of a licensed polysomnographic technologist or a licensed doctor of medicine or osteopathic medicine. Any such student or trainee shall be identified to patients as a student or trainee in polysomnographic technology. However, any such student or trainee shall be required to have a license to practice after 18 months from the start of the educational program or traineeship or six months from the conclusion of such program or traineeship, whichever is earlier.*

D. For the purposes of this chapter, unless the context requires otherwise:

"Polysomnographic technology" means the process of analyzing, scoring, attended monitoring, and recording of physiologic data during sleep and wakefulness to assist in the clinical assessment and diagnosis of sleep/wake disorders and other disorders, syndromes, and dysfunctions that either are sleep related, manifest during sleep, or disrupt normal sleep/wake cycles and activities.

"Practice of polysomnographic technology" means the professional services practiced in any setting under the direction and supervision of a licensed physician involving the monitoring, testing, and treatment of individuals suffering from any sleep disorder. Other procedures include but are not limited to:

a. Application of electrodes and apparatus necessary to monitor and evaluate sleep disturbances, including application of devices that allow a physician to diagnose and treat sleep disorders, which disorders include but shall not be limited to insomnia, sleep-related breathing disorders, movement disorders, disorders of excessive somnolence, and parasomnias;

b. Under the direction of a physician, institution and evaluation of the effectiveness of therapeutic modalities and procedures including the therapeutic use of oxygen and positive airway pressure (PAP) devices, such as continuous positive airway pressure (CPAP) and bi-level positive airway pressure of non-ventilated patients;

c. Initiation of cardiopulmonary resuscitation, maintenance of patient's airway (which does not include endotracheal intubation);

d. Transcription and implementation of physician orders pertaining to the practice of polysomnographic technology;

e. Initiation of treatment changes and testing techniques required for the implementation of polysomnographic protocols under the direction and supervision of a licensed physician; and

f. Education of patients and their families on the procedures and treatments used during polysomnographic technology or any equipment or procedure used for the treatment of any sleep disorder.

Project 5579 - none

BOARD OF MEDICINE

Student trainee

Part II

Requirements for Licensure as a Polysomnographic Technologist

18VAC85-140-45. Practice as a student or trainee.

A student enrolled in an educational program in polysomnographic technology or a person engaged in a traineeship is not required to hold a license to practice polysomnographic technology, provided that such student or trainee is under the direct supervision of a licensed polysomnographic technologist or a licensed doctor of medicine or osteopathic medicine.

1. Any such student or trainee shall be identified to patients as a student or trainee in polysomnographic technology.

2. Such student or trainee is required to have a license to practice after 18 months from the start of the educational program or traineeship or six months from the conclusion of such program or traineeship, whichever is earlier.

~~Part II~~

~~Requirements for Licensure as a Polysomnographic Technologist~~

18VAC85-140-50. Application requirements.

An applicant for licensure shall submit the following on forms provided by the board:

1. A completed application and a fee as prescribed in 18VAC85-140-40.

2. Verification of a professional credential in polysomnographic technology as required in 18VAC85-140-60.

3. Verification of practice as required on the application form.

4. If licensed or certified in any other jurisdiction, documentation of any disciplinary action taken or pending in that jurisdiction.

2018 SESSION

CHAPTER 374

*An Act to amend and reenact § **54.1-2956.13** of the Code of Virginia, relating to registration of surgical assistants; renewal of registration.*

[H 1378]
Approved March 19, 2018

Be it enacted by the General Assembly of Virginia:

1. That § **54.1-2956.13** of the Code of Virginia is amended and reenacted as follows:

§ **54.1-2956.13**. Registered surgical assistant; use of title; registration.

A. No person shall use or assume the title "registered surgical assistant" unless such person is registered with the Board.

B. The Board shall register as a registered surgical assistant any applicant who presents satisfactory evidence that he (i) holds a current credential as a surgical assistant or surgical first assistant issued by the National Board of Surgical Technology and Surgical Assisting, the National Surgical Assistant Association, or the National Commission for Certification of Surgical Assistants or their successors, (ii) has successfully completed a surgical assistant training program during the person's service as a member of any branch of the armed forces of the United States, or (iii) has practiced as a surgical assistant at any time in the six months prior to July 1, 2014, provided he registers with the Board by December 31, 2016.

C. For renewal of a registration, a surgical assistant who was registered based on a credential as a surgical assistant or surgical first assistant issued by the National Board of Surgical Technology and Surgical Assisting, the National Surgical Assistant Association, or the National Commission for the Certification of Surgical Assistants or their successors shall attest that the credential is current at the time of renewal.

Project 5575 - none

BOARD OF MEDICINE

Surgical assistant renewal

18VAC85-160-60. Renewal of registration for a surgical assistant.

A surgical assistant who was registered based on a credential as a surgical assistant or surgical first assistant issued by the National Board of Surgical Technology and Surgical Assisting, the National Surgical Assistant Association, or the National Commission for the Certification of Surgical Assistants or their successors shall attest that the credential is current at the time of renewal.

Agenda Item: Regulatory –Emergency Action on regulations for autonomous practice for nurse practitioners

Enclosed are:

Copy of HB793 as passed by the 2018 General Assembly

Copy of draft regulations recommended by the Regulatory Advisory Panel (RAP), comprised of Members of the Committee of the Joint Boards and members of the Advisory Committee

Copies of comments on the draft regulations & summary of comment

Staff note:

The 2nd enactment clause on HB793 requires regulations to be in effect within 280 days of enactment, which is 1/9/19. The Boards of Nursing and Medicine must adopt identical regulations.

On July 17, 2017, the Board of Nursing adopted the draft included in your agenda package, which is the version recommended by the RAP.

Board action:

Adoption of regulations as recommended by the RAP or as amended by board members by emergency action.

CHAPTER 776

An Act to amend and reenact §§ 22.1-271.7, 32.1-263, 32.1-282, 54.1-2901, 54.1-2903, 54.1-2957, 54.1-2957.01, 54.1-3300, 54.1-3300.1, 54.1-3301, 54.1-3482, and 54.1-3482.1 of the Code of Virginia, relating to nurse practitioners; practice agreements.

[H 793]

Approved April 4, 2018

Be it enacted by the General Assembly of Virginia:

1. That §§ 22.1-271.7, 32.1-263, 32.1-282, 54.1-2901, 54.1-2903, 54.1-2957, 54.1-2957.01, 54.1-3300, 54.1-3300.1, 54.1-3301, 54.1-3482, and 54.1-3482.1 of the Code of Virginia are amended and reenacted as follows:

§ 22.1-271.7. Public middle school student-athletes; pre-participation physical examination.

No public middle school student shall be a participant on or try out for any school athletic team or squad with a predetermined roster, regular practices, and scheduled competitions with other middle schools unless such student has submitted to the school principal a signed report from a licensed physician, a licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician attesting that such student has been examined, within the preceding 12 months, and found to be physically fit for athletic competition.

§ 32.1-263. Filing death certificates; medical certification; investigation by Office of the Chief Medical Examiner.

A. A death certificate, including, if known, the social security number or control number issued by the Department of Motor Vehicles pursuant to § 46.2-342 of the deceased, shall be filed for each death that occurs in the Commonwealth. Non-electronically filed death certificates shall be filed with the registrar of any district in the Commonwealth within three days after such death and prior to final disposition or removal of the body from the Commonwealth. Electronically filed death certificates shall be filed with the State Registrar of Vital Records within three days after such death and prior to final disposition or removal of the body from the Commonwealth. Any death certificate shall be registered by such registrar if it has been completed and filed in accordance with the following requirements:

1. If the place of death is unknown, but the dead body is found in the Commonwealth, the death shall be registered in the Commonwealth and the place where the dead body is found shall be shown as the place of death. If the date of death is unknown, it shall be determined by approximation, taking into consideration all relevant information, including information provided by the immediate family regarding the date and time that the deceased was last seen alive, if the individual died in his home; and

2. When death occurs in a moving conveyance, in the United States of America and the body is first removed from the conveyance in the Commonwealth, the death shall be registered in the Commonwealth and the place where it is first removed shall be considered the place of death. When a death occurs on a moving conveyance while in international waters or air space or in a foreign country or its air space and the body is first removed from the conveyance in the Commonwealth, the death shall be registered in the Commonwealth but the certificate shall show the actual place of death insofar as can be determined.

B. The licensed funeral director, funeral service licensee, office of the state anatomical program, or next of kin as defined in § 54.1-2800 who first assumes custody of a dead body shall file the certificate of death with the registrar. He shall obtain the personal data, including the social security number of the deceased or control number issued to the deceased by the Department of Motor Vehicles pursuant to § 46.2-342, from the next of kin or the best qualified person or source available and obtain the medical certification from the person responsible therefor.

C. The medical certification shall be completed, signed in black or dark blue ink, and returned to the funeral director within 24 hours after death by the physician in charge of the patient's care for the illness or condition which resulted in death except when inquiry or investigation by the Office of the Chief Medical Examiner is required by § 32.1-283 or 32.1-285.1, or by the physician that pronounces death pursuant to § 54.1-2972.

In the absence of such physician or with his approval, the certificate may be completed and signed by the following: (i) another physician employed or engaged by the same professional practice; (ii) a physician assistant supervised by such physician; (iii) a nurse practitioner practicing ~~as part of a patient care team as defined in § 54.1-2900~~ *in accordance with the provisions of § 54.1-2957*; (iv) the chief medical officer or medical director, or his designee, of the institution, hospice, or nursing home in which death occurred; (v) a physician specializing in the delivery of health care to hospitalized or emergency department patients who is employed by or engaged by the facility where the death occurred; (vi) the physician who performed an autopsy upon the decedent; or (vii) an individual to whom the physician

has delegated authority to complete and sign the certificate, if such individual has access to the medical history of the case and death is due to natural causes.

D. When inquiry or investigation by the Office of the Chief Medical Examiner is required by § 32.1-283 or 32.1-285.1, the Chief Medical Examiner shall cause an investigation of the cause of death to be made and the medical certification portion of the death certificate to be completed and signed within 24 hours after being notified of the death. If the Office of the Chief Medical Examiner refuses jurisdiction, the physician last furnishing medical care to the deceased shall prepare and sign the medical certification portion of the death certificate.

E. If the death is a natural death and a death certificate is being prepared pursuant to § 54.1-2972 and the physician, nurse practitioner, or physician assistant is uncertain about the cause of death, he shall use his best medical judgment to certify a reasonable cause of death or contact the health district physician director in the district where the death occurred to obtain guidance in reaching a determination as to a cause of death and document the same.

If the cause of death cannot be determined within 24 hours after death, the medical certification shall be completed as provided by regulations of the Board. The attending physician or the Chief Medical Examiner, an Assistant Chief Medical Examiner, or a medical examiner appointed pursuant to § 32.1-282 shall give the funeral director or person acting as such notice of the reason for the delay, and final disposition of the body shall not be made until authorized by the attending physician, the Chief Medical Examiner, an Assistant Chief Medical Examiner, or a medical examiner appointed pursuant to § 32.1-282.

F. A physician, nurse practitioner, or physician assistant who, in good faith, signs a certificate of death or determines the cause of death shall be immune from civil liability, only for such signature and determination of causes of death on such certificate, absent gross negligence or willful misconduct.

§ 32.1-282. Medical examiners.

A. The Chief Medical Examiner may appoint for each county and city one or more medical examiners, who shall be licensed as a doctor of medicine or osteopathic medicine, a physician assistant, or a nurse practitioner in the Commonwealth and appointed as agents of the Commonwealth, to assist the Office of the Chief Medical Examiner with medicolegal death investigations. A physician assistant appointed as a medical examiner shall have a practice agreement with and be under the continuous supervision of a physician medical examiner in accordance with § 54.1-2952. A nurse practitioner appointed as a medical examiner shall ~~have a practice agreement with and~~ practice ~~in collaboration with a physician medical examiner~~ in accordance with § 54.1-2957.

B. At the request of the Chief Medical Examiner, the Assistant Chief Medical Examiner, or their designees, medical examiners may assist the Office of the Chief Medical Examiner with cases requiring medicolegal death investigations in accordance with § 32.1-283.

C. The term of each medical examiner appointed, other than an appointment to fill a vacancy, shall begin on the first day of October of the year of appointment. The term of each medical examiner shall be three years; however, an appointment to fill a vacancy shall be for the unexpired term.

§ 54.1-2901. Exceptions and exemptions generally.

A. The provisions of this chapter shall not prevent or prohibit:

1. Any person entitled to practice his profession under any prior law on June 24, 1944, from continuing such practice within the scope of the definition of his particular school of practice;

2. Any person licensed to practice naturopathy prior to June 30, 1980, from continuing such practice in accordance with regulations promulgated by the Board;

3. Any licensed nurse practitioner from rendering care in ~~collaboration and consultation with a patient care team physician as part of a patient care team pursuant to §~~ *accordance with the provisions of §§* 54.1-2957 *and 54.1-2957.01* or any nurse practitioner licensed by the Boards of ~~Nursing and~~ Medicine *and Nursing* in the category of certified nurse midwife practicing pursuant to subsection H of § 54.1-2957 when such services are authorized by regulations promulgated jointly by the ~~Board~~ *Boards* of Medicine and ~~the Board of~~ Nursing;

4. Any registered professional nurse, licensed nurse practitioner, graduate laboratory technician or other technical personnel who have been properly trained from rendering care or services within the scope of their usual professional activities which shall include the taking of blood, the giving of intravenous infusions and intravenous injections, and the insertion of tubes when performed under the orders of a person licensed to practice medicine or osteopathy, a nurse practitioner, or a physician assistant;

5. Any dentist, pharmacist or optometrist from rendering care or services within the scope of his usual professional activities;

6. Any practitioner licensed or certified by the Board from delegating to personnel supervised by him, such activities or functions as are nondiscretionary and do not require the exercise of professional judgment for their performance and which are usually or customarily delegated to such persons by practitioners of the healing arts, if such activities or functions are authorized by and performed for such practitioners of the healing arts and responsibility for such activities or functions is assumed by such practitioners of the healing arts;

7. The rendering of medical advice or information through telecommunications from a physician licensed to practice medicine in Virginia or an adjoining state, or from a licensed nurse practitioner, to emergency medical personnel acting in an emergency situation;

8. The domestic administration of family remedies;

9. The giving or use of massages, steam baths, dry heat rooms, infrared heat or ultraviolet lamps in public or private health clubs and spas;

10. The manufacture or sale of proprietary medicines in this Commonwealth by licensed pharmacists or druggists;

11. The advertising or sale of commercial appliances or remedies;

12. The fitting by nonitinerant persons or manufacturers of artificial eyes, limbs or other apparatus or appliances or the fitting of plaster cast counterparts of deformed portions of the body by a nonitinerant bracemaker or prosthetist for the purpose of having a three-dimensional record of the deformity, when such bracemaker or prosthetist has received a prescription from a licensed physician, licensed nurse practitioner, or licensed physician assistant directing the fitting of such casts and such activities are conducted in conformity with the laws of Virginia;

13. Any person from the rendering of first aid or medical assistance in an emergency in the absence of a person licensed to practice medicine or osteopathy under the provisions of this chapter;

14. The practice of the religious tenets of any church in the ministration to the sick and suffering by mental or spiritual means without the use of any drug or material remedy, whether gratuitously or for compensation;

15. Any legally qualified out-of-state or foreign practitioner from meeting in consultation with legally licensed practitioners in this Commonwealth;

16. Any practitioner of the healing arts licensed or certified and in good standing with the applicable regulatory agency in another state or Canada when that practitioner of the healing arts is in Virginia temporarily and such practitioner has been issued a temporary authorization by the Board from practicing medicine or the duties of the profession for which he is licensed or certified (i) in a summer camp or in conjunction with patients who are participating in recreational activities, (ii) while participating in continuing educational programs prescribed by the Board, or (iii) by rendering at any site any health care services within the limits of his license, voluntarily and without compensation, to any patient of any clinic which is organized in whole or in part for the delivery of health care services without charge as provided in § 54.1-106;

17. The performance of the duties of any active duty health care provider in active service in the army, navy, coast guard, marine corps, air force, or public health service of the United States at any public or private health care facility while such individual is so commissioned or serving and in accordance with his official military duties;

18. Any masseur, who publicly represents himself as such, from performing services within the scope of his usual professional activities and in conformance with state law;

19. Any person from performing services in the lawful conduct of his particular profession or business under state law;

20. Any person from rendering emergency care pursuant to the provisions of § 8.01-225;

21. Qualified emergency medical services personnel, when acting within the scope of their certification, and licensed health care practitioners, when acting within their scope of practice, from following Durable Do Not Resuscitate Orders issued in accordance with § 54.1-2987.1 and Board of Health regulations, or licensed health care practitioners from following any other written order of a physician not to resuscitate a patient in the event of cardiac or respiratory arrest;

22. Any commissioned or contract medical officer of the army, navy, coast guard or air force rendering services voluntarily and without compensation while deemed to be licensed pursuant to § 54.1-106;

23. Any provider of a chemical dependency treatment program who is certified as an "acupuncture detoxification specialist" by the National Acupuncture Detoxification Association or an equivalent certifying body, from administering auricular acupuncture treatment under the appropriate supervision of a National Acupuncture Detoxification Association certified licensed physician or licensed acupuncturist;

24. Any employee of any assisted living facility who is certified in cardiopulmonary resuscitation (CPR) acting in compliance with the patient's individualized service plan and with the written order of the attending physician not to resuscitate a patient in the event of cardiac or respiratory arrest;

25. Any person working as a health assistant under the direction of a licensed medical or osteopathic doctor within the Department of Corrections, the Department of Juvenile Justice or local correctional facilities;

26. Any employee of a school board, authorized by a prescriber and trained in the administration of insulin and glucagon, when, upon the authorization of a prescriber and the written request of the parents as defined in § 22.1-1, assisting with the administration of insulin or administrating glucagon to a student diagnosed as having diabetes and who requires insulin injections during the school day or for whom glucagon has been prescribed for the emergency treatment of hypoglycemia;

27. Any practitioner of the healing arts or other profession regulated by the Board from rendering

free health care to an underserved population of Virginia who (i) does not regularly practice his profession in Virginia, (ii) holds a current valid license or certificate to practice his profession in another state, territory, district or possession of the United States, (iii) volunteers to provide free health care to an underserved area of the Commonwealth under the auspices of a publicly supported all volunteer, nonprofit organization that sponsors the provision of health care to populations of underserved people, (iv) files a copy of the license or certification issued in such other jurisdiction with the Board, (v) notifies the Board at least five business days prior to the voluntary provision of services of the dates and location of such service, and (vi) acknowledges, in writing, that such licensure exemption shall only be valid, in compliance with the Board's regulations, during the limited period that such free health care is made available through the volunteer, nonprofit organization on the dates and at the location filed with the Board. The Board may deny the right to practice in Virginia to any practitioner of the healing arts whose license or certificate has been previously suspended or revoked, who has been convicted of a felony or who is otherwise found to be in violation of applicable laws or regulations. However, the Board shall allow a practitioner of the healing arts who meets the above criteria to provide volunteer services without prior notice for a period of up to three days, provided the nonprofit organization verifies that the practitioner has a valid, unrestricted license in another state;

28. Any registered nurse, acting as an agent of the Department of Health, from obtaining specimens of sputum or other bodily fluid from persons in whom the diagnosis of active tuberculosis disease, as defined in § 32.1-49.1, is suspected and submitting orders for testing of such specimens to the Division of Consolidated Laboratories or other public health laboratories, designated by the State Health Commissioner, for the purpose of determining the presence or absence of tubercle bacilli as defined in § 32.1-49.1;

29. Any physician of medicine or osteopathy or nurse practitioner from delegating to a registered nurse under his supervision the screening and testing of children for elevated blood-lead levels when such testing is conducted (i) in accordance with a written protocol between the physician or nurse practitioner and the registered nurse and (ii) in compliance with the Board of Health's regulations promulgated pursuant to §§ 32.1-46.1 and 32.1-46.2. Any follow-up testing or treatment shall be conducted at the direction of a physician or nurse practitioner;

30. Any practitioner of one of the professions regulated by the Board of Medicine who is in good standing with the applicable regulatory agency in another state or Canada from engaging in the practice of that profession when the practitioner is in Virginia temporarily with an out-of-state athletic team or athlete for the duration of the athletic tournament, game, or event in which the team or athlete is competing;

31. Any person from performing state or federally funded health care tasks directed by the consumer, which are typically self-performed, for an individual who lives in a private residence and who, by reason of disability, is unable to perform such tasks but who is capable of directing the appropriate performance of such tasks; or

32. Any practitioner of one of the professions regulated by the Board of Medicine who is in good standing with the applicable regulatory agency in another state from engaging in the practice of that profession in Virginia with a patient who is being transported to or from a Virginia hospital for care.

B. Notwithstanding any provision of law or regulation to the contrary, military medical personnel, as defined in § 2.2-2001.4, while participating in a pilot program established by the Department of Veterans Services pursuant to § 2.2-2001.4, may practice under the supervision of a licensed physician or podiatrist.

§ 54.1-2903. What constitutes practice.

Any person shall be regarded as practicing the healing arts who actually engages in such practice as defined in this chapter, or who opens an office for such purpose, or who advertises or announces to the public in any manner a readiness to practice or who uses in connection with his name the words or letters "Doctor," "Dr.," "M.D.," "D.O.," "D.P.M.," "D.C.," "Healer," *"N.P.,"* or any other title, word, letter or designation intending to designate or imply that he is a practitioner of the healing arts or that he is able to heal, cure or relieve those suffering from any injury, deformity or disease. No person regulated under this chapter shall use the title "Doctor" or the abbreviation "Dr." in writing or in advertising in connection with his practice unless he simultaneously uses a clarifying title, initials, abbreviation or designation or language that identifies the type of practice for which he is licensed.

Signing a birth or death certificate, or signing any statement certifying that the person so signing has rendered professional service to the sick or injured, or signing or issuing a prescription for drugs or other remedial agents, shall be prima facie evidence that the person signing or issuing such writing is practicing the healing arts within the meaning of this chapter except where persons other than physicians are required to sign birth certificates.

§ 54.1-2957. Licensure and practice of nurse practitioners.

A. As used in this section:

"Clinical experience" means the postgraduate delivery of health care directly to patients pursuant to a practice agreement with a patient care team physician.

"Collaboration" means the communication and decision-making process among *a nurse practitioner,*

patient care team physician, and other health care providers who are members of a patient care team related to the treatment *that includes the degree of cooperation necessary to provide treatment* and care of a patient and includes (i) communication of data and information about the treatment and care of a patient, including exchange of clinical observations and assessments, and (ii) development of an appropriate plan of care, including decisions regarding the health care provided, accessing and assessment of appropriate additional resources or expertise, and arrangement of appropriate referrals, testing, or studies.

"Consultation" means the communicating of data and information, exchanging of clinical observations and assessments, accessing and assessing of additional resources and expertise, problem-solving, and arranging for referrals, testing, or studies.

B. The Board of Medicine and the Board of Nursing shall jointly prescribe the regulations governing the licensure of nurse practitioners. It ~~shall be~~ *is* unlawful for a person to practice as a nurse practitioner in the Commonwealth unless he holds such a joint license.

C. ~~Except as provided in subsection H,~~ a *Every* nurse practitioner ~~shall only practice as part of a patient care team. Each member of a patient care team shall have specific responsibilities related to the care of the patient or patients and shall provide health care services within the scope of his usual professional activities. Nurse practitioners practicing as part of a patient care team~~ *other than a nurse practitioner licensed by the Boards of Medicine and Nursing as a certified nurse midwife or a certified registered nurse anesthetist or a nurse practitioner who meets the requirements of subsection I* shall maintain appropriate collaboration and consultation, as evidenced in a written or electronic practice agreement, with at least one patient care team physician. ~~Nurse practitioners~~ *A nurse practitioner who meets the requirements of subsection I may practice without a written or electronic practice agreement. A nurse practitioner who is licensed by the Boards of Medicine and Nursing as a certified nurse midwife shall practice pursuant to subsection H. A nurse practitioner* who ~~are~~ *is a* certified registered nurse anesthetists shall practice under the supervision of a licensed doctor of medicine, osteopathy, podiatry, or dentistry. ~~Nurse practitioners~~ *A nurse practitioner who is* appointed as *a* medical ~~examiners~~ *examiner* pursuant to § 32.1-282 shall practice in collaboration with a licensed doctor of medicine or osteopathic medicine who has been appointed to serve as a medical examiner pursuant to § 32.1-282. Collaboration and consultation among nurse practitioners and patient care team physicians may be provided through telemedicine as described in § 38.2-3418.16. ~~Practice of patient care teams in all settings shall include the periodic review of patient charts or electronic health records and may include visits to the site where health care is delivered in the manner and at the frequency determined by the patient care team.~~

Physicians on patient care teams may require that a nurse practitioner be covered by a professional liability insurance policy with limits equal to the current limitation on damages set forth in § 8.01-581.15.

Service on a patient care team by a patient care team member shall not, by the existence of such service alone, establish or create liability for the actions or inactions of other team members.

D. The ~~Board~~ *Boards* of Medicine and ~~the Board of~~ Nursing shall jointly promulgate regulations specifying collaboration and consultation among physicians and nurse practitioners working as part of patient care teams that shall include the development of, and periodic review and revision of, a written or electronic practice agreement; guidelines for availability and ongoing communications that define consultation among the collaborating parties and the patient; and periodic joint evaluation of the services delivered. Practice agreements shall include ~~a provision~~ *provisions* for ~~appropriate physician~~ *(i) periodic review of health records, which may include visits to the site where health care is delivered, in the manner and at the frequency determined by the nurse practitioner and the patient care team physician and (ii)* input *from appropriate health care providers* in complex clinical cases and patient emergencies and for referrals. Evidence of a practice agreement shall be maintained by a nurse practitioner and provided to the Boards upon request. For nurse practitioners providing care to patients within a hospital or health care system, the practice agreement may be included as part of documents delineating the nurse practitioner's clinical privileges or the electronic or written delineation of duties and responsibilities in collaboration and consultation with a patient care team physician.

E. The Boards *of Medicine and Nursing* may issue a license by endorsement to an applicant to practice as a nurse practitioner if the applicant has been licensed as a nurse practitioner under the laws of another state and, ~~in the opinion~~ *pursuant to regulations* of the Boards, the applicant meets the qualifications for licensure required of nurse practitioners in the Commonwealth. *A nurse practitioner to whom a license is issued by endorsement may practice without a practice agreement with a patient care team physician pursuant to subsection I if such application provides an attestation to the Boards that the applicant has completed the equivalent of at least five years of full-time clinical experience, as determined by the Boards, in accordance with the laws of the state in which the nurse practitioner was licensed.*

F. Pending the outcome of the next National Specialty Examination, the Boards may jointly grant temporary licensure to nurse practitioners.

G. In the event a physician who is serving as a patient care team physician dies, becomes disabled,

retires from active practice, surrenders his license or has it suspended or revoked by the Board, or relocates his practice such that he is no longer able to serve, and a nurse practitioner is unable to enter into a new practice agreement with another patient care team physician, the nurse practitioner may continue to practice upon notification to the designee or his alternate of the Boards and receipt of such notification. Such nurse practitioner may continue to treat patients without a patient care team physician for an initial period not to exceed 60 days, provided the nurse practitioner continues to prescribe only those drugs previously authorized by the practice agreement with such physician and to have access to appropriate ~~physician~~ input *from appropriate health care providers* in complex clinical cases and patient emergencies and for referrals. The designee or his alternate of the Boards shall grant permission for the nurse practitioner to continue practice under this subsection for another 60 days, provided the nurse practitioner provides evidence of efforts made to secure another patient care team physician and of access to physician input.

H. Nurse practitioners licensed by the Boards of Medicine and Nursing in the category of certified nurse midwife shall practice in consultation with a licensed physician in accordance with a practice agreement between the nurse practitioner and the licensed physician. Such practice agreement shall address the availability of the physician for routine and urgent consultation on patient care. Evidence of a practice agreement shall be maintained by a nurse practitioner and provided to the Boards upon request. The Boards shall jointly promulgate regulations, consistent with the Standards for the Practice of Midwifery set by the American College of Nurse-Midwives, governing such practice.

I. A nurse practitioner, other than a nurse practitioner licensed by the Boards of Medicine and Nursing in the category of certified nurse midwife or certified registered nurse anesthetist, who has completed the equivalent of at least five years of full-time clinical experience as a licensed nurse practitioner, as determined by the Boards, may practice in the practice category in which he is certified and licensed without a written or electronic practice agreement upon receipt by the nurse practitioner of an attestation from the patient care team physician stating (i) that the patient care team physician has served as a patient care team physician on a patient care team with the nurse practitioner pursuant to a practice agreement meeting the requirements of this section and § 54.1-2957.01; (ii) that while a party to such practice agreement, the patient care team physician routinely practiced with a patient population and in a practice area included within the category for which the nurse practitioner was certified and licensed; and (iii) the period of time for which the patient care team physician practiced with the nurse practitioner under such a practice agreement. A copy of such attestation shall be submitted to the Boards together with a fee established by the Boards. Upon receipt of such attestation and verification that a nurse practitioner satisfies the requirements of this subsection, the Boards shall issue to the nurse practitioner a new license that includes a designation indicating that the nurse practitioner is authorized to practice without a practice agreement. In the event that a nurse practitioner is unable to obtain the attestation required by this subsection, the Boards may accept other evidence demonstrating that the applicant has met the requirements of this subsection in accordance with regulations adopted by the Boards.

A nurse practitioner authorized to practice without a practice agreement pursuant to this subsection shall (a) only practice within the scope of his clinical and professional training and limits of his knowledge and experience and consistent with the applicable standards of care, (b) consult and collaborate with other health care providers based on the clinical conditions of the patient to whom health care is provided, and (c) establish a plan for referral of complex medical cases and emergencies to physicians or other appropriate health care providers.

A nurse practitioner practicing without a practice agreement pursuant to this subsection shall obtain and maintain coverage by or shall be named insured on a professional liability insurance policy with limits equal to the current limitation on damages set forth in § 8.01-581.15.

§ 54.1-2957.01. Prescription of certain controlled substances and devices by licensed nurse practitioners.

A. In accordance with the provisions of this section and pursuant to the requirements of Chapter 33 (§ 54.1-3300 et seq.), a licensed nurse practitioner, other than a certified registered nurse anesthetist, shall have the authority to prescribe Schedule II through Schedule VI controlled substances and devices as set forth in Chapter 34 (§ 54.1-3400 et seq.). ~~Nurse practitioners shall have such prescriptive authority upon the provision~~

B. A nurse practitioner who does not meet the requirements for practice without a written or electronic practice agreement set forth in subsection I of § 54.1-2957 shall prescribe controlled substances or devices only if such prescribing is authorized by a written or electronic practice agreement entered into by the nurse practitioner and a patient care team physician. Such nurse practitioner shall provide to the ~~Board~~ *Boards* of Medicine and ~~the Board of~~ Nursing ~~of~~ such evidence as ~~they~~ *the Boards* may jointly require that the nurse practitioner has entered into and is, at the time of writing a prescription, a party to a written or electronic practice agreement with a patient care team physician that clearly states the prescriptive practices of the nurse practitioner. Such written or electronic practice agreements shall include the controlled substances the nurse practitioner is or is not authorized to prescribe and may restrict such prescriptive authority as described in the practice agreement. Evidence

of a practice agreement shall be maintained by a nurse practitioner pursuant to § 54.1-2957. Practice agreements authorizing a nurse practitioner to prescribe controlled substances or devices pursuant to this section *either* shall ~~either~~ be signed by the patient care team physician ~~who is practicing as part of a patient care team with the nurse practitioner~~ or shall clearly state the name of the patient care team physician who has entered into the practice agreement with the nurse practitioner.

~~B.~~ It shall be unlawful for a nurse practitioner to prescribe controlled substances or devices pursuant to this section unless *(i)* such prescription is authorized by the written or electronic practice agreement *or (ii) the nurse practitioner is authorized to practice without a written or electronic practice agreement pursuant to subsection I of § 54.1-2957.*

C. The ~~Board of Nursing and the Board~~ *Boards* of Medicine *and Nursing* shall promulgate ~~such~~ regulations governing the prescriptive authority of nurse practitioners as are deemed reasonable and necessary to ensure an appropriate standard of care for patients. ~~Regulations promulgated pursuant to this section~~ *Such regulations* shall include~~,~~ ~~at a minimum, such~~ requirements as may be necessary to ensure continued nurse practitioner competency, which may include continuing education, testing, or any other requirement, and shall address the need to promote ethical practice, an appropriate standard of care, patient safety, the use of new pharmaceuticals, and appropriate communication with patients.

D. This section shall not limit the functions and procedures of certified registered nurse anesthetists or of any nurse practitioners which are otherwise authorized by law or regulation.

E. The following restrictions shall apply to any nurse practitioner authorized to prescribe drugs and devices pursuant to this section:

1. The nurse practitioner shall disclose to the patient at the initial encounter that he is a licensed nurse practitioner. Any ~~member of a patient care team~~ *party to a practice agreement* shall disclose, upon request of a patient or his legal representative, the name of the patient care team physician and information regarding how to contact the patient care team physician.

2. Physicians shall not serve as a patient care team physician on a patient care team at any one time to more than six nurse practitioners.

F. This section shall not prohibit a licensed nurse practitioner from administering controlled substances in compliance with the definition of "administer" in § 54.1-3401 or from receiving and dispensing manufacturers' professional samples of controlled substances in compliance with the provisions of this section.

G. Notwithstanding any provision of law or regulation to the contrary, a nurse practitioner licensed by the Boards of ~~Nursing and~~ Medicine *and Nursing* in the category of certified nurse midwife and holding a license for prescriptive authority may prescribe (i) Schedules II through V controlled substances in accordance with any prescriptive authority included in a practice agreement with a licensed physician pursuant to subsection H of § 54.1-2957 and (ii) Schedule VI controlled substances without the requirement for inclusion of such prescriptive authority in a practice agreement.

§ 54.1-3300. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Board" means the Board of Pharmacy.

"Collaborative agreement" means a voluntary, written, or electronic arrangement between one pharmacist and his designated alternate pharmacists involved directly in patient care at a single physical location where patients receive services and (i) any person licensed to practice medicine, osteopathy, or podiatry together with any person licensed, registered, or certified by a health regulatory board of the Department of Health Professions who provides health care services to patients of such person licensed to practice medicine, osteopathy, or podiatry; (ii) a physician's office as defined in § 32.1-276.3, provided *that* such collaborative agreement is signed by each physician participating in the collaborative practice agreement; (iii) any licensed physician assistant working under the supervision of a person licensed to practice medicine, osteopathy, or podiatry; or (iv) any licensed nurse practitioner working ~~as part of a patient care team as defined in § 54.1-2900~~ *in accordance with the provisions of § 54.1-2957,* involved directly in patient care which authorizes cooperative procedures with respect to patients of such practitioners. Collaborative procedures shall be related to treatment using drug therapy, laboratory tests, or medical devices, under defined conditions or limitations, for the purpose of improving patient outcomes. A collaborative agreement is not required for the management of patients of an inpatient facility.

"Dispense" means to deliver a drug to an ultimate user or research subject by or pursuant to the lawful order of a practitioner, including the prescribing and administering, packaging, labeling, or compounding necessary to prepare the substance for delivery.

"Pharmacist" means a person holding a license issued by the Board to practice pharmacy.

"Pharmacy" means every establishment or institution in which drugs, medicines, or medicinal chemicals are dispensed or offered for sale, or a sign is displayed bearing the word or words "pharmacist," "pharmacy," "apothecary," "drugstore," "druggist," "drugs," "medicine store," "drug sundries," "prescriptions filled," or any similar words intended to indicate that the practice of pharmacy is being conducted.

"Pharmacy intern" means a student currently enrolled in or a graduate of an approved school of

pharmacy who is registered with the Board for the purpose of gaining the practical experience required to apply for licensure as a pharmacist.

"Pharmacy technician" means a person registered with the Board to assist a pharmacist under the pharmacist's supervision.

"Practice of pharmacy" means the personal health service that is concerned with the art and science of selecting, procuring, recommending, administering, preparing, compounding, packaging, and dispensing of drugs, medicines, and devices used in the diagnosis, treatment, or prevention of disease, whether compounded or dispensed on a prescription or otherwise legally dispensed or distributed, and shall include the proper and safe storage and distribution of drugs; the maintenance of proper records; the responsibility of providing information concerning drugs and medicines and their therapeutic values and uses in the treatment and prevention of disease; and the management of patient care under the terms of a collaborative agreement as defined in this section.

"Supervision" means the direction and control by a pharmacist of the activities of a pharmacy intern or a pharmacy technician whereby the supervising pharmacist is physically present in the pharmacy or in the facility in which the pharmacy is located when the intern or technician is performing duties restricted to a pharmacy intern or technician, respectively, and is available for immediate oral communication.

Other terms used in the context of this chapter shall be defined as provided in Chapter 34 (§ 54.1-3400 et seq.) unless the context requires a different meaning.

§ 54.1-3300.1. Participation in collaborative agreements; regulations to be promulgated by the Boards of Medicine and Pharmacy.

A pharmacist and his designated alternate pharmacists involved directly in patient care may participate with (i) any person licensed to practice medicine, osteopathy, or podiatry together with any person licensed, registered, or certified by a health regulatory board of the Department of Health Professions who provides health care services to patients of such person licensed to practice medicine, osteopathy, or podiatry; (ii) a physician's office as defined in § 32.1-276.3, provided *that* such collaborative agreement is signed by each physician participating in the collaborative practice agreement; (iii) any licensed physician assistant working under the supervision of a person licensed to practice medicine, osteopathy, or podiatry; or (iv) any licensed nurse practitioner working ~~as part of a patient care team as defined in § 54.1-2900~~ *in accordance with the provisions of § 54.1-2957*, involved directly in patient care in collaborative agreements which authorize cooperative procedures related to treatment using drug therapy, laboratory tests, or medical devices, under defined conditions or limitations, for the purpose of improving patient outcomes. However, no person licensed to practice medicine, osteopathy, or podiatry shall be required to participate in a collaborative agreement with a pharmacist and his designated alternate pharmacists, regardless of whether a professional business entity on behalf of which the person is authorized to act enters into a collaborative agreement with a pharmacist and his designated alternate pharmacists.

No patient shall be required to participate in a collaborative procedure without such patient's consent. A patient who chooses to not participate in a collaborative procedure shall notify the prescriber of his refusal to participate in such collaborative procedure. A prescriber may elect to have a patient not participate in a collaborative procedure by contacting the pharmacist or his designated alternative pharmacists or by documenting the same on the patient's prescription.

Collaborative agreements may include the implementation, modification, continuation, or discontinuation of drug therapy pursuant to written or electronic protocols, provided implementation of drug therapy occurs following diagnosis by the prescriber; the ordering of laboratory tests; or other patient care management measures related to monitoring or improving the outcomes of drug or device therapy. No such collaborative agreement shall exceed the scope of practice of the respective parties. Any pharmacist who deviates from or practices in a manner inconsistent with the terms of a collaborative agreement shall be in violation of § 54.1-2902; such violation shall constitute grounds for disciplinary action pursuant to §§ 54.1-2400 and 54.1-3316.

Collaborative agreements may only be used for conditions which have protocols that are clinically accepted as the standard of care, or are approved by the Boards of Medicine and Pharmacy. The Boards of Medicine and Pharmacy shall jointly develop and promulgate regulations to implement the provisions of this section and to facilitate the development and implementation of safe and effective collaborative agreements between the appropriate practitioners and pharmacists. The regulations shall include guidelines concerning the use of protocols, and a procedure to allow for the approval or disapproval of specific protocols by the Boards of Medicine and Pharmacy if review is requested by a practitioner or pharmacist.

Nothing in this section shall be construed to supersede the provisions of § 54.1-3303.

§ 54.1-3301. Exceptions.

This chapter shall not be construed to:

1. Interfere with any legally qualified practitioner of dentistry, or veterinary medicine or any physician acting on behalf of the Virginia Department of Health or local health departments, in the compounding of his prescriptions or the purchase and possession of drugs as he may require;

2. Prevent any legally qualified practitioner of dentistry, or veterinary medicine or any prescriber, as defined in § 54.1-3401, acting on behalf of the Virginia Department of Health or local health departments, from administering or supplying to his patients the medicines that he deems proper under the conditions of § 54.1-3303 or from causing drugs to be administered or dispensed pursuant to §§ 32.1-42.1 and 54.1-3408, except that a veterinarian shall only be authorized to dispense a compounded drug, distributed from a pharmacy, when (i) the animal is his own patient, (ii) the animal is a companion animal as defined in regulations promulgated by the Board of Veterinary Medicine, (iii) the quantity dispensed is no more than a 72-hour supply, (iv) the compounded drug is for the treatment of an emergency condition, and (v) timely access to a compounding pharmacy is not available, as determined by the prescribing veterinarian;

3. Prohibit the sale by merchants and retail dealers of proprietary medicines as defined in Chapter 34 (§ 54.1-3400 et seq.) of this title;

4. Prevent the operation of automated drug dispensing systems in hospitals pursuant to Chapter 34 (§ 54.1-3400 et seq.) of this title;

5. Prohibit the employment of ancillary personnel to assist a pharmacist as provided in the regulations of the Board;

6. Interfere with any legally qualified practitioner of medicine, osteopathy, or podiatry from purchasing, possessing or administering controlled substances to his own patients or providing controlled substances to his own patients in a bona fide medical emergency or providing manufacturers' professional samples to his own patients;

7. Interfere with any legally qualified practitioner of optometry, certified or licensed to use diagnostic pharmaceutical agents, from purchasing, possessing or administering those controlled substances as specified in § 54.1-3221 or interfere with any legally qualified practitioner of optometry certified to prescribe therapeutic pharmaceutical agents from purchasing, possessing, or administering to his own patients those controlled substances as specified in § 54.1-3222 and the TPA formulary, providing manufacturers' samples of these drugs to his own patients, or dispensing, administering, or selling ophthalmic devices as authorized in § 54.1-3204;

8. Interfere with any physician assistant with prescriptive authority receiving and dispensing to his own patients manufacturers' professional samples of controlled substances and devices that he is authorized, in compliance with the provisions of § 54.1-2952.1, to prescribe according to his practice setting and a written agreement with a physician or podiatrist;

9. Interfere with any licensed nurse practitioner with prescriptive authority receiving and dispensing to his own patients manufacturers' professional samples of controlled substances and devices that he is authorized, in compliance with the provisions of § 54.1-2957.01, to prescribe ~~according to his practice setting and a written or electronic agreement with a physician~~;

10. Interfere with any legally qualified practitioner of medicine or osteopathy participating in an indigent patient program offered by a pharmaceutical manufacturer in which the practitioner sends a prescription for one of his own patients to the manufacturer, and the manufacturer donates a stock bottle of the prescription drug ordered at no cost to the practitioner or patient. The practitioner may dispense such medication at no cost to the patient without holding a license to dispense from the Board of Pharmacy. However, the container in which the drug is dispensed shall be labeled in accordance with the requirements of § 54.1-3410, and, unless directed otherwise by the practitioner or the patient, shall meet standards for special packaging as set forth in § 54.1-3426 and Board of Pharmacy regulations. In lieu of dispensing directly to the patient, a practitioner may transfer the donated drug with a valid prescription to a pharmacy for dispensing to the patient. The practitioner or pharmacy participating in the program shall not use the donated drug for any purpose other than dispensing to the patient for whom it was originally donated, except as authorized by the donating manufacturer for another patient meeting that manufacturer's requirements for the indigent patient program. Neither the practitioner nor the pharmacy shall charge the patient for any medication provided through a manufacturer's indigent patient program pursuant to this subdivision. A participating pharmacy, including a pharmacy participating in bulk donation programs, may charge a reasonable dispensing or administrative fee to offset the cost of dispensing, not to exceed the actual costs of such dispensing. However, if the patient is unable to pay such fee, the dispensing or administrative fee shall be waived;

11. Interfere with any legally qualified practitioner of medicine or osteopathy from providing controlled substances to his own patients in a free clinic without charge when such controlled substances are donated by an entity other than a pharmaceutical manufacturer as authorized by subdivision 10. The practitioner shall first obtain a controlled substances registration from the Board and shall comply with the labeling and packaging requirements of this chapter and the Board's regulations; or

12. Prevent any pharmacist from providing free health care to an underserved population in Virginia who (i) does not regularly practice pharmacy in Virginia, (ii) holds a current valid license or certificate to practice pharmacy in another state, territory, district or possession of the United States, (iii) volunteers to provide free health care to an underserved area of this Commonwealth under the auspices of a publicly supported all volunteer, nonprofit organization that sponsors the provision of health care to populations of underserved people, (iv) files a copy of the license or certificate issued in such other

jurisdiction with the Board, (v) notifies the Board at least five business days prior to the voluntary provision of services of the dates and location of such service, and (vi) acknowledges, in writing, that such licensure exemption shall only be valid, in compliance with the Board's regulations, during the limited period that such free health care is made available through the volunteer, nonprofit organization on the dates and at the location filed with the Board. The Board may deny the right to practice in Virginia to any pharmacist whose license has been previously suspended or revoked, who has been convicted of a felony or who is otherwise found to be in violation of applicable laws or regulations. However, the Board shall allow a pharmacist who meets the above criteria to provide volunteer services without prior notice for a period of up to three days, provided the nonprofit organization verifies that the practitioner has a valid, unrestricted license in another state.

This section shall not be construed as exempting any person from the licensure, registration, permitting and record keeping requirements of this chapter or Chapter 34 of this title.

§ 54.1-3482. Practice of physical therapy; certain experience and referrals required; physical therapist assistants.

A. It shall be unlawful for a person to engage in the practice of physical therapy except as a licensed physical therapist, upon the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician, except as provided in this section.

B. A physical therapist who has completed a doctor of physical therapy program approved by the Commission on Accreditation of Physical Therapy Education or who has obtained a certificate of authorization pursuant to § 54.1-3482.1 may evaluate and treat a patient for no more than 30 consecutive days after an initial evaluation without a referral under the following conditions: (i) the patient is not receiving care from any licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician for the symptoms giving rise to the presentation at the time of the presentation to the physical therapist for physical therapy services or (ii) the patient is receiving care from a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician at the time of his presentation to the physical therapist for the symptoms giving rise to the presentation for physical therapy services and (a) the patient identifies a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician from whom he is currently receiving care; (b) the patient gives written consent for the physical therapist to release all personal health information and treatment records to the identified practitioner; and (c) the physical therapist notifies the practitioner identified by the patient no later than 14 days after treatment commences and provides the practitioner with a copy of the initial evaluation along with a copy of the patient history obtained by the physical therapist. Treatment for more than 30 consecutive days after evaluation of such patient shall only be upon the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician. A physical therapist may contact the practitioner identified by the patient at the end of the 30-day period to determine if the practitioner will authorize additional physical therapy services until such time as the patient can be seen by the practitioner. A physical therapist shall not perform an initial evaluation of a patient under this subsection if the physical therapist has performed an initial evaluation of the patient under this subsection for the same condition within the immediately preceding 60 days.

C. A physical therapist who has not completed a doctor of physical therapy program approved by the Commission on Accreditation of Physical Therapy Education or who has not obtained a certificate of authorization pursuant to § 54.1-3482.1 may conduct a one-time evaluation that does not include treatment of a patient without the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician; if appropriate, the physical therapist shall immediately refer such patient to the appropriate practitioner.

D. Invasive procedures within the scope of practice of physical therapy shall at all times be performed only under the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician.

E. It shall be unlawful for any licensed physical therapist to fail to immediately refer any patient to a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, or a licensed nurse

practitioner practicing in accordance with ~~his~~ ~~practice~~ ~~agreement~~ *the provisions of § 54.1-2957* when such patient's medical condition is determined, at the time of evaluation or treatment, to be beyond the physical therapist's scope of practice. Upon determining that the patient's medical condition is beyond the scope of practice of a physical therapist, a physical therapist shall immediately refer such patient to an appropriate practitioner.

F. Any person licensed as a physical therapist assistant shall perform his duties only under the direction and control of a licensed physical therapist.

G. However, a licensed physical therapist may provide, without referral or supervision, physical therapy services to (i) a student athlete participating in a school-sponsored athletic activity while such student is at such activity in a public, private, or religious elementary, middle or high school, or public or private institution of higher education when such services are rendered by a licensed physical therapist who is certified as an athletic trainer by the National Athletic Trainers' Association Board of Certification or as a sports certified specialist by the American Board of Physical Therapy Specialties; (ii) employees solely for the purpose of evaluation and consultation related to workplace ergonomics; (iii) special education students who, by virtue of their individualized education plans (IEPs), need physical therapy services to fulfill the provisions of their IEPs; (iv) the public for the purpose of wellness, fitness, and health screenings; (v) the public for the purpose of health promotion and education; and (vi) the public for the purpose of prevention of impairments, functional limitations, and disabilities.

§ 54.1-3482.1. Certain certification required.

A. The Board shall promulgate regulations establishing criteria for certification of physical therapists to provide certain physical therapy services pursuant to subsection B of § 54.1-3482 without referral from a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with ~~his~~ ~~practice~~ ~~agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician. The regulations shall include but not be limited to provisions for (i) the promotion of patient safety; (ii) an application process for a one-time certification to perform such procedures; and (iii) minimum education, training, and experience requirements for certification to perform such procedures.

B. The minimum education, training, and experience requirements for certification shall include evidence that the applicant has successfully completed (i) a transitional program in physical therapy as recognized by the Board or (ii) at least three years of active practice with evidence of continuing education relating to carrying out direct access duties under § 54.1-3482.

2. That the Boards of Medicine and Nursing shall jointly promulgate regulations to implement the provisions of this act, which shall govern the practice of nurse practitioners practicing without a practice agreement in accordance with the provisions of this act, to be effective within 280 days of its enactment.

3. That the Department of Health Professions shall, by November 1, 2020, report to the General Assembly a process by which nurse practitioners who practice without a practice agreement may be included in the online Practitioner Profile maintained by the Department of Health Professions.

4. That the Boards of Medicine and Nursing shall report on data on the implementation of this act, including the number of nurse practitioners who have been authorized to practice without a practice agreement, the geographic and specialty areas in which nurse practitioners are practicing without a practice agreement, and any complaints or disciplinary actions taken against such nurse practitioners, along with any recommended modifications to the requirements of this act including any modifications to the clinical experience requirements for practicing without a practice agreement, to the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health and the Chairman of the Joint Commission on Health Care by November 1, 2021.

DRAFT REGULATIONS RECOMMENDED BY THE REGULATORY ADVISORY PANEL

BOARDS OF MEDICINE AND NURSING

Autonomous practice

Part I

General Provisions

18VAC90-30-10. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Approved program" means a nurse practitioner education program that is accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs/Schools, American College of Nurse Midwives, Commission on Collegiate Nursing Education, or the National League for Nursing Accrediting Commission or is offered by a school of nursing or jointly offered by a school of medicine and a school of nursing that grant a graduate degree in nursing and which hold a national accreditation acceptable to the boards.

"Autonomous practice" means practice in a category in which a nurse practitioner is certified and licensed without a written or electronic practice agreement with a patient care team physician in accordance with 18VAC90-30-86.

"Boards" means the Virginia Board of Nursing and the Virginia Board of Medicine.

"Certified nurse midwife" means an advanced practice registered nurse who is certified in the specialty of nurse midwifery and who is jointly licensed by the Boards of Medicine and Nursing as a nurse practitioner pursuant to § 54.1-2957 of the Code of Virginia.

"Certified registered nurse anesthetist" means an advanced practice registered nurse who is certified in the specialty of nurse anesthesia, who is jointly licensed by the Boards of Medicine and Nursing as a nurse practitioner pursuant to § 54.1-2957, and who practices under the supervision of a doctor of medicine, osteopathy, podiatry, or dentistry but is not subject to the practice agreement requirement described in § 54.1-2957.

"Collaboration" means the communication and decision-making process among members of a patient care team related to the treatment and care of a patient and includes (i) communication of data and information about the treatment and care of a patient, including exchange of clinical observations and assessments, and (ii) development of an appropriate plan of care, including decisions regarding the health care provided, accessing and assessment of appropriate additional resources or expertise, and arrangement of appropriate referrals, testing, or studies.

"Committee" means the Committee of the Joint Boards of Nursing and Medicine.

"Consultation" means the communicating of data and information, exchanging of clinical observations and assessments, accessing and assessing of additional resources and expertise, problem solving, and arranging for referrals, testing, or studies.

"Licensed nurse practitioner" means an advanced practice registered nurse who has met the requirements for licensure as stated in Part II (18VAC90-30-60 et seq.) of this chapter.

"National certifying body" means a national organization that is accredited by an accrediting agency recognized by the U.S. Department of Education or deemed acceptable by the National Council of State Boards of Nursing and has as one of its purposes the certification of nurse anesthetists, nurse midwives or nurse practitioners, referred to in this chapter as professional certification, and whose certification of such persons by examination is accepted by the committee.

"Patient care team physician" means a person who holds an active, unrestricted license issued by the Virginia Board of Medicine to practice medicine or osteopathic medicine.

"Practice agreement" means a written or electronic statement, jointly developed by the collaborating patient care team physician(s) and the licensed nurse practitioner(s) that describes the procedures to be followed and the acts appropriate to the specialty practice area to be performed by the licensed nurse practitioner(s) in the care and management of patients. The practice agreement also describes the prescriptive authority of the nurse practitioner, if applicable. For a nurse practitioner licensed in the category of certified nurse midwife, the practice agreement is a statement jointly developed with the consulting physician.

18VAC90-30-20. Delegation of authority.

A. The boards hereby delegate to the executive director of the Virginia Board of Nursing the authority to issue the initial licensure and the biennial renewal of such licensure to those persons who meet the requirements set forth in this chapter, to grant authorization for autonomous practice to those persons who have met the qualifications of 18VAC90-30-86, and to grant extensions or exemptions for compliance with continuing competency requirements as set forth in subsection E of 18VAC90-30-105. Questions of eligibility shall be referred to the Committee of the Joint Boards of Nursing and Medicine.

B. All records and files related to the licensure of nurse practitioners shall be maintained in the office of the Virginia Board of Nursing.

18VAC90-30-50. Fees.

A. Fees required in connection with the licensure of nurse practitioners are:

1. Application	$125
2. Biennial licensure renewal	$80
3. Late renewal	$25
4. Reinstatement of licensure	$150

5. Verification of licensure to another jurisdiction	$35
6. Duplicate license	$15
7. Duplicate wall certificate	$25
8. Return check charge	$35
9. Reinstatement of suspended or revoked license	$200
10. Autonomous practice attestation	$100

B. For renewal of licensure from July 1, 2017, through June 30, 2019, the following fee shall be in effect:

Biennial renewal	$60

18VAC90-30-85. Qualifications for licensure by endorsement.

A. An applicant for licensure by endorsement as a nurse practitioner shall:

1. Provide verification of licensure as a nurse practitioner or advanced practice nurse in another U.S. jurisdiction with a license in good standing, or, if lapsed, eligible for reinstatement;

2. Submit evidence of professional certification that is consistent with the specialty area of the applicant's educational preparation issued by an agency accepted by the boards as identified in 18VAC90-30-90; and

3. Submit the required application and fee as prescribed in 18VAC90-30-50.

B. An applicant shall provide evidence that includes a transcript that shows successful completion of core coursework that prepares the applicant for licensure in the appropriate specialty.

C. An applicant for licensure by endorsement who is also seeking authorization for autonomous practice shall comply with subsection F of 18VAC90-30-86.

18VAC90-30-86. Autonomous practice (for nurse practitioners other than certified nurse midwives or certified registered nurse anesthetists).

A. A nurse practitioner with a current, unrestricted license, other than someone licensed in the category of certified nurse midwife or certified registered nurse anesthetist, may qualify for autonomous practice by completion of the equivalent of five years of full-time clinical experience as a nurse practitioner.

1. Five years of full-time clinical experience shall be defined as 1,600 hours per year for a total of 8,000 hours.

2. Clinical experience shall be defined as the postgraduate delivery of health care directly to patients pursuant to a practice agreement with a patient care team physician.

B. Qualification for authorization for autonomous practice shall be determined upon submission of a fee as specified in 18VAC90-30-50 and an attestation acceptable to the boards. The attestation shall be signed by the nurse practitioner and the nurse practitioner's patient care team physician stating that:

1. The patient care team physician served as a patient care team physician on a patient care team with the nurse practitioner pursuant to a practice agreement meeting the requirements of this chapter and §§ 54.1-2957 and 54.1-2957.01 of the Code of Virginia;

2. While a party to such practice agreement, the patient care team physician routinely practiced with a patient population and in a practice area included within the category, as specified in 18VAC90-30-70, for which the nurse practitioner was certified and licensed; and

3. The period of time and hours of practice during which the patient care team physician practiced with the nurse practitioner under such a practice agreement.

C. The nurse practitioner may submit attestations for more than one patient care team physician with whom he practiced during the equivalent of five years of practice, but all attestations shall be submitted to the boards at the same time.

D. If a nurse practitioner is licensed and certified in more than one category, as specified in 18VAC90-30-70, a separate fee and attestation that meets the requirements of subsection B shall be submitted for each category. If the hours of practice are applicable to the patient population and in practice areas included within each of the categories of licensure and certification, those hours may be counted towards a second attestation.

E. In the event a patient care team physician has died, become disabled, retired, or relocated to another state, or other circumstance that inhibits the ability of the nurse practitioner from obtaining an attestation as specified in subsection B, the nurse practitioner may submit other evidence of meeting the qualifications for autonomous practice along with an attestation signed by the nurse practitioner. Other evidence may include employment records, military service, Medicare or Medicaid reimbursement records, or other similar records that verify full-time clinical practice in the role of a nurse practitioner in the category for which he is licensed and certified. The burden shall be on the nurse practitioner to provide sufficient evidence to support the nurse practitioner's inability to obtain an attestation from a patient care team physician.

F. A nurse practitioner to whom a license is issued by endorsement may engage in autonomous practice if such application includes an attestation acceptable to the boards that the nurse practitioner has completed the equivalent of five years of full-time clinical experience as specified in subsection A of this section and in accordance with the laws of the state in which the nurse practitioner was previously licensed.

G. A nurse practitioner authorized to practice autonomously shall:

1. Only practice within the scope of his clinical and professional training and limits of his knowledge and experience and consistent with the applicable standards of care;

2. Consult and collaborate with other health care providers based on the clinical conditions of the patient to whom health care is provided; and

3. Establish a plan for referral of complex medical cases and emergencies to physicians or other appropriate health care providers.

18VAC90-30-110. Reinstatement of license.

A. A licensed nurse practitioner whose license has lapsed may be reinstated within one renewal period by payment of the current renewal fee and the late renewal fee.

B. An applicant for reinstatement of license lapsed for more than one renewal period shall:

1. File the required application and reinstatement fee;

2. Be currently licensed as a registered nurse in Virginia or hold a current multistate licensure privilege as a registered nurse; and

3. Provide evidence of current professional competency consisting of:

a. Current professional certification by the appropriate certifying agency identified in 18VAC90-30-90;

b. Continuing education hours taken during the period in which the license was lapsed, equal to the number required for licensure renewal during that period, not to exceed 120 hours; or

c. If applicable, current, unrestricted licensure or certification in another jurisdiction.

4. If qualified for autonomous practice, provide the required fee and attestation in accordance with 18VAC90-30-86.

C. An applicant for reinstatement of license following suspension or revocation shall:

1. Petition for reinstatement and pay the reinstatement fee;

2. Present evidence that he is currently licensed as a registered nurse in Virginia or hold a current multistate licensure privilege as a registered nurse; and

3. Present evidence that he is competent to resume practice as a licensed nurse practitioner in Virginia to include:

a. Current professional certification by the appropriate certifying agency identified in 18VAC90-30-90; or

b. Continuing education hours taken during the period in which the license was suspended or revoked, equal to the number required for licensure renewal during that period, not to exceed 120 hours.

The committee shall act on the petition pursuant to the Administrative Process Act, § 2.2-4000 et seq. of the Code of Virginia.

Part III

Practice of Licensed Nurse Practitioners

18VAC90-30-120. Practice of licensed nurse practitioners other than certified registered nurse anesthetists or certified nurse midwives.

A. A nurse practitioner licensed in a category other than certified registered nurse anesthetist or certified nurse midwife shall be authorized to render care in collaboration and consultation with a licensed patient care team physician as part of a patient care team or if determined by the boards to qualify in accordance with 18VAC90-30-86, authorized to practice autonomously without a practice agreement with a patient care team physician.

B. The practice shall be based on specialty education preparation as an advanced practice registered nurse in accordance with standards of the applicable certifying organization, as identified in 18VAC90-30-90.

C. All nurse practitioners licensed in any category other than certified registered nurse anesthetist or certified nurse midwife shall practice in accordance with a written or electronic practice agreement as defined in 18VAC90-30-10 or in accordance with 18VAC90-30-86.

D. The written or electronic practice agreement shall include provisions for:

1. The periodic review of patient charts or electronic patient records by a patient care team physician and may include provisions for visits to the site where health care is delivered in the manner and at the frequency determined by the patient care team;

2. Appropriate physician input in complex clinical cases and patient emergencies and for referrals; and

3. The nurse practitioner's authority for signatures, certifications, stamps, verifications, affidavits, and endorsements provided it is:

a. In accordance with the specialty license of the nurse practitioner and within the scope of practice of the patient care team physician;

b. Permitted by § 54.1-2957.02 or applicable sections of the Code of Virginia; and

c. Not in conflict with federal law or regulation.

E. The practice agreement shall be maintained by the nurse practitioner and provided to the boards upon request. For nurse practitioners providing care to patients within a hospital or health care system, the practice agreement may be included as part of documents delineating the nurse practitioner's clinical privileges or the electronic or written delineation of duties and

responsibilities; however, the nurse practitioner shall be responsible for providing a copy to the boards upon request.

Part III

Practice Requirements

18VAC90-40-90. Practice agreement.

A. With the ~~exception of~~ exceptions listed in subsection E of this section, a nurse practitioner with prescriptive authority may prescribe only within the scope of the written or electronic practice agreement with a patient care team physician.

B. At any time there are changes in the patient care team physician, authorization to prescribe, or scope of practice, the nurse practitioner shall revise the practice agreement and maintain the revised agreement.

C. The practice agreement shall contain the following:

1. A description of the prescriptive authority of the nurse practitioner within the scope allowed by law and the practice of the nurse practitioner.

2. An authorization for categories of drugs and devices within the requirements of § 54.1-2957.01 of the Code of Virginia.

3. The signature of the patient care team physician who is practicing with the nurse practitioner or a clear statement of the name of the patient care team physician who has entered into the practice agreement.

D. In accordance with § 54.1-2957.01 of the Code of Virginia, a physician shall not serve as a patient care team physician to more than six nurse practitioners with prescriptive authority at any one time.

E. Exceptions.

1. A nurse practitioner licensed in the category of certified nurse midwife and holding a license for prescriptive authority may prescribe in accordance with a written or electronic practice agreement with a consulting physician or may prescribe Schedule VI controlled substances without the requirement for inclusion of such prescriptive authority in a practice agreement.

2. A nurse practitioner who is licensed in a category other than certified nurse midwife or certified registered nurse anesthetist and who has met the qualifications for autonomous practice as set forth in 18VAC90-30-86 may prescribe without a practice agreement with a patient care team physician.

Commonwealth of Virginia

Yeatts, Elaine <elaine.yeatts@dhp.virginia.gov>

Comments on Transition to Practice (HB 793) Regulations

1 message

Denise Daly Konrad <dkonrad@vhcf.org> Thu, Jun 21, 2018 at 9:25 AM
To: "Elaine.yeatts@dhp.virginia.gov" <Elaine.yeatts@dhp.virginia.gov>
Cc: Deborah Oswalt <doswalt@vhcf.org>

Elaine Yeatts

Senior Policy Analyst

Virginia Department of Health Professions

9960 Mayland Drive

Henrico, VA 23233

Dear Ms. Yeatts:

Thank you for the opportunity to comment on the draft regulations to implement HB 793 distributed at the May 17 meeting of the Joint Boards of Nursing and Medicine.

The Virginia Health Care Foundation's (*VHCF*) comments, like those submitted on May 4, 2018, are related to situations where an NP is licensed and credentialed to practice in more than one specialty area. I do not believe that the General Assembly contemplated or discussed the implications of the 5 year requirement for NPs with credentials in multiple practice areas as HB 793 evolved. During the 2018 legislative session, when I asked the Medical Society of Virginia's (*MSV*) lobbyist, Scott Johnson, about MSV's intent for application of the 5 year requirement for these NPs, he said it was envisioned that only one five year period would be required.

We encourage the Department of Health Professions and the Joint Board of Medicine and Nursing to adopt a regulatory approach for transition to practice that does not exceed a total of 5 years (*8000 hours*) of collaboration for an NP who is credentialed and licensed in more than one specialty area. To accomplish this, it may be that an individualized approach to each application for full practice authority will be needed. We ask you to develop a framework that will enable the Joint Board to review, understand and consider each NP's individual level of training, credentials and work experience

related to the field in which s/he desires to practice independently, rather than a more "cookie cutter" approach that establishes a uniform norm.

Requiring an NP to collaborate with a physician for an additional 5 years for each specialty area in which s/he chooses to work independently will create significant barriers to practice at a time when the Commonwealth has an insufficient number of providers. NPs wishing to practice in a new specialty area will bring years of practice experience to patient care, with additional training and expertise in more than one specialty area.

While NPs can obtain post-Master's certificates in a number of areas to facilitate the transition from one practice area to another, the Foundation is most knowledgeable about working with NPs who return to school to become a Psychiatric-Mental Health Nurse Practitioner (*Psych NP*) after years of practice in another area.

Virginia is experiencing a significant challenge in meeting the needs of thousands of Virginians needing behavioral health care services:

- More than 3/4 of Virginia is federally-designated as mental health professional shortage area; 40% of Virginians live in these communities.
- This shortage will soon become worse, because, two-thirds of practicing psychiatrists are age 50 or older with an insufficient number in training to replace them.
- *The Milbank Quarterly* reports that many primary care providers are not well-equipped or comfortable diagnosing and managing behavioral health conditions or prescribing psychotropic medicines. This is a problem since it reports that as many as 70% of primary care visits stem from psychosocial issues.

Psych NPs are an important key to helping the Commonwealth address this gap between demand and available behavioral health providers. They are the only professionals other than psychiatrists who are trained and licensed to prescribe and manage psychotropic medicines, which are so important to the treatment of many mental illnesses.

There are a growing number of Virginia NPs pursuing a post-Master's Psych NP certificate to help meet this demand. These are typically family nurse practitioners or other medically-trained nurse practitioners with years of practice experience. This combination of both medical and behavioral health training is particularly valuable – as more practices move to integrate behavioral health care with primary care and we more fully understand the interplay between physical and behavioral health.

For the past 10 years, VHCF has focused much effort and money to help increase access to behavioral health services for uninsured and underserved Virginians. In the process, we have discovered the state's shortage of behavioral health professionals, the important role and scope of practice of Psych NPs, and that there are only 213 of these valuable health professionals in Virginia (*71 localities don't have any*). For the last 4 years, VHCF has worked with Virginia's Schools of Nursing to encourage education of more Psych NPs and invested nearly $200,000 in scholarships, which pay tuition and fees for existing nurse practitioners who return to school to obtain a post-master's Psych NP certificate. We will continue providing scholarships for experienced NPs to earn a post-Master's Psych NP certificate.

While there are may not be many post-Master's trained Psych NPs who wish to practice independently, we want to ensure those who do are able to do so without barriers. Following our suggestion of a more customized approach when reviewing applications from NPs with credentials in multiple specialties will help. In considering this request, it is important to remember that all NPs are credentialed to practice independently upon successful completion of their coursework, clinical experience and passage of their national certification exam.

Thank you, again, for the opportunity to provide comments on the enactment of regulations to implement HB 793. Should you have any questions, please do not hesitate to contact me at 804.828.5804.

Sincerely,

Deborah D. Oswalt

Denise Daly Konrad

Director of Strategic Initiatives and Policy

VIRGINIA HEALTH CARE FOUNDATION

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FX 804|355-6189

www.msv.org

June 21, 2018

Kevin O'Connor, MD
President
Virginia Board of Medicine
9960 Mayland Drive
Henrico, VA 23233

RE: Public comment on draft regulations to implement HB793

Dear Chairman O'Connor,

The Medical Society of Virginia (MSV) serves as the voice for more than 30,000 physicians, residents, medical students, physician assistants and physician assistant students, representing all medical specialties in all regions of the Commonwealth. These clinicians deliver health care each day to the millions of residents of the Commonwealth. The MSV appreciates the opportunity to provide comment on the first draft of the nurse practitioner (NP) regulations.

House Bill 793 will allow nurse practitioners the ability to transition to practice without maintaining a practice agreement with a patient care team physician. While many say that nurse practitioners are not looking to practice medicine, the fact is that statutorily they will be able to do just that. While most health care providers practice with good intent, regulations ensure practitioners do not unknowingly engage in practices that may cause patients harm. All practitioners, especially those that practice autonomously must be held to the same standard of care. The MSV has seven main areas of concern regarding the initial draft regulations and kindly request that these be addressed by the Virginia Board of Medicine.

1. **10,000 Hours**: HB 793 calls for 5 years of full time practice before an NP can apply. For the average person, full time means 40 hours a week, for a total of 10,000 hours in a 5 year period. We believe that the minimum 10,000 hour requirement should be reinstated. **10,000 hours is half the time a medical resident** would practice over 5 years prior to practicing autonomously.

2. **Second Specialty Attestation**: If a nurse practitioner receives a second nationally-recognized specialty certification, the Joint Boards must permit a maximum of 10 percent of relevant hours from the NP's initial specialty certification and attestation to be reused. For example, a family nurse practitioner seeking to become a psychiatric nurse practitioner could reuse a maximum of 1,000 hours that were related to mental health. Presumably, going back and earning a new specialty certification means learning new information and acquiring skills that you previously did not have; therefore, it makes sense to require a substantial number of new hours in which one would put these new skills into practice.

3. **Patient Population and Specialty Alignment:** It is critical that these regulations detail how spell out a **specialty area and/or patient population must be aligned** between the patient care team physician and nurse practitioner while under a collaborative practice agreement. For example, a family nurse practitioner practicing in a collaborative agreement with a gastroenterologist is not receiving significant and relevant clinical experience to ensure safe, autonomous practice as a primary care provider. The MSV has developed a crosswalk (below) for consideration as a basic framework.

Physician	Nurse Practitioner
Family Physician	Family nurse practitioners
Pediatrician or Family Physician (treats children)	Pediatric nurse practitioner
Internal Medicine or Family Physician	Adult nurse practitioner or geriatric nurse practitioner
Psychiatrist or Family Physician	Psychiatric nurse practitioner
Emergency Physician	Acute/geriatric acute care nurse practitioner
Obstetrician and Gynecologist Physician	Women's health nurse practitioner

4. **Adherence to National Specialty Certifications**: These regulations specify that a nurse practitioner can practice independently in the specialty in which they are licensed and certified. Many physician specialties, such as gastroenterology, dermatology, cardiology, etc., do not have a corresponding national nurse practitioner certification. Therefore, there should be no independently practicing NPs in any category without a nationally recognized certification, especially among those that would perform invasive procedures.

5. **Prescribing Limitations:** Studies have shown that some NPs overprescribe opioids and anti-psychotics. As Virginia deals with an opioid epidemic, these regulations should ensure autonomous NPs have the appropriate education, training, and experience prior to prescribing and should determine what schedules are appropriate for nurse practitioners to prescribe in an autonomous setting.

6. **Attestation:** The Joint Boards must implement a process that in the event a physician is unwilling to sign a nurse practitioner's attestation, the physician has the option to provide their rationale. This process will protect both the physician and the nurse practitioner.

7. **Core Competencies:** Finally, there is nothing in this draft of the regulations that ensures a nurse practitioner is has achieved the basic competencies necessary for autonomous practice. While the MSV remains opposed to this apprenticeship-style learning, we request that the Board develop a robust standard that defines competencies that should be met over the minimum hours of full-time clinical experience. This knowledge base and a plan for transition to practice should be specified at the onset of the transition to practice period of training and is necessary to maintaining a sufficient standard of care in the Commonwealth.

The Medical Society of Virginia appreciates the opportunity to provide comments on this important issue.

VAFP

VIRGINIA'S FAMILY PHYSICIANS

June 21, 2018

Kevin P. O'Connor, M.D., F.A.C.S.
Chair, Virginia Board of Medicine
Department of Health Professions
9960 Mayland Drive
Henrico, VA 23233

Dear Chairman O'Connor:

The Virginia Academy of Family Physicians (VAFP) represents over 3,000 practicing family physicians, family medicine residents and medical students across the Commonwealth. The VAFP appreciates the opportunity to provide comment on the draft regulations implementing House Bill 793. Because patient safety is our first priority, the VAFP also shares the concerns raised by the Medical Society of Virginia, the Virginia College of Emergency Physicians, and the Virginia Chapter of the American Academy of Pediatrics, and respectfully requests that the Board of Medicine amend the regulations as detailed below:

1. **10,000 Hours**: HB 793 calls for 5 years of full time practice before an NP can apply. For the average health care provider, full time means 40 hours a week, for a total of 10,000 hours in a 5-year period. For physicians, full time can mean as much as 80 hours per week. Accordingly, VAFP believes that the minimum 10,000-hour requirement should be reinstated. **10,000 hours is half the time a medical resident** would practice over 5 years prior to practicing autonomously. Accordingly, 10,000 hours is the absolute minimum total hours that the Joint Boards should require for autonomous practice.

   Specifically, VAFP requests that the Board of Medicine return the following amendment to the Joint Boards:

   18VAC90-30-86. Autonomous practice (for nurse practitioners other than certified nurse midwives or certified registered nurse anesthetists).

   A. A nurse practitioner with a current, unrestricted license, other than someone licensed in the category of certified nurse midwife or certified registered nurse anesthetist, may qualify for autonomous practice by completion of the equivalent of five years of full-time clinical experience as a nurse practitioner.

   1. Five years of full-time clinical experience shall be defined as ~~1,600~~ *at least 2,000* hours per year for a total of ~~8,000~~ *10,000* hours.

2. **Patient Population and Specialty Alignment:** It is critical that these regulations spell out how a **specialty area and/or patient population must be aligned** between the patient care team physician and nurse practitioner while under a collaborative practice agreement. For example, a family nurse practitioner practicing in a collaborative agreement with a gastroenterologist is not receiving significant and relevant clinical experience to ensure safe, autonomous practice as a primary care provider. The VAFP endorses the specialty crosswalk developed by MSV (as noted on page 2) for consideration as a basic framework:

VIRGINIA ACADEMY OF FAMILY PHYSICIANS
1503 SANTA ROSA ROAD, SUITE 207, RICHMOND, VIRGINIA 23229
PHONE: 804-968-5200 FAX: 804-968-4418
WWW.VAFP.ORG

Physician	Nurse Practitioner
Family Physician	Family nurse practitioners
Pediatrician or Family Physician (treats children)	Pediatric nurse practitioner
Internal Medicine or Family Physician	Adult nurse practitioner or geriatric nurse practitioner
Psychiatrist or Family Physician	Psychiatric nurse practitioner
Emergency Physician	Acute/geriatric acute care nurse practitioner
Obstetrician and Gynecologist Physician	Women's health nurse practitioner

3. **Prescribing Limitations:** Studies have shown that NPs tend to overprescribe opioids and anti-psychotics. As Virginia deals with an opioid epidemic, these regulations should ensure autonomous NPs have the appropriate education, training, and experience prior to prescribing and should determine what schedules are appropriate for nurse practitioners to prescribe in an autonomous setting. The Joint Boards should also consider settling DEA Controlled Substance Schedule limits (e.g. excluding autonomous prescribing of Schedule II medications) and establishing appropriate days supply limits absent consultation with a physician.

4. **Attestation:** The Joint Boards must implement a process that, in the event a physician is unwilling to sign a nurse practitioner's attestation, the physician has the option to provide his or her rationale for withholding attestation. This process will protect the physician, the nurse practitioner, and the patient.

   Additionally, the Joint Board should develop a guidance document identifying the core competencies that should be met by nurse practitioners prior to entering autonomous practice. Consistency in attestation decisions, and patient safety, will be ensured by clear guidelines for core competencies to be met by the nurse practitioner.

The Virginia Academy of Family Physicians appreciates the opportunity to provide comments on these draft regulations. VAFP respectfully requests that the Board of Medicine return amendments to the Joint Boards which address the concerns raised by VAFP, the Medical Society of Virginia, the Virginia College of Emergency Physicians, and the Virginia Chapter of the American Academy of Pediatrics.

Respectfully,

Rupen S. Amin, M.D., MBA, FAAFP
President

Jesus L. Lizarzaburu, M.D., FAAFP
Legislative Chair

VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION

4200 INNSLAKE DRIVE, SUITE 203, GLEN ALLEN, VIRGINIA 23060-6772
P.O. BOX 31394, RICHMOND, VIRGINIA 23294-1394
(804) 965-1227 FAX (804) 965-0475

SENT VIA EMAIL TO (Elaine.yeatts@dhp.virginia.gov)

June 21, 2018

Ms. Elaine Yeatts
Senior Policy Analyst
Department of Health Professions
9960 Mayland Drive
Henrico, Virginia 23233

RE: Public Comment on Draft Regulations to Implement HB793

Dear Ms. Yeatts:

Thank you for the opportunity to comment on the draft regulations to implement HB793 (Chapter 776 of the 2018 General Assembly) authorizing nurse practitioners who meet certain qualifications to practice without a practice agreement with a patient care team physician. The Virginia Hospital & Healthcare Association (VHHA) submits this letter to express its support for the draft regulations and recommended amendments as adopted by the Committee of the Joint Boards of Nursing and Medicine and its Advisory Committee. VHHA also submits the following specific comments on the draft regulations and recommended amendments:

Definition of full-time experience
VHHA supports defining five years of full-time experience as 1,600 hours per year for a total of 8,000 hours. As was discussed by the Committee, the definition of full-time employment can vary by employer. The recommended amendments would allow employers the flexibility to define full-time employment at a level of 32 hours or more, which is appropriate.

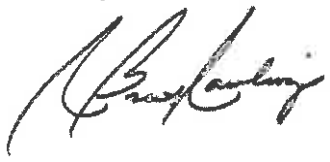
Content of attestation
The draft language includes the statutory requirements for the attestation while allowing the patient care team physician and nurse practitioner to determine whether or not the patient care team physician routinely practiced with a patient population and in a practice area included within the category for which the nurse practitioner was certified and licensed. VHHA favors an approach that limits the attestation to those elements required by the statute.

Other evidence of meeting qualifications for autonomous practice
The Regulatory Advisory Panel's amendment to the last sentence of 18VAC90-30-86(E) to require a nurse practitioner to provide evidence to support his/her inability to obtain an attestation rather than evidence to support the patient care team physician's inability to sign an attestation recognizes there may be reasons a nurse practitioner cannot obtain an attestation other than a physician's inability to sign an attestation. Providing examples of acceptable "other

evidence" that would demonstrate an applicant met the requirements helps applicants understand the types of documentations acceptable to the Board.

Thank you again for this opportunity to comment.

Sincerely,



R. Brent Rawlings
Vice President & General Counsel

June 19, 2018

Elaine Yeatts
Senior Policy Analyst
Department of Health Professions
9960 Mayland Drive
Henrico, VA 23233

Re: Draft Regulations to implement HB793 (Chapter 776 of 2018 General Assembly)

Dear Ms. Yeatts:

I am writing on behalf of the University of Virginia Health System (UVAHS), and we are grateful for the opportunity to comment on the draft regulations to implement HB 793 recently promulgated by the Board of Nursing and the Board of Medicine ("Boards"). We appreciate the work that the Boards have done thus far to develop implementing regulations. UVAHS desires to comment on a few areas that we believe need clarifying.

18VAC90-30-86 - Multiple Attestations

The second sentence of proposed paragraph D of 18VAC90-30-86 is confusing. It states: "If the hours of practice are applicable to the patient population and in practice areas included within each of the categories of licensure and certification, those hours may be counted towards a second attestation."

One could interpret this statement in different ways, including that the applicant would need to fulfill five years in each attestation area, or alternatively, that one five year period could apply concurrently for each attestation area. More than likely the language means that similar experience can count for a portion of time towards each attestation area. However, what if an applicant had four years of experience in adult primary care in an outpatient setting where psychiatric care was integrated into primary care and one year of experience in inpatient adult psychiatry? Could the applicant combine the time with the two experiences and receive two licenses—one as a psychiatric Nurse Practitioner and one as an adult/geriatric primary care Nurse Practitioner? If the applicant is hired to work in an adult psychiatric unit, would it be safe to allow him or her to practice independently with only one year of training in that setting? If such a time split will be allowed to fulfill the time requirement for different attestations, the Boards may wish to think about setting a minimum amount of time that needs to be devoted to each attestation area, being mindful of the amount of time it takes to train medical residents in specialty practice areas, and that a single attestation requires five years.

The proposed regulations require the equivalent of five years of collaborative practice in a specific practice area and patient population. It will be important for hiring entities and credentials committees to know the specific patient population and practice area for which the Nurse Practitioner qualified for independent practice. We believe it would be helpful to require the applicants to answer an open ended question to describe the populations with which they worked and the practice areas in which they worked. Additionally, we suggest that the Boards make the information about the specific patient population and practice area readily available to hiring entities and credentials committees. The most straightforward way to accomplish this would be to specify the patient population and practice area on the license issued by the Boards. As an alternative, the Boards could develop a system to share this information with hiring entities and credentials committees by secure electronic means.

18VAC90-30-86 - Endorsement

Proposed paragraph F of 18VAC90-30-86 addresses Nurse Practitioners who receive a license by endorsement. Currently Virginia does not issue a separate Virginia license to nurses allowed to practice in Virginia under the Nurse Licensure Compact Agreement. Will the Boards issue a Virginia license to an independent Nurse Practitioner from a Compact state whom the Boards authorize to practice in Virginia by endorsement? Additionally, if a Nurse Practitioner seeking a license by endorsement practiced the requisite number of years in a state that has a supervisory model of practice rather than a collaborative model of practice, would that impact endorsement?

18 VAC90-30-120 - Practice Agreements

The Boards may wish to reexamine the language of proposed 18VAC90-30-120 and consider rewriting it to make it less confusing. As it currently stands, the language could be interpreted to mean that independent Nurse Practitioners still have to maintain a practice agreement (which would not make sense). One suggestion is to modify the language in paragraphs A and C along the following lines:

> "A. A nurse practitioner licensed in a category other than *(i)* certified registered nurse anesthetist, ~~or~~ *(ii)* certified nurse midwife, or *(iii) nurse practitioner authorized to practice autonomously in accordance with 18VAC90-30-86,*[1] shall be authorized to render care in collaboration and consultation with a licensed patient care team physician as part of a patient care team ~~or if determined by the boards to qualify in accordance with 18VAC90-30-86, authorized to practice autonomously without a practice agreement with a patient care team physician.~~"
>
> "C. All nurse practitioners licensed in any category other than certified registered nurse anesthetist, ~~or~~ certified nurse midwife, *or in accordance with 18VAC90-30-86,* shall practice in accordance with a written or electronic practice agreement as defined in 18VAC90-30-10. ~~or in accordance with 18VAC90-30-86.~~

Additionally it might be helpful to reword paragraph E to make it clear that autonomous/independent Nurse Practitioners do not have to maintain a practice agreement.

"Autonomous" versus "Independent"

It is our observation that other clinicians who are authorized to practice independently are usually referred to as "licensed independent practitioners". We believe the use of the term "autonomous" to describe an independent Nurse Practitioner could lead to confusion, and we encourage the Boards to reconsider the use of this language.

Thank you for your consideration of these comments.

Sincerely,

Carol H. Craig

Carol H. Craig
Government Relations Specialist
University of Virginia Health System

[1] Perhaps the Boards should create a new name for this category of Nurse Practitioners such as "Autonomous Nurse Practitioner" or "Independent Nurse Practitioner" and insert this name in (iii).

American Academy of Pediatrics

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Virginia Chapter

Virginia Chapter
2821 Emerywood Parkway
Suite 200
Richmond, VA 23298
Phone: 804/643-6631
Fax: 804/788-9987
jchappell@ramdocs.org

Samuel Bartle, MD, FACEP, FAAP
President
Virginia Chapter, American Academy of Pediatrics
2821 Emerywood Parkway
Suite 200
Richmond, VA 23294

June 21, 2018

William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

Jay P. Douglas, MSM, RN, CSAC, FRE
Executive Director
Board of Nursing
Perimeter Center
9960 Mayland Drive
Henrico, VA 23233-1463

RE: VA AAP Comments on Nurse Practitioner Transition to Practice DRAFT Regulations

Dear Dr. Harp and Ms. Douglas,

Thank you for the opportunity to provide written public comment on the draft regualtions released in May as we attempt to establish guidelines for nurse practitioners transiting to independent practice. The Virginia Chapter, American Academy of Pediatrics is strongly committed to ensuring that the care we provide to children under this new model is high quality and meets the needs of all children in the Commonwalth.

To that end, we are asking the Joint Board for the following changes to the draft regulations. We stand together with the Medical Society of Virginia, the Virginia Academy of Family Physicians and the Virginia College of Emergency Physicians in asking you to make these crucial amendments.

Please provide further clarification on the specialty of the physician who can practice with a nurse practitioner during their five years of training. It is imperative that nurse practitioners that want to practice independently in pediatrics work with a primary care pediatrician or a family physician that sees a significant number of children in their practice. Every day we encounter situations with our patients that make it starkly clear that children are not mini adults and nowhere is that more apparent than in general pediatric practice. The clarification can be as simple as the following new language in red:

2. While a party to such practice agreement, the patient care team physician

AAP Headquarters
141 Northwest Point Blvd
Elk Grove Village, IL 60007-1098
Phone: 847/434-4000
Fax: 847/434-8000
E-mail: kidsdocs@aap.org
www.aap.org

routinely practiced with a patient population and in a *primary care or specialty* practice area included within the category, as specified in 18VAC90-30-70, for which the nurse practitioner was certified and licensed; and

Secondly, we are also asking the Joint Board to reverse their decision on defining "full time" as 34 hours a week versus the 40 hours a week that the legislation was intended to reflect. develop and establish guidance on the necessary components for the five years of training. The five years and 10,000 hours was a well thought out decision that was meant to be reflective of the additional education and residency training that physicians receive by substituting clinical experience for nurse practitioners. The more exposure NP's have to the different disgnoses and conditions, especially in children, the better prepared they are to practice alone. We urge you to change the language:

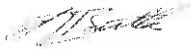
A. A nurse practitioner with a current, unrestricted license, other than someone licensed in the category of certified nurse midwife or certified registered nurse anesthetist, may qualify for autonomous practice by completion of the equivalent of five years of full-time clinical experience as a nurse practitioner.

1. Five years of full-time clinical experience shall be defined as ~~1,600~~ *at least 2,000* hours per year for a total of ~~8,000~~ *10,000* hours.

Finally, we, like the Medical Society of Virginia, believe that it is critical to establish key core competencies to ensure a base level of knowledge and experience is achieved, preparing a nurse practitioner to be able to practice outside of a team model. Physicians have to complete a rigorous and standardized residency component of our training and while we don't expect the process to mirror a residency, it makes sense to use that as a touchstone when looking at the necessary components that NPs should show proficiency in before they transition. We also ask you to look at the need for ongoing competency and how that is measured, such as a requirement for continued education.

We truly appreciate the opportunity to provide the Joint Board with our comments on the draft regulations. If you have further questions, do not hesitate to contact me or our lobbyist, Aimee Perron Seibert (aimee@commonwealthstrategy.net or 804.647.3140).

Sincerely,



Samuel T. Bartle, MD, FAAP
President, Virginia Chapter
American Academy of Pediatrics

VIRGINIA COLLEGE OF EMERGENCY PHYSICIANS

Bruce Lo, MD, FACEP
President
Virginia College of Emergency Physicians
2984 Emerywood Parkway
Suite 202
Richmond, VA 23294

June 21, 2018

William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

Jay P. Douglas, MSM, RN, CSAC, FRE
Executive Director
Board of Nursing
Perimeter Center
9960 Mayland Drive
Henrico, VA 23233-1463

RE: Nurse Practitioner Transition to Practice DRAFT Regulations

Dear Dr. Harp and Ms. Douglas,

On behalf of the Virginia College of Emergency Physicians, we are submitting our official comments on the first DRAFT regulations to implement Delegate Robinson's HB793, authorizing the creation of a path for nurse practitioners to transition to independent practice.

As we commented previously, there continue to be areas we believe need further clarification that were not addressed in the first draft of the regulations released in May.

Those points are as follows, which reflect similar sentiments of our colleagues at the Medical Society of Virginia, Virginia Academy of Family Physicians and the Virginia Chapter, American Academy of Pediatrics.

1. 2.; and 3. Requirements for attestation of practice.

1. **Five years of clinical experience.** We strongly support following the intent of HB793 that requires five years of full time practice, which was meant to mean 10,000 hours of clinical practice. It is commonly understood that a typical workweek is 40 hours per week and for physicians, a typical week can often mean 80 hours a week. Using the 40-hour equivalent is not an unreasonable request and we ask that full time experience is reinstated to mean 2,000 hours a year for five years for a total of 10,000 hours. Uniform benchmarks and standards protect patients by ensuring that 1. the nurse practitioner is getting the appropriate training they need to appropriately

prepare them for practicing alone and, 2. that the physician is providing the appropriate training to the nurse practitioners.

We ask you to make the following changes:

A. A nurse practitioner with a current, unrestricted license, other than someone licensed in the category of certified nurse midwife or certified registered nurse anesthetist, may qualify for autonomous practice by completion of the equivalent of five years of full-time clinical experience as a nurse practitioner.

1. Five years of full-time clinical experience shall be defined as ~~1,600~~ *at least 2,000* hours per year for a total of ~~8,000~~ *10,000* hours.

2. **Specifications for the specialty of the physician and the license of the nurse practitioner.** As emergency physicians, we believe it is critical to provide further specification in the regulations for the primary/specialty practice area of a physician and the license/certification of the nurse practitioner for the five years they must practice together. We work daily with patients across the spectrum of age and gender, but the care we provide is acute, emergent and episodic. We do not believe the current language is clear enough by referring only to the "patient population" that is served. Is that adults, children, or geriatric? Acute, emergent, chronic or preventative patients?

   We do not believe that if a family practice nurse practitioner works for five years with an emergency physician, that after five years they can practice as a FNP. Rather, we would attest to them being able to practice in an acute care setting. Likewise, we do not believe that a FNP that works for five years in a primary care setting is able to transition to an emergent care setting.

   Physicians learn specialty specific training during residency which has objective, nationally approved standards, and this type of question must be answered during the regulatory process so there are clear guidelines for both the physicians and the nurse practitioners and expectations are clear from the start.

   We urge you go change the language to the following to provide specificity as we move forward:

   2. While a party to such practice agreement, the patient care team physician routinely practiced with a patient population and in a *primary care or specialty* practice area included within the category, as specified in 18VAC90-30-70, for which the nurse practitioner was certified and licensed; and

3. Finally, we encourage the Joint Board to develop a clear and concise process for providing the attestation at the completion of the five years, including measurable objectives that are clear, objective, and reproducible from the beginning of the process. Physicians must complete step examinations prior to licensing, and board certification exams prior to board certification, which provide standardized, objective measures of readiness for independent practice. We support similar standards for NP independent practice to ensure that when independent practice is granted, patient safety is foremost.

To conclude, we appreciate the opportunity to provide written comments on the draft regulations. We look forward to being an active participant in the regulatory process. Do not hesitate to contact me or Aimee Perron Seibert (804.647.3140/aimee@commonwealthstrategy.net) with any questions for concerns.

Respectfully yours,

Dr. Bruce Lo, MD, FACEP
President
Virginia College of Emergency Physicians

Comments on Draft Regulations

Comment submitted by multiple persons:

Dear Senior Policy Analyst Yeatts,

As a Virginia physician (medical student), I appreciate the ability to comment on the proposed regulations governing autonomous practice of nurse practitioners (NPs). While many say that nurse practitioners are not looking to practice medicine, the fact is that statutorily they will be able to do just that. While most health care providers practice with good intent, regulations ensure practitioners do not unknowingly engage in practices that may cause patients harm. All practitioners, especially those that practice autonomously must be held to the same standard of care. With that in mind, there are 6 main areas of concern regarding these regulations, which must be addressed:

1. 10,000 Hours: HB 793 calls for 5 years of full time practice before an NP can apply. For the average person, full time means 40 hours a week, for a total of 10,000 hours in a 5 year period. I believe that the minimum 10,000 hour requirement should be reinstated. 10,000 hours is half the time a medical resident would practice over 5 years prior to practicing autonomously.

2. Second Specialty Attestation: If a nurse practitioner receives a second specialty certification, the Joint Boards must permit a maximum of 10 percent of relevant hours from the NP's initial certification and attestation to be reused towards a new certification and attestation. For example, a family nurse practitioner seeking to become a psychiatric nurse practitioner could reuse a maximum of 1000 hours that were related to mental health. Presumably, going back and earning a new specialty certification means learning new information and acquiring skills that you previously did not have; therefore, it makes sense to require a substantial number of new hours in which one would put these new skills into practice.

3. Patient Population and Specialty Alignment: It is critical that these regulations spell out a strict specialty area and patient population alignment between the patient care team physician and nurse practitioner while under a collaborative practice agreement. For example, a family nurse practitioner practicing in an agreement with a gastroenterologist is not receiving significant and relevant clinical experience to ensure safe, autonomous practice as a primary care provider.

4. Adherence to National Specialty Certifications: These regulations specify that a nurse practitioner can practice independently in the specialty in which they are licensed and certified. Many physician specialties, such as gastroenterology, dermatology, cardiology, etc., do not have a corresponding national NP certification. Therefore, there should be no independently practicing NPs in any category without a nationally recognized certification, especially among those that would perform invasive procedures.

5. Prescribing Limitations: Studies have shown that NPs tend to overprescribe opioids and anti-psychotics. As Virginia deals with an opioid epidemic, these regulations should ensure autonomous NPs have the appropriate education, training, and experience prior to prescribing and should review what schedules are appropriate for nurse practitioners to prescribe in an autonomous setting.

6. Attestation: The Joint Boards must implement a process that in the event a physician is unwilling to sign a nurse practitioner's attestation, the physician may provide their rationale. This process will protect both the physician and the nurse practitioner.

Thank you for your work to develop safe, appropriate regulations to ensure the safety of patients in the Commonwealth of Virginia.

Sincerely,

William C Reha MD MBA

15394 Bald Eagle Ln
Woodbridge, VA 22191
wcreha@comcast.net

Andrea Styron
679 Claremont Ave
Harrisonburg, VA 22801
4andreastyron@gmail.com

Lee Ouyang
517 W 20th St
Norfolk, VA 23517
leeouyang@gmail.com

David R. Maizel, MD
1281 Hebden COVE
Virginia Beach, VA 23452
drmaizel@gmail.com

Alan Wynn
12280 Pondwater Ct
Woodbridge, VA 22192
wynnva@comcast.net

Carl J. Christian Bergman, MD
4921 Pretty Lake Ave Apt 216
Norfolk, VA 23518
christian.c.bergman@gmail.com

Russell C Libby, MD
1347 Lancia Dr
McLean, VA 22102
rlibby@vapg.com

Timothy Wilson
12 Ralston Rd
Henrico, VA 23229
TimothyRWilsonMD@gmail.com

Mark Romness
1601 Far Hills Rd
Charlottesville, VA 22901
mromnessmd@gmail.com

Bruce Lo
1329 Lakeside Rd
Virginia Beach, VA 23455
brucelo1@yahoo.com

Arthur Vayer
15253 Bowmans Folly Dr
Manassas, VA 20112
ajvayermd@verizon.net

David Smith
10701 Rosemary Dr
Manassas, VA 20109
dasmith51@comcast.net

William Fox
1121 Vegas Ct
Charlottesville, VA 22901
wefox@hotmail.com

Dr. Claiborne Irby
10 Stonehurst Grn
Richmond, VA 23226
longbone6@gmail.com

MORAYO OMOJOKUN
8691 Stonewall Rd
Manassas, VA 20110
MOMOJOKUN@MANASSASFAMILYMEDICINE.COM

Trice Gravatte
1139 S Blue Ridge Ave
Culpeper, VA 22701
lg8f@virginia.edu

W. Kevin Watterson MD
13671 Glendower Rd
Midlothian, VA 23113
kevin@rockwellphysicians.com

Trice Gravatte
1139 S Blue Ridge Ave
Culpeper, VA 22701
lg8f@virginia.edu

Jessica Edwards
440 Glendobbin Rd
Winchester, VA 22603
jedwardsmd@hotmail.com

Lisa Shea Kennedy, M.D. , FAAFP
216 Sparrow Rd
Chesapeake, VA 23325
fpladydoc@gmail.com

Kevin Parsons
1311 Lafayette Blvd
Norfolk, VA 23509
parsonkr@evms.edu

January-Jill Ogoy
6402 Aberdeen Pl
Suffolk, VA 23435
january_ogoy@bshsi.org

Ian Smithson
320 Hayfield Dr
Lynchburg, VA 24503
ianrsmithson@gmail.com

William C Reha MD MBA
15394 Bald Eagle Ln
Woodbridge, VA 22191
wcreha@comcast.net

Sandy Chung
46962 Fairhills Ct
Sterling, VA 20165
sandyleechung1@gmail.com

Robert Schnarrs
538 S Lake Cir
Chesapeake, VA 23322
rhs817@aol.com

Joel Bennett
5517 Benoni Dr
Glen Allen, VA 23059
j.joelbennett@verizon.net

Samuel Caughron
523 Lexington Ave
Charlottesville, VA 22902
Caughron@aol.com
Sander Leivy
608 Kensington Ct SE
Roanoke, VA 24014
sleivy@cox.net

Robert Schnarrs
538 S Lake Cir
Chesapeake, VA 23322
rhs817@aol.com

Joel Bennett
5517 Benoni Dr
Glen Allen, VA 23059
j.joelbennett@verizon.net

Samuel Caughron
523 Lexington Ave
Charlottesville, VA 22902
Caughron@aol.com

Arthur Vayer
15253 Bowmans Folly Dr
Manassas, VA 20112
ajvayermd@verizon.net

Bhavin Suthar
12142 Sawhill Blvd
Spotsylvania, VA 22553
bssuthar@aol.com

Samantha Wickman
1800 Jefferson Park Ave Apt 76
Charlottesville, VA 22903
svc4wr@virginia.edu

Grace Lee
1336 Maple Ave SW
Roanoke, VA 24016
grace21@vt.edu

Timothy Raines
3212 Hampton Hwy Ste B
Yorktown, VA 23693
golfmd237@msn.com

Sanjay Desai
6 W Glenbrooke Cir
Henrico, VA 23229
sdesai.md@gmail.com

Lydia McNeary, MD
3482 W Ridge Rd SW
Roanoke, VA 24014
lmcneary@gmail.com

Marcella Fierro
8702 Berwickshire Dr
Henrico, VA 23229
marcella@fierroforensics.com

Dewey Bailey
514 Cassell Ln SW
Roanoke, VA 24014
djb@endocrinologymed.com

Sonali Nanda
102 Stuart Pl
Charlottesville, VA 22903
sn4z@virginia.edu

Rajanya Petersson
3116 Floyd Ave
Richmond, VA 23221
rajpetersson@gmail.com

william reha
15394 Bald Eagle Ln
Woodbridge, VA 22191
wcreha@comcast.net

Mike Brackenrich
200 Horseshoe Farm Rd
Pembroke, VA 24136
drmike@pemtel.net

Ash Tilak
8777 Hampshire Glen Dr S

Jacksonville, FL 32256
at2rg@virginia.edu

Saji Slavin MD MSHA FACP
1802 Greenville Ave
Richmond, VA 23220
svslavin2@gmail.com

Teresa Martz
850 Estes St
Charlottesville, VA 22903
tm3zt@virginia.edu

Eduardo Fraifeld
PO Box 11775
Danville, VA 24543
efraifeld@me.com

Henry Wilson
107 Fairlea Ct
Lynchburg, VA 24503
hbwilson1@gmail.com

Mark Hylton
5600 Qualla Farms Pl
Chesterfield, VA 23832
jmhylton75@gmail.com

Matt Wishnoff
2600 E Cary St
Richmond, VA 23223
wishnoffms@vcu.edu

jeremy owens
2165 Catworth Dr
Virginia Beach, VA 23456
owensj@evms.edu

Chi Young
8616 Changing Leaf Ter
Bristow, VA 20136
chy9900@yahoo.com

Dilbagh Sidhu
10506 Dominion Valley Dr
Fairfax Station, VA 22039
dsidhu@aol.com

Varun Choudhary
11400 Grey Oaks Estates Run
Glen Allen, VA 23059
psychdrvc@yahoo.com

JKessel, MD
240 Baier Dr
Salem, VA 24153
jk.surfwv@yahoo.com

Daniel B. Drysdale, MD
240 Deercroft Dr
Blacksburg, VA 24060
dbdrys@gmail.com

William L. Simpson, MD
164 Old Orchard Ln
Warrenton, VA 20186
BillSimpsonMD@msn.com

Tiffany Kimbrough, MD FAAP
10639 Runnymeade Dr
Glen Allen, VA 23059
kimbrout@gmail.com

Steven Nakao
2280 Opitz Blvd Ste 320
Woodbridge, VA 22191
snakao@gmail.com

John Cary
PO Box 1907
Manassas, VA 20108
john.cary58@gail.com

Katherine Marsh
900 Rosser Ln
Charlottesville, VA 22903
kstavoe@gmail.com

Douglas Brown
5501 Brickshire Dr
Providence Forge, VA 23140
mrmd911@aol.com

Arthur Vayer
15253 Bowmans Folly Dr
Manassas, VA 20112
ajvayer@verizon.net

Mark Malkin
334 Lexington Rd
Richmond, VA 23226
mark.malkin@vcuhealth.org

Pedro Jose
6721 Springfield Dr
Lorton, VA 22079
pjose@mfa.gwu.edu

Gary Spivack
1631 33rd St NW
Washington, DC 20007
gspivack@mind-shape.com

Dr. Claiborne Irby
10 Stonehurst Grn

Richmond, VA 23226
longbone6@gmail.com

Susan Miller
1417 Grove Ave
Richmond, VA 23220
susan.miller1417@gmail.com

Leigh Lather
227 Huntley Ave
Charlottesville, VA 22903
lac7c@virginia.edu

Jessica Edwards
440 Glendobbin Rd
Winchester, VA 22603
jedwardsmd@hotmail.com

David Gardner
1503 Hearthglow Ct
Henrico, VA 23238
dfgardner18@gmail.com

Jeremy Powers, MD
9511 Tuxford Rd
North Chesterfield, VA 23236
jeremypowers@gmail.com

Edward C, Nemergut, MD
1103 Tilman Rd
Charlottesville, VA 22901
edward.c.nemergut@gmail.com

Paul Ohai
4709 Summer Lake Ct
Moseley, VA 23120
p.ohai@verizon.net

Parisa Farhi
1802 Happy Hollow Rd
Blacksburg, VA 24060
pxf101@hotmail.com

Robert Blackwood
902 Greenway Ct
Norfolk, VA 23507
drblackwood@gmail.com

These commenters included a different introductory paragraph:

Pat Pletke
2423 Castle Pl
Lynchburg, VA 24503
pat.pletke@gmail.com
Dear Senior Policy Analyst Yeatts,

As a Virginia physician, I appreciate the ability to comment on the proposed regulations governing autonomous practice of nurse practitioners (NPs). As a physician practicing hospice medicine in collaboration with 2 nurse practitoners and 2 other physicians, I am aware of all that NPS bring to the care of our patients. While many say that nurse practitioners are not looking to practice medicine, the fact is that statutorily they will be able to do just that. While most health care providers practice with good intent, regulations ensure practitioners do not unknowingly engage in practices that may cause patients harm. All practitioners, especially those that practice autonomously must be held to the same standard of care. With that in mind, there are 6 main areas of concern regarding these regulations, which must be addressed:

John Partridge
14501 Leafield Dr
Midlothian, VA 23113
john.partridge@vpfw.com
I retired April 6 from private medical practice after a 43 year career.
During training, service for seven years in the US Army Reserve Medical Corps, and for several years in private practice I had the opportunity to work directly with nurse practitioners. I have also occasionally turned to nurse practitioners for my personal medical care. In general I hold nurse practitioners in high regard. But it is clear to me that nurse practitioners function at a different level than do physicians. The insights I would bring as a physician in how to best deal with a case were sometimes quite different from the initial analysis and plan of the nurse practitioner. I hesitate to think of impact upon patients if nurse practitioners are freed to function independent of physician collaboration.
While many say that nurse practitioners are not looking to practice medicine, the fact is that statutorily they will be able to do just that. While most health care providers practice with good intent, regulations ensure practitioners do not unknowingly engage in practices that may cause patients harm. All practitioners, especially those that practice autonomously must be held to the same standard of care.

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VIRGINIA REGULATORY TOWN HALL

Logged in as
Elaine J. Yeatts

Agency **Department of Health Professions**

Board **Board of Nursing**

All good comments for this forum **Show Only Flagged**

Back to List of Comments

Commenter: Lisa Krieg, DNP, FNP-BC, Bon Secours Health System 5/22/18 9:11 pm

HB 793

By passing the current draft regulations as is, this will help ensure that the legislation maintains its original intent: **to lower barriers to practice in Virginia**.

Commenter: Cynthia M Fagan 5/22/18 9:33 pm

HB793 Draft Reguations

I support of passage of the current draft regulations which will help ensure that the legislation maintains its original intent to lower barriers to practice in Virginia and to increase access to care for citizens of the Commonwealth.

Commenter: Ameanthea Blanco-Knezovich, DNP, FNP-C 5/22/18 10:10 pm

HB793

Passing the current draft regulations will help ensure that the legislation maintains its original intent: **to lower barriers to practice in Virginia**.

Commenter: Susan Roberts, ANP 5/23/18 5:28 am

HB 793 draft regulations

I encourage to the passing of HB 793 draft regulations as written to help enable autonomous Nurse Practitioner practice in Virginia. As it is, NPs face too many unnecessary obstacles that prove to be costly and time-consuming in providing basic patient care. As an experienced NP practicing in a very rural area, my patients rely on me for their chronic and acute medical needs. Our goal should be to enable more providers to practice in underserved areas.

Commenter: Mary Nichols, PhD, APRN, FNP-BC 5/23/18 9:27 am

HB 793 Draft Regulations

Nuse Practitioners increase access to health care for all Americans. **The current draft regulations help ensure that the attestation process is fair, opening the door to autonomous practice for NPs throughout Virginia.** Passing the current draft regulations will help ensure that the legislation maintains its original intent: **to lower barriers to practice in Virginia**.

Commenter: Carole Everhart, Everhart Primary Health Care 5/23/18 12:51 pm

Regulations for HB 793

This comment is to encourage the passage of the draft regulations to HB 793 as currently written. the current draft regulations help ensure that the attestation process is fair, opening the door to autonomous practice for NPs throughout Virginia. Passing the current draft regulations withoutany additional changes will help ensure that the legislation maintains its original intent: **to lower barriers to practice in Virginia**.

Commenter: Melissa Tucker, CMG Altavista 5/23/18 1:09 pm

HB 793

I am in favor of the HB 793 as drafted without any additional changes. In my position as a NP at a family practice office in Altavista, Va, we have had numberous physicians come and go. The physicians are unable to collaborate with more than a certain number of NPs. This has effected us greatly as a lot of NPs practice in this rural area. I have been practicing for 7 years and feel completely confident practicing autonomously and working with the physicians as colleagues. The collaborative contract has only been a hindrance to my practice. By being able to practice without these restrictions it would help our patient population significantly by allowing as many NPs as the organization wants to hire, be able to practice.

Thanks,

Melissa Tucker, FNP-C

Commenter: Shelly Smith, DNP, ANP-BC 5/25/18 7:58 am

HB 793 Regs

Esteemed Colleagues

Thank you for allowing public comment on the proposed regulations for HB 793. I support these regulations as written. The draft regulations are an effective way to promote access to care for Virginians by allowing nurse practitioners who meet the proposed requirements to transition to an independent license. I appreciate that the proposed regulations are avoid additoinal burden to nurse practitioners by using the language in the legislation. Thank you for your diligent work.

Shelly Smith

Commenter: Valerie Wrobel, MSN, AGNP, BC 5/25/18 1:46 pm

Draft regulations need no further barriers added.

The current draft regulations re HB793 help ensure that the attestation process is fair, opening the door to autonomous practice for NPs throughout Virginia. This bill's intent has been to lower barriers to practice in Virginia and ease access to healthcare for citizens. Thus, I encourage your support for the draft regulations as they stand, without any additional changes.

Respectfully,

Valerie J S Wrobel, MSN, RN, AGNP - BC,

President VCNP Northern Virginia Region

Commenter: Debbie Dellinger 5/27/18 8:03 am

Support of HB 793 Draft Regulations

I support the passage of the current draft regulations. This passage will ensure that the legislation maintains its original intent which would lower barriers to practice in Virginia. This is necessary as it would increase access to care for our patients in state of Virginia.

Commenter: Marilyn Grossman 5/29/18 9:31 pm

HB 793 Regulations

As a FNP practicing in Danville, I support the current draft of regulations in relation to HB 793.

Commenter: Brittany K Hines, MSN AGACNP-BC FNP-C 5/30/18 3:08 pm

Support of HB 793 Regulations

I support the HB793 draft regulations as written.

Brittany K Hines MSN AGACNP-BC FNP-C

Commenter: Cathy Duncan, FNP 5/31/18 10:54 am

Support for HB793

I strongly encourage both boards to accept HB 793 as proposed. Any additions or changes would add barriers to autonomous practice for nurse practitioners. The regulations as proposed provide for attestation in a fair way.

Commenter: Tracey Avery-Geter, MSN, WHNP-BC 6/1/18 12:57 pm

Support of HB 793

I fully support the draft regulations to HB 793 as written with no additions or corrections. As a Nurse Practitioner in public health, passing the current draft regulations will increase access to care for citizens of the Commonwealth while lowering barriers to practice in Virginia. I urge both boards to accept the regulations as proposed.

Commenter: Dian Evans, PhD, FNP-BC, ENP-BC American Academy of Emergency NPs 6/3/18 9:21 am

HB 793 draft regulations

I support the draft regulations of HB 793 as they currently stand. IThey help to ensure the public safety.

Commenter: Cherie Wright, FNP-BC 6/3/18 9:40 pm

HB 793

I want to voice my support for the draft regulations as they stand, without any additional changes. Passing the current draft regulations as they are written will provide a fair attestation process and will help to ensure that the legislation maintains its original intent: **to lower barriers to practice in Virginia.**

Commenter: Marsha Stonehill, MSN, PMHNP/CNS, BC 6/3/18 10:24 pm

HB793 Draft Regulations

I want to voice my support for the draft regulations as they stand, without any additional changes. Passing the current draft regulations as they are written will provide a fair attestation process and will help to ensure that the legislation maintains its original intent: to lower barriers to practice in Virginia. As the regulations are currently drafted, I will be able to move forward with the transition and open a practice in King George, VA. My initial experience (in 2003) was in California with a psychiatric group for the first 4 years and I should be able to locate them without any difficulty. However, my next years of employment were in Virginia at Remuda Ranch which closed down due lack of third party reimbursement. In my efforts to catch up with those psychiatrists, I've not had much luck so far. The current draft regulations will prevent what is not in my control from being a hindrance. Thank you!

Commenter: Hishani Perera, Embracing Health 6/3/18 10:51 pm

In support of HB 793

I want to voice my support for the draft regulations as they stand, without any additional changes. Passing the current draft regulations as they are written will provide a fair attestation process and will help ensure that the legislation maintains its original intent: to lower barriers to practice in Virginia.

Commenter: Sapient Health Services, PLLC 6/4/18 12:48 pm

HB793 Regulations, Comments

Thank you to the committee for a smooth process in acceptance of the draft regulations at the May 17th meeting. The regulations, as they are proposed, will provide sufficient guidance to providers with regard to implementation of HB793. I request that the BON and BOM pass the regulations as proposed to move this bill forward as soon as possible to remove one of the major barriers in the Commonwealth to access to care.

Phyllis C Everett, NP-C

Owner, Adult NP

Sapient Health Services, PLLC dba Huddleston Health and Wellness

Commenter: Christopher Steven Hewitt 6/5/18 5:03 pm

Full practice authority for nurse practitioners

Definitely in full support of full practice authority for nurse practitioners in the state of Virginia. It has been evidenced in multiple states that full practice Authority for nurse practitioners is both safe and effective. Virginia residents deserve increased access to primary care and other specialties.

Commenter: Caroline Stowe 6/5/18 7:13 pm

Support

I support this bill without any amendments, and I strongly encourage both sides to pass this bill. Any changes would severely limit access for patients to well-qualifies providers.

Commenter: Heather Blair MSN FNP-BC 6/5/18 11:01 pm

HB793

I encourage you to pass HB 793 enabling nurse practitioners to provide autonomous care. This will improve access to health care for many patients.

Commenter: Brianna Garcia, MSN candidate University of Pennsylvania 6/5/18 11:30 pm

In support of reducing VA NP practice restrictions

I am in support of this legislation as proposed. In accordance with the IOM's Future of Nursing report, nurses should practice to the full extent of their education and training. Autonomous practice for NPs will allow for improved access to care for the residents of Virginia. As a newly trained provider deciding where to practice, practice restrictions can be a deterrent to practicing in that state. This legislation is a step in the right direction.

Commenter: Virginia Thurston, MSN, FNP-BC 6/6/18 11:10 am

HB793

I am in support. We need this to pass to be able to provide better access to care

Commenter: Rosie Taylor-Lewis, DNP, ANP-BC, GNP, PMHNP student RU; Interim PD DNP SUO — 6/6/18 4:11 pm

HB793

I commend the work of composing the lanuage of the regulations that passed by committee recently. It follows the intent of the General Assembly. I support the current regulations and request that any proposed changes restricting full practice to qualifying NPs be addressed.

Commenter: Suzanne Barron — 6/6/18 4:13 pm

HB793 draft regulation

I support of passage of the current draft regulations which will help ensure that the legislation maintains its original intent to lower barriers to practice in Virginia and to increase access to care for citizens of the Commonwealth. Suzanne Barron, MS, FNP-BC

Commenter: Kathryn Whitley, M.S.N., NP-C Henry-Martinsville Health Department — 6/6/18 5:05 pm

Draft Regulations for NP Practice

I support passage of the current draft regulations which will help ensure that the legislation maintains its original intent to lower barriers to practice in Virginia and to increase access to care for citizens of the Commonwealth. I am employed as a Nurse Practitioner for the Virginia Department of Health.

Commenter: Carola Bruflat MSN WHNP-BC/FNP-BC — 6/6/18 6:04 pm

In Support of the Draft Regulations for HB 793

I am writing today in support of the draft regulations for HB 793 as they stand and without any additional changes. Passing the current draft regulations as written will ensure that the legislation reflects it's initial intent - to lower the barriers to practice in the Commonwealth of Virginia.

Commenter: Hazel L. Ruff — 6/6/18 7:28 pm

HB 793

I would like to emphasize ad support the current draft regulations to HB 793 will help ensure that the legislation will maintain its original intent: to lower barriers to practice in Virginia.

Commenter: Karen Hill — 6/6/18 8:55 pm

HB793

Please continue with HB793 as it is. Our goal is to decrease barriers that NPs currently face and to increase services to our communities!!

Commenter: Nancy Hargis

6/6/18 10:05 pm

HB 793

Please pass HB 793 as is. We need as many NPs as possible to care for pts with no restrictions. Less restrictions, more quaillity care!

Commenter: cheryl oscar

6/7/18 9:13 am

draft regulations

TPassing the current draft regulations will help ensure that the legislation maintains its original intent: to lower barriers to practice in Virginia. Virginia does not want to fall behind other states in terms of providing patient access to quality health care from NPs.

Commenter: Jan Zarefoss, AGACNP -BC

6/7/18 1:53 pm

support of passage of the current draft regulations which will help ensure that the legislation mai

Commenter: Brandon Burr, FNP, PMHNP, 757 Family Medicine

6/7/18 3:14 pm

CBD. THCA oil

Currently the board of pharmacy and board of medicine in va doesn't allow for NPs to recommend or prescribe CBD oil in the state of Virginia. I am a practice owner in both Maryland and Virginia treating veterans and I know the efficacy of cannabis oils. As NPs We need to be able to recommend these oils in the state of Virginia and it not be excluded by physicians. Thank you for your consideration and hard work.

Commenter: Candi O'Rourke, WHNP-BC

6/8/18 9:29 pm

HB793

HB793 needs to be approved in its current form to allow the safe and full autonomous practice of NPs in VA to further patient care and access.

Commenter: Danielle E. Chellappoo, NP-C, AOCNP 6/9/18 10:00 am

RE: HB 793

I want to voice my support for the draft regulations as they stand, without any additional changes. Passing the current draft regulations as they are written will provide a fair attestation process and will help to ensure that the legislation maintains its original intent: to lower barriers to practice in Virginia.

Commenter: Diane Hancock,MSN,GNP,RN 6/10/18 12:20 pm

HB 793

I am in full support of HB 793 without any amendments.

Commenter: Pamela S. McCullough, CPNP, CNE, DNP 6/11/18 9:13 am

HB 793

I would like to take this time to voice my support for the draft regulations as they stand. I do not support any additional changes. Passing the current draft regulations as they are written will provide a fair attestion process and will help to ensure the legislation maintains its original intent: to lower barriers to practice in Virginia. The current draft regulations help ensure the attestation process is fair. Any additional restrictive language will result in harming vulnerable populations seeking healthcare. Promoting health, and preventing chronic disease for all citizens of the Commonweath of Virgina is our shared goal.

Commenter: Megan Hebdon, Pulaski Free Clinic and Radford University 6/14/18 9:07 pm

HB 793

Development of draft regulations that maintain the original intent of HB 793 is vital--to lower barriers for NP practice in the state of Virginia. Healthcare access is a major issue in our country, especially for individuals living in rural areas or who are affected by health disparities such as poverty, low education levels, and little to no insurance. Nurse practitioners who are able to practice to the full extent of their training and education are an important way to increase healthcare access for underserved populations. There are major health crises in our nation, such as the opioid crisis, obesity epidemic, and aging population. Nurse practitioners are well prepared to address these concerns through our background in bedside patient care, our training that emphasizes patient education, therapeutic communication, and holistic care, and our ability to collaborate with other members of the healthcare team.

I have moved three times during my career as an NP. In two states, I could not practice unless I established agreements with physicians in the communities, which was extremely difficult without any history or work relationships in the areas. In order to work, I sought employment at existing health care practices with supervising physicians. These options provided me with great experience, but did not facilitate my goal to care for under- or uninsured populations. I believe that reducing barriers for NP practice will strengthen the healthcare workforce in Virginia, will improve healthcare access, and will address the major health issues in the Commonwealth and nationwide.

Commenter: Anne Bejian MSN NP-C 6/14/18 10:10 pm

Draft regulations for HB 793

Passing the current draft regulations will help ensure that the legislation maintains its original intent: to lower barriers to practice in Virginia. Please accept the draft regulations as is.

Commenter: Sarah W. Southard 6/15/18 12:05 pm

HB 793

As a NP in Virginia for 23 years, I ask that you please pass the current draft regulations to make sure that HB 793 maintains its original intent to lower barriers to practice for NPs in Virginia. Thank you.

Commenter: Charles Fisher, ACNP, UVA Health System 6/16/18 7:44 am

Support to implement HB793

Thank you for supporting this bill, HB793. Please approve it and support improved health care for all Virginians.

Commenter: Kristine Schultz, RN - Riverside Regional Medical Center 6/17/18 12:01 pm

Support of HB793

I support the implementation of HB793.

Commenter: Tirsit Abebe BSN-RN, DREAM-HOPE Home healthcare services 6/17/18 1:57 pm

In support of the draft regulation for HB 793

NP will play key roles in improving healthcare outcomes, and I fully support reducing Virginia NP practice restriction. One of the problem is few state including VA State, adapted full practice authority license and practice laws for NPs to obtain written or electronic practice agreements with physician or multidisplinary team. This shows NP has many restricted practices and required supervision to delegate or team management by outside health discipline in order to provide patient care.

I believe NPs education and training is not the same as physicians, even though physician and NPs possess a similar goal of improving patient outcomes, barriers to successful collaboration exist. As NPs obtaining admitting privileges to acute care facilities, possess significant obstacle for continuity of care, patient outcome and coordination of patient care. This impact areas of NP management, health policy, and risk management, quality control, and diagnosing and managing disease process.

Allowing NPs also to practice autonomously will impact healthcare providers, policy makers, and payers as increasing demand for services. Healthcare professional will be challenged to meet the needs of an aging and diverse population within an emerging NP workforce shortage. In

anticipation of the an increased NP healthcare providers that will needed in the future, I support the NPs allowed to practice autonomously, and permit to practice to the full extent of their education and training. These help build the workforce necessary to meet the country's healthcare needs at large, and contribute their unique skills to the delivery of patient-centered acute care and community setting healthcare.

Commenter: Linda Wilkinson, Va. Assoc. of Free & Charitable Clinics 6/19/18 3:01 pm

HB793 SUPPORT

The Virginia Association of Free & Charitable Clinics supports full implementation of HB793 (signed by the governor on 4/4/18). By allowing NPs to practice up to the full extent of their license and training, Virginia will help improve access to healthcare for thousands of vulnerable patients across the commonwealth. NPs are highly skilled and caring professionals with the best interest of patients central to their treatment plans. NPs provide high quality care often under difficult circumstances. Without their support of free clinics and our patients, hundreds if not thousands, of patients would not have access to care. VAFCC supports regulations that do not hinder access for patients or providers to delivering care.

Commenter: Barbara Heidi Wilson, NP 6/19/18 3:11 pm

HB 793

Virginians are counting on our boards to delivery regulations that are consistent wth the legislation recently passed that would allow clients to have better access to well-qualified nurse practitioners. With the expansion of Medicaid in our state we will have even more demand for the primary care and prevention services that nurse practitioners can so expertly provide.

Commenter: Karen Budd, MSN, FNP-BC, George Mason University 6/19/18 9:23 pm

In support of HB793

To facilitate improved access to well qualified nurse practitioners for the citizens of Virginia I support and strongly urge you to support the draft regulations as adopted by the Regulatory Advisory Panel to implement HB793. With the recent expansion of Medicaid in Virginia demand for access to quality health care provided by well qualified nurse practitioners has become even more important.

Commenter: Joseph Grisetti, Carilion Clinic 6/20/18 7:39 am

Support of HB793

Please consider passing HB793 without further delay or changes.

Commenter: Mike Hanger; West Point Family Practice 6/20/18 8:24 am

Support of HB 793 as is.

I am in support of HB 793 being passed as is, without change or delay, and encourage

consideration of the need for NPs to be able to meet the Commonwealth's needs without any additional restrictions.

Commenter: Kathryn B. Reid 6/20/18 8:57 am

Support the draft regulations for HB 793

The draft regulations support the intent of HB 793. Please support these proposed regulations!

Commenter: Margarita Simón 6/20/18 8:59 am

Finding collaborating physicians

In general, unless you work in a practice or for a health care system?, it is almost impossible to find a collaborating physician. Many state they don't want the legal liabilities or responsibility. Having been a nurse 43 years, an FNP 20 years & a certified wound care nurse, 15 years, I have not been able to secure a collaborating physician to do my wound care practice since I left the health care system & private practice in that system 1 1/2 years ago. I hope that when the time comes for attestation, I won't have difficulties from the physicians I once worked with. My goal is to work part time until I finally retire. It is such a barrier to have to have a collaborating physician who also does not have my expertise.

Commenter: Deborah Hayes RN MSN FNP-C, Piedmont Pediatrics 6/20/18 9:07 am

HB793

I encourage the passing of the current draft regulations to ensure the legislation maintains it's original intent to lower barriers for Nurse Practitioners to practice in the state of Virginia.

Commenter: Deborah Quinn, Dermatology 6/20/18 9:34 am

Hb 793.

Thank you for the opportunity to comment. I highly encourage the passage of the draft regulations to HB 793 as currently written. It is vital that the attestation process is fair and allows experienced Nurse Practioners the opportunity to practice autonomously throughout Virginia. Passing the current draft regulations without additional changes will help ensure that the legislation maintains its original intent: **to lower barriers to practice in Virginia**..

Commenter: Bon Secours Primary Care Chesapeake Virginia 6/20/18 10:07 am

Support HB 793

The draft regulations support the intent of HB 793. Please remember the health of our citizens in our great commonwealth. Please remember the intent is to help lower barriers to practice in this state.

Commenter: Barbara G. Schimming, MSN, RN, FNP-C Bon Secours Primary 6/20/18 10:09 am

Care

Support HB 793

Please support HB 793 draft. Please remember the originial intent for this bill is to lower barriers to healthcare for the citizens in the commonwealth of Virginia.

Commenter: Sandra Hearn DNP CPNP Eastern Shore Rural Health System 6/20/18 6:46 pm

Support draft regulations HB793

Now more than ever supporting the draft regulations is imperative to expand access to all Virginians. We have time and time again proven nurse practitioners are capable of caring for those in great need of healthcare, uninsured and underserved.

Commenter: Christine Schmitthenner, 6/20/18 8:25 pm

support draft regulation for HB793

Please support the draft regulations for HB793 to support the intent of the legislation which was passed.

Commenter: Kori Lapham, FNP-Inova Health Systems-Urgent Care 6/20/18 10:39 pm

Support for HB 793 Draft Regulations

Good Day,

I support the passage of the current draft regulations which will ensure that the legislation maintains its original intent to lower barriers to practice in Virginia and to increase access to care for citizens of the Commonwealth.

Please see article below to support lowering practice barriers for APRNs, as published by the Brookings Institution on June 13, 2018.

Improving Efficiency in the Health-Care System: Removing Anticompetitive Barriers for Advanced Practice Registered Nurses and Physician Assistants

Thank you for your time.

Commenter: Lydia D. Shelton, WHNP/FNP 6/21/18 6:12 am

HB793

I encourage the passage of the current draft regulations for HB 793. These regulations will help to ensure this legislation maintains its original intent to lower the barriers for Nurse Practitioners to practice in the state of Virginia. This legislation will move the state of Virginia forward in achieving the goal of Virginia being the healthiest state by increasing access to health care for all Virginians.

Commenter: B Walsh, Sinclair Health Clinic

6/21/18 8:29 am

HB793

Thank you so much for this bill, it will truly help more patients receive care in the state of Virginia. I have one request/comment. There are many routes for Nurse Practitioners to practice, the career like medicine has many specialties and flexibility. For nurse practitioners that are certified and licensed in more than one specialty does it really have to be a 5 year obligation to practice in both specializations before being allowed autonomous practice? For example if a nurse practitioner has over 5 years in one specialty area, and then becomes certified and licensed in another specialty area but does not have the full five years of practice in that area does he/she still have to complete 5 years in both specialties before applying for autonomous practice? -- or does that provider apply for autonomous practice for one specialty that they qualify for and then complete the five years and apply for autonomous practice in their next specialty? How will this work for providers that have been granted autonomous practice and then return to school to become licensed and certified in another specialty? Last question, once a provider becomes autonomous how will this affect if the are trained and learn a new procedure, ie transmagnetic stimulation, will that provider have to contact their referring team physician for practice hours?

Thank you for this opportunity for clarification.

Commenter: Valre Welch, CPNP

6/21/18 9:13 am

HB793

It is extremely important to maintain the intent of HB793 which is to lower barriers to practice and increase access to care for Virginia residents.

Commenter: Dr. Kelley M. Anderson, Georgetown Unviersity

6/21/18 10:33 am

Nurse Practitioners Providing Access to Care to Virginians

On June 13, the Brookings Institution released a new policy proposal titled ***Improving Efficiency in the Health-Care System: Removing Anticompetitive Barriers for Advanced Practice Registered Nurses and Physician Assistants*** written by Emory University professors Kathleen Adams and Sara Markowitz. The authors consider the evidence, which shows barriers that states place on the scope of practice for NPs and PAs increase healthcare costs and add administrative burdens without additional health and safety benefits. The report includes recommendations that **state policymakers eliminate supervision requirements** and allow full prescription authority to advanced practice registered nurses.

Brookings Institute Report

In an era characterized by high levels of U.S. health-care spending and inadequate health outcomes, it is vital for policymakers to explore opportunities for enhancing productivity. Important productivity gains could be achieved by altering the mix of labor inputs used in the health-care sector. However, the potential for these gains is sharply limited by anticompetitive policy barriers in the form of restrictive scope of practice (SOP) laws imposed on physician assistants and advanced practice registered nurses. In this proposal we discuss evidence that shows how these laws restrict competition, generate administrative burdens, and contribute to increased health-care costs, all while having no discernable health benefits. We discuss how moving to a fully authorized SOP for these providers can free up labor markets, allowing for a more-cost-effective and more-productive use of practitioners, while potentially fostering innovation and still protecting public health. A key outcome would be improved access to care as gains in productivity increases capacity in the health-care system. We conclude with a discussion of state and federal policies that either remove

these barriers directly or encourage state legislative bodies to do so.

Commenter: Dr. Kelley M. Anderson, Georgetown Unviersity 6/21/18 10:39 am

Brookings Institute Report - Link

Brookings Institute Report - June 2018

http://www.hamiltonproject.org/assets/files/AdamsandMarkowitz_20180611.pdf

Commenter: Associates of York 6/21/18 11:38 am

insurance reimbursement

I am confused about the the Board of Nursing requirment that the NP practice only in thieir certified specialties..If there is an NP that is certfied in another specialty under a collaborative aggreement will they be able to be reimbursed by major insurance carriers or quallify for insurance panels ? We have a few NP's new to our practice and recent graduates in other specialties who are being supervised by a psychiatrist. Do they need to be actively in a program that will give them this specialty certification.? If the BON's requirement is to be certified in their academic and BC specialties will this new independent practice for NP impact carriers making a case that they will only reimburse for those who are providing services who are Board Certified in the area they are billing, ie, can a Board Certified geriatric NP bill for services in psychiatry provided they have a collaborative agreement with a psychiatrist? If so, can an NP who then becomes an independent practitioner in five years switch to another specialty and continue to function as an independent provider ?

Ms. Klusman

Commenter: Margaret Constante 6/21/18 3:13 pm

HB 793

I support of passage of the current draft regulations which will help ensure that the legislation maintains its original intent to lower barriers to practice in Virginia and to increase access to care for citizens of the Commonwealth.

Commenter: Judy B. Jenks 6/21/18 7:31 pm

HB 793

It is imperative we lower barriers for NPs to practice in Virginia. The public and professional sector have made it clear they value NPs as healthcare providers. Further barriers would clearly be a result of territorial and hierarchical posturing by the power of the medical society, with whom the Governor shows allegiance. Politics should not supersede the healthcare needs of the citizens of Virginia. Virginia has some of the richest counties in the nation near DC, and some of the most economically desperate in the southwestern areas. In spite of the rich counties, we still rely on charity mobile clinics to provide care in southwest Virginia. At this point, the current system and physician distribution are not working for most of the state. And yet, the medical society of Virginia wants to keep making decisions about how healthcare is to be delivered while they continue to fail

the citizens. I am sure many physicians and politicians will make an appearance at the Wise County RAM clinic in July and have a "feel good" moment and positive press. In the meantime, NPs will diligently continue to provide healthcare in the medically underserved areas, as they do each and every day of the year. Now is not the time to compromise, now is the time to do what is right and break down those barriers. Just ask any patient of an NP.

Commenter: Maribeth Capuno RN, MSN, ANP-BC

6/21/18 7:58 pm

HB 793

I support the passage of HB 793 as written with current regulations. This will help advance the ability of Nurse Practitioners to meet the health care needs for all resident of the Commonwealth

Commenter: Pegasus Pychiatric and Wellness Center

6/21/18 9:15 pm

FNP vs Pych NP

For many years there where few psych NP's and numerous FNP's filled in the gap for psych care ; will we not be recognized for attestation?-because we were filling in a huge need to service a very vulnerable and underserved population outside of the family practice arena . I feel we need to be recognized for our service and be able to practice without collaborating if we meet the 5000 hours of practice and be reimbursed by insurances.

Commenter: Amy Black, NP

6/21/18 9:47 pm

In support of HB 793

I support of passage of the current draft regulations which will help ensure that the legislation maintains its original intent to lower barriers to practice in Virginia and to increase access to care for citizens of the Commonwealth.

Virginia.gov Agencies | Governor

VIRGINIA REGULATORY TOWN HALL

Logged in as
Elaine J. Yeatts

Agency **Department of Health Professions**

Board **Board of Medicine**

All good comments for this forum **Show Only Flagged**

Back to List of Comments

Commenter: Rosie Taylor-Lewis, DNP, ANP-BC, GNP, PMHNP student RU; Interim PD DNP SUO

6/11/18 8:46 am

HB793 Regulations

I advocate that the regulations unanimously passed in May be enacted on 7/17 including allowing diverse attestations that will qualify and quantify the competency of the nurse practitioner. Specific to additional certifications and endorsements, **I ask the board to acknowledge and waive any additional 5 year period requirement for second certifications**. We need our experienced NPs to return for additional credentialing in order to provide augmented care to population health, especially in the area of mental and behavioral health. Physicians who seek other "skills" and certifications do not have waiting periods. An imposed waiting period will impact patient access.

Commenter: Anonymous

6/21/18 11:43 pm

Draft regs - Autonomous Practice

There appears to be a shortage of available clinicians in the Commonwealth to provide healthcare services. It is strongly in the public interest to allow and promote qualified practitioners to manage patients independently without restrictions. Cumbersome requirements for practice only serve to inhibit access to care. Maryland and DC allow independent practice. There is no compelling reason why Virginia cannot do the same. Requiring by law, collaborative practice severely limits the ability of NPs to start businesses, thereby limiting public access especially in underserved areas.

Regulations should clarify that autonomous practice means that NPs are not required as routine practice to collaborate/consult. Also, requiring physician collaboration reduces efficiency of the physician.

The numbers 5 years and 8000 hours should be reduced, even most physician residencies are shorter.

The wording of "1600 hours per year" and "full-time clinical experience" should be eliminated. Very simply, a certain number of hours can be required (without any mention of full-time or 5 years). For example, 4000 hours could be required. No mention of full time needed. (What if a NP works part-time for 10 years? Is this equivalent?)

Re: autonomous practice by endorsement (90-30-86 Subsection F) makes reference to subsection A. NPs originally practicing in states that allow full independent practice may not be able to meet

requirement A2 (of 90-30-86 section A) because they may have been practicing for years in a state that does not require a physician practice agreement.

A physician may be unwilling to sign an attestation for self-serving business reasons despite the NP meeting requirements. Therefore, the documentation burden should be light for an NP providing documentation of hours worked.

Eliminate 90-30-86 subsection G.2 as this can be construed to require collaboration on every case.

SUMMARY – PUBLIC COMMENTS ON 5-17-17 DRAFT NP REGS (HB793)

Virginia Healthcare Foundation

- Encourage a regulatory approach for transition to practice that does not exceed a total of 5 years of collaboration for an NP who is licensed in more than one specialty area (category)
- Customized/individualized approach when reviewing applications - Develop a framework for review when considering each NP's individual level of training, credentials and work experience
- Wants a system that promotes NPs adding an additional licensure category e.g. Psych MHNP due to need to expand access to care in this area

Medical Society of Virginia

- 10,000 hours – ½ the time a medical resident practices in 5 years
- 2nd specialty attestation – limit past hours to 10% (or 1,000 hours)
- Detail needed re "specialty area and/or patient population must be aligned" between patient care team physician and NP while under practice agreement – Specialty crosswalk provided
- Adherence to National *Specialty* Certifications
- Prescribing Limitations – proper/education/training and experience prior to prescribing
- Attestation – Give physician the option to provide a rationale for their refusal to sign
- Core Competencies – nothing in the draft that ensure an NP has achieved the basic competencies for autonomous practice – Robust standard needed to define competencies

Virginia Academy of Family Physicians

- Shares MSV concerns
- 2,000 yr/10,000 hours – same as MSV
- Patient population and specialty/category alignment – regs need to spell out how aligned while under the collab Practice Agreement – same as MSV
- Prescribing Limitations – same as MSV
- Attestation – same as MSV
- Guidance document identifying the core competencies that should be met prior to autonomous practice

Virginia Hospital and Healthcare Association

- Definition of FT experience – supports 1,600/yr or 8,000
- Content of attestation – supports an approach that limits the attestation to those elements required by the statute
- Other evidence – provide examples of other evidence that would demonstrate applicant met requirements

UVA Health System

- Multiple Attestations – Paragraph D 18VAC90-30-86 is confusing—"If the hours of practice are applicable to the patient population and in practice areas included within each of the categories of licensure and certification, those hours may be counted towards a 2nd attestation."
    - Possible Interpretations: 5 years in each attestation area, or one 5-yr period could apply concurrently for each attestation area. Clarity needed. Maybe a minimum amount of time?
    - Suggest open-ended question on attestation form to describe the populations and practice areas worked
    - Specify patient population and practice area on the license
    - System to share information with hiring entities and credentials by secure electronic means
- Licensure by endorsement –
    - Virginia doesn't currently issue a separate RN license to nurses with multistate privilege. Can an RN with msp be the basis for issuing an autonomous NP license?
    - Will NP under supervisory model in another state impact endorsement?
- Practice Agreements – Provides editorial changes to 18VAC90-30-120 A & C (pg 2 of letter)
- Consider substituting "independent" for "autonomous" ie "licensed independent practitioners"

American Academy of Pediatrics

- Amendment: "While a party to such practice agreement, the patient care team physician routinely practiced with a patient population *and in a primary care or specialty practice area* included within the category, as specified in 18VAC90-30-70 . . ."
- Reverse FT – should be 2,000/10,000 hours
- NPs need to show proficiency before they transition – need for ongoing competency and how that is measured i.e. continuing education

Virginia College of Emergency Physicians

- 5 years FT should be 2,000 yr/10,000
- Specifications for MD specialty and NP licensure – "patient population" is not clear enough Acute/emergent/primary/chronic/preventative?? Clear guidelines needed
- Requesting an amendment with same verbiage as American Academy of Pediatrics re primary/specialty practice
- Attestation of 5 years – clear, objective, and reproducible – NPs need board certification exams like those of MDs

80 Letters from Physicians/Medical Students

- Same as MSV list of 6 areas of concern

70 other commenters (numerous NPs) in support of current regs – no further barriers to practice – support regs as recommended by the RAP

Agenda Item: Consideration of Statutory Amendments

Staff Note: This item is intended to be a placeholder. The Committee may discuss amendments to Code Sections 54.1-2900 for the definition of athletic training, 54.1-2909 to update the designation of the Board's practitioner monitoring program and strike redundant language already ensconced in 54.1-2908, to strike 54.1-2923.1 which is an outdated reference to programs for impaired practitioners, and 54.1-2957.19 to include predecessor credentialing organizations and to remove loss of active candidate status as the trigger for loss of a temporary license for genetic counselors. On the following pages you will find drafts of the proposed amendments to 54.1-2900, 54.1-2909 & 2908, the full text of 54.1-2923.1, and amendments to 54.1-2957.19. There may be further handouts at the meeting.

Board Action: To consider the amendments as presented and vote to approve or decline.

2019 Session of the General Assembly

Department of Health Professions
Board of Medicine

A BILL to amend the *Code of Virginia* by amending § 54.1-2900, relating to the definition of the practice of athletic training.

Be it enacted by the General Assembly of Virginia:

That § 54.1-2900 of the *Code of Virginia* is amended and reenacted as follows:

As used in this chapter, unless the context requires a different meaning:

"Acupuncturist" means an individual approved by the Board to practice acupuncture. This is limited to "licensed acupuncturist" which means an individual other than a doctor of medicine, osteopathy, chiropractic or podiatry who has successfully completed the requirements for licensure established by the Board (approved titles are limited to: Licensed Acupuncturist, Lic.Ac., and L.Ac.).

"Auricular acupuncture" means the subcutaneous insertion of sterile, disposable acupuncture needles in predetermined, bilateral locations in the outer ear when used exclusively and specifically in the context of a chemical dependency treatment program.

"Board" means the Board of Medicine.

"Certified nurse midwife" means an advanced practice registered nurse who is certified in the specialty of nurse midwifery and who is jointly licensed by the Boards of Medicine and Nursing as a nurse practitioner pursuant to § 54.1-2957.

"Certified registered nurse anesthetist" means an advanced practice registered nurse who is certified in the specialty of nurse anesthesia, who is jointly licensed by the Boards of Medicine and Nursing as a nurse practitioner pursuant to § 54.1-2957, and who practices under the supervision of a doctor of medicine, osteopathy, podiatry, or dentistry but is not subject to the practice agreement requirement described in § 54.1-2957.

"Genetic counselor" means a person licensed by the Board to engage in the practice of genetic counseling.

"Healing arts" means the arts and sciences dealing with the prevention, diagnosis, treatment and cure or alleviation of human physical or mental ailments, conditions, diseases, pain or infirmities.

"Medical malpractice judgment" means any final order of any court entering judgment against a licensee of the Board that arises out of any tort action or breach of contract action for personal injuries or wrongful death, based on health care or professional services rendered, or that should have been rendered, by a health care provider, to a patient.

"Medical malpractice settlement" means any written agreement and release entered into by or on behalf of a licensee of the Board in response to a written claim for money damages that arises out of any personal injuries or wrongful death, based on health care or professional services rendered, or that should have been rendered, by a health care provider, to a patient.

"Nurse practitioner" means an advanced practice registered nurse who is jointly licensed by the Boards of Medicine and Nursing pursuant to § 54.1-2957.

"Occupational therapy assistant" means an individual who has met the requirements of the Board for licensure and who works under the supervision of a licensed occupational therapist to assist in the practice of occupational therapy.

"Patient care team" means a multidisciplinary team of health care providers actively functioning as a unit with the management and leadership of one or more patient care team physicians for the purpose of providing and delivering health care to a patient or group of patients.

"Patient care team physician" means a physician who is actively licensed to practice medicine in the Commonwealth, who regularly practices medicine in the Commonwealth, and who provides management and leadership in the care of patients as part of a patient care team.

"Physician assistant" means an individual who has met the requirements of the Board for licensure and who works under the supervision of a licensed doctor of medicine, osteopathy, or podiatry.

"Practice of acupuncture" means the stimulation of certain points on or near the surface of the body by the insertion of needles to prevent or modify the perception of pain or to normalize physiological functions, including pain control, for the treatment of certain ailments or conditions of the body and includes the techniques of

electroacupuncture, cupping and moxibustion. The practice of acupuncture does not include the use of physical therapy, chiropractic, or osteopathic manipulative techniques; the use or prescribing of any drugs, medications, serums or vaccines; or the procedure of auricular acupuncture as exempted in § 54.1-2901 when used in the context of a chemical dependency treatment program for patients eligible for federal, state or local public funds by an employee of the program who is trained and approved by the National Acupuncture Detoxification Association or an equivalent certifying body.

"Practice of athletic training" means the prevention, recognition, evaluation, and treatment of injuries or conditions related to athletic, ~~or~~ recreational or occupational activity that requires physical skill and utilizes strength, power, endurance, speed, flexibility, range of motion or agility ~~or a substantially similar injury or condition resulting from occupational activity~~ immediately upon the onset of such injury or condition; and subsequent treatment and rehabilitation of such injuries or conditions under the direction of the patient's physician or under the direction of any doctor of medicine, osteopathy, chiropractic, podiatry, or dentistry, while using heat, light, sound, cold, electricity, exercise or mechanical or other devices.

"Practice of behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

"Practice of chiropractic" means the adjustment of the 24 movable vertebrae of the spinal column, and assisting nature for the purpose of normalizing the transmission of nerve energy, but does not include the use of surgery, obstetrics, osteopathy or the administration or prescribing of any drugs, medicines, serums or vaccines. "Practice of chiropractic" shall include performing the physical examination of an applicant for a commercial driver's license or commercial learner's permit pursuant to § 46.2-341.12 if the practitioner has (i) applied for and received certification as a medical examiner pursuant to 49 C.F.R. Part 390, Subpart D and (ii) registered with the National Registry of Certified Medical Examiners.

"Practice of genetic counseling" means (i) obtaining and evaluating individual and family medical histories to assess the risk of genetic medical conditions and diseases in a patient, his offspring, and other family members; (ii) discussing the features, history, diagnosis, environmental factors, and risk management of genetic medical conditions and diseases; (iii) ordering genetic laboratory tests and other diagnostic studies necessary for genetic assessment; (iv) integrating the results with personal and family

medical history to assess and communicate risk factors for genetic medical conditions and diseases; (v) evaluating the patient's and family's responses to the medical condition or risk of recurrence and providing client-centered counseling and anticipatory guidance; (vi) identifying and utilizing community resources that provide medical, educational, financial, and psychosocial support and advocacy; and (vii) providing written documentation of medical, genetic, and counseling information for families and health care professionals.

"Practice of medicine or osteopathic medicine" means the prevention, diagnosis and treatment of human physical or mental ailments, conditions, diseases, pain or infirmities by any means or method.

"Practice of occupational therapy" means the therapeutic use of occupations for habilitation and rehabilitation to enhance physical health, mental health, and cognitive functioning and includes the evaluation, analysis, assessment, and delivery of education and training in basic and instrumental activities of daily living; the design, fabrication, and application of orthoses (splints); the design, selection, and use of adaptive equipment and assistive technologies; therapeutic activities to enhance functional performance; vocational evaluation and training; and consultation concerning the adaptation of physical, sensory, and social environments.

"Practice of podiatry" means the prevention, diagnosis, treatment, and cure or alleviation of physical conditions, diseases, pain, or infirmities of the human foot and ankle, including the medical, mechanical and surgical treatment of the ailments of the human foot and ankle, but does not include amputation of the foot proximal to the transmetatarsal level through the metatarsal shafts. Amputations proximal to the metatarsal-phalangeal joints may only be performed in a hospital or ambulatory surgery facility accredited by an organization listed in § 54.1-2939. The practice includes the diagnosis and treatment of lower extremity ulcers; however, the treatment of severe lower extremity ulcers proximal to the foot and ankle may only be performed by appropriately trained, credentialed podiatrists in an approved hospital or ambulatory surgery center at which the podiatrist has privileges, as described in § 54.1-2939. The Board of Medicine shall determine whether a specific type of treatment of the foot and ankle is within the scope of practice of podiatry.

"Practice of radiologic technology" means the application of ionizing radiation to human beings for diagnostic or therapeutic purposes.

"Practice of respiratory care" means the (i) administration of pharmacological, diagnostic, and therapeutic agents related to respiratory care procedures necessary to implement a treatment, disease prevention, pulmonary rehabilitative, or diagnostic

regimen prescribed by a practitioner of medicine or osteopathic medicine; (ii) transcription and implementation of the written or verbal orders of a practitioner of medicine or osteopathic medicine pertaining to the practice of respiratory care; (iii) observation and monitoring of signs and symptoms, general behavior, general physical response to respiratory care treatment and diagnostic testing, including determination of whether such signs, symptoms, reactions, behavior or general physical response exhibit abnormal characteristics; and (iv) implementation of respiratory care procedures, based on observed abnormalities, or appropriate reporting, referral, respiratory care protocols or changes in treatment pursuant to the written or verbal orders by a licensed practitioner of medicine or osteopathic medicine or the initiation of emergency procedures, pursuant to the Board's regulations or as otherwise authorized by law. The practice of respiratory care may be performed in any clinic, hospital, skilled nursing facility, private dwelling or other place deemed appropriate by the Board in accordance with the written or verbal order of a practitioner of medicine or osteopathic medicine, and shall be performed under qualified medical direction.

"Qualified medical direction" means, in the context of the practice of respiratory care, having readily accessible to the respiratory therapist a licensed practitioner of medicine or osteopathic medicine who has specialty training or experience in the management of acute and chronic respiratory disorders and who is responsible for the quality, safety, and appropriateness of the respiratory services provided by the respiratory therapist.

"Radiologic technologist" means an individual, other than a licensed doctor of medicine, osteopathy, podiatry, or chiropractic or a dentist licensed pursuant to Chapter 27 (§ 54.1-2700 et seq.), who (i) performs, may be called upon to perform, or is licensed to perform a comprehensive scope of diagnostic or therapeutic radiologic procedures employing ionizing radiation and (ii) is delegated or exercises responsibility for the operation of radiation-generating equipment, the shielding of patient and staff from unnecessary radiation, the appropriate exposure of radiographs, the administration of radioactive chemical compounds under the direction of an authorized user as specified by regulations of the Department of Health, or other procedures that contribute to any significant extent to the site or dosage of ionizing radiation to which a patient is exposed.

"Radiologic technologist, limited" means an individual, other than a licensed radiologic technologist, dental hygienist, or person who is otherwise authorized by the Board of Dentistry under Chapter 27 (§ 54.1-2700 et seq.) and the regulations pursuant thereto, who performs diagnostic radiographic procedures employing equipment that emits ionizing radiation that is limited to specific areas of the human body.

"Radiologist assistant" means an individual who has met the requirements of the Board for licensure as an advanced-level radiologic technologist and who, under the direct supervision of a licensed doctor of medicine or osteopathy specializing in the field of radiology, is authorized to (i) assess and evaluate the physiological and psychological responsiveness of patients undergoing radiologic procedures; (ii) evaluate image quality, make initial observations, and communicate observations to the supervising radiologist; (iii) administer contrast media or other medications prescribed by the supervising radiologist; and (iv) perform, or assist the supervising radiologist to perform, any other procedure consistent with the guidelines adopted by the American College of Radiology, the American Society of Radiologic Technologists, and the American Registry of Radiologic Technologists.

"Respiratory care" means the practice of the allied health profession responsible for the direct and indirect services, including inhalation therapy and respiratory therapy, in the treatment, management, diagnostic testing, control, and care of patients with deficiencies and abnormalities associated with the cardiopulmonary system under qualified medical direction.

2019 Session of the General Assembly

Department of Health Professions

A BILL to amend the *Code of Virginia* by amending § 54.1-2909, relating to the reporting requirements for the Board of Medicine.

Be it enacted by the General Assembly of Virginia:

That § 54.1-2909 of the *Code of Virginia* is amended and reenacted as follows:

§ 54.1-2909. Further reporting requirements; civil penalty; disciplinary action.

A. The following matters shall be reported within 30 days of their occurrence to the Board:

1. Any disciplinary action taken against a person licensed under this chapter in another state or in a federal health institution or voluntary surrender of a license in another state while under investigation;

2. Any malpractice judgment against a person licensed under this chapter;

3. Any settlement of a malpractice claim against a person licensed under this chapter; and

4. Any evidence that indicates a reasonable probability that a person licensed under this chapter is or may be professionally incompetent; has engaged in intentional or negligent conduct that causes or it likely to cause injury to a patient or patients; has engaged in unprofessional conduct; or may be mentally or physically unable to engage safely in the practice of his profession.

The reporting requirements set forth in this section shall be met if these matters are reported to the National Practitioner Data Bank under the Health Care Quality Improvement Act, 42 U.S.C. § 11101 et seq., and notice that such a report has been submitted is provided to the Board.

B. The following persons and entities are subject to the reporting requirements set forth in this section:

1. Any person licensed under this chapter who is the subject of a disciplinary action, settlement, judgment or evidence for which reporting is required pursuant to this section;

2. Any other person licensed under this chapter, except as provided ~~in the protocol agreement entered into by the Medical Society of Virginia and the Board for the Operation of the Impaired Physicians Program~~ by a contract agreement with the Health Practitioner Monitoring Program;

3. ~~The presidents of all professional societies in the Commonwealth, and their component societies whose members are regulated by the Board, except as provided for in the protocol agreement entered into by the Medical Society of Virginia and the Board for the Operation of the Impaired Physicians Program~~;

~~4.~~ All health care institutions licensed by the Commonwealth;

~~5.~~4. The malpractice insurance carrier of any person who is the subject of a judgment or settlement; and

~~6.~~5. Any health maintenance organization licensed by the Commonwealth.

C. No person or entity shall be obligated to report any matter to the Board if the person or entity has actual notice that the matter has already been reported to the Board.

D. Any report required by this section shall be in writing directed to the Board, shall give the name and address of the person who is the subject of the report and shall describe the circumstances surrounding the facts required to be reported. Under no circumstances shall compliance with this section be construed to waive or limit the privilege provided in § 8.01-581.17.

E. Any person making a report required by this section, providing information pursuant to an investigation or testifying in a judicial or administrative proceeding as a result of such report shall be immune from any civil liability or criminal prosecution resulting therefrom unless such person acted in bad faith or with malicious intent.

F. The clerk of any circuit court or any district court in the Commonwealth shall report to the Board the conviction of any person known by such clerk to be licensed under this chapter of any (i) misdemeanor involving a controlled substance, marijuana or substance abuse or involving an act of moral turpitude or (ii) felony.

G. Any person who fails to make a report to the Board as required by this section shall be subject to a civil penalty not to exceed $5,000. The Director shall report the assessment of such civil penalty to the Commissioner of the Department of Health or the Commissioner of Insurance at the State Corporation Commission. Any person assessed a civil penalty pursuant to this section shall not receive a license, registration or certification or renewal of such unless such penalty has been paid.

H. Disciplinary action against any person licensed, registered or certified under this chapter shall be based upon the underlying conduct of the person and not upon the report of a settlement or judgment submitted under this section.

(1986, c. 434, § 54-317.4:1; 1988, c. 765; 1998, c. 744; 2003, cc. 753, 762.)

Code of Virginia
Title 54.1. Professions and Occupations
Chapter 29. Medicine and Other Healing Arts

§ 54.1-2908. Reports of disciplinary action against health professionals; immunity from liability; civil penalty.

A. The president of the Medical Society of Virginia, the Osteopathic Medical Association, the Virginia Chiropractors Association, Inc., and the Virginia Podiatric Medical Association shall report within 30 days to the Board of Medicine any disciplinary action taken by his organization against any member of his organization licensed under this chapter if such disciplinary action is a result of conduct involving intentional or negligent conduct that causes or is likely to cause injury to a patient or patients, professional ethics, professional incompetence, moral turpitude, drug addiction or alcohol abuse.

B. The president of any association, society, academy or organization shall report within 30 days to the Board of Medicine any disciplinary action taken against any of its members licensed under this chapter if such disciplinary action is a result of conduct involving intentional or negligent conduct that causes or is likely to cause injury to a patient or patients, professional ethics, professional incompetence, moral turpitude, drug addiction or alcohol abuse.

C. Any report required by this section shall be in writing directed to the Board of Medicine, shall give the name and address of the person who is the subject of the report and shall fully describe the circumstances surrounding the facts required to be reported. The report shall include the names and contact information of individuals with knowledge about the facts required to be reported and the names and contact information of all individuals from whom the association, society, academy, or organization sought information to substantiate the facts required to be reported. All relevant medical records maintained by the reporting entity shall be attached to the report if patient care or the health professional's health status is at issue. The reporting association, society, academy or organization shall also provide notice to the Board that it has submitted any required report to the National Practitioner Data Bank under the Health Care Quality Improvement Act, 42 U.S.C. § 11101 et seq.

The reporting association, society, academy or organization shall give the health professional who is the subject of the report an opportunity to review the report. The health professional may submit a separate report if he disagrees with the substance of the report.

D. No person or entity shall be obligated to report any matter to the Board if the person or entity has actual notice that the matter has already been reported to the Board.

E. Any person making a report required by this section, providing information pursuant to an investigation or testifying in a judicial or administrative proceeding as a result of such report shall be immune from any civil liability resulting therefrom unless such person acted in bad faith or with malicious intent.

F. In the event that any organization enumerated in subsection A or any component thereof receives a complaint against one of its members, such organization may, in lieu of considering disciplinary action against such member, request that the Board investigate the matter pursuant to this chapter, in which event any person participating in the decision to make such a request or testifying in a judicial or administrative proceeding as a result of such request shall be immune from any civil liability alleged to have resulted therefrom unless such person acted in bad faith or with malicious intent.

G. Any person who fails to make a report to the Board as required by this section shall be subject to a civil penalty not to exceed $5,000. Any person assessed a civil penalty pursuant to this section shall not receive a license, registration or certification or renewal of such from any health regulatory board unless such penalty has been paid.

1977, c. 639, § 54-317.4; 1978, c. 541; 1983, c. 40; 1986, c. 434; 1988, c. 765; 1996, cc. 937, 980; 2000, c. 688; 2003, cc. 753, 762.

The chapters of the acts of assembly referenced in the historical citation at the end of this section may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

7/25/2018

Code of Virginia
Title 54.1. Professions and Occupations
Chapter 29. Medicine and Other Healing Arts

§ 54.1-2923.1. Programs for impaired practitioners.

A. The Board may implement an impaired practitioners program for persons regulated under this chapter. For this purpose, the Board may enter into contracts with a nonprofit corporation or professional organization which may include, but need not be limited to, the following components:

1. A requirement that the contractor enter into contracts with providers of treatment;

2. Evaluation of reports of suspected impairment;

3. Intervention in cases of verified impairment;

4. Referrals of impaired practitioners to treatment programs;

5. Monitoring of the treatment and rehabilitation of impaired practitioners, including any practitioners ordered to enter the program by the Board;

6. Post-treatment monitoring and support of rehabilitated impaired practitioners;

7. Performance of such other activities as may be agreed upon by the Board; and

8. Provision of prevention and education services.

B. Any contract executed pursuant to subsection A shall be financed by a surcharge on each license or certificate issued under this chapter. Such funds shall be used solely for the implementation of the impaired practitioners program.

1997, c. 469.

2019 Session of the General Assembly

Department of Health Professions

A BILL to amend the *Code of Virginia* by amending § 54.1-2957.19, relating to the accreditation of educational programs in genetic counseling.

Be it enacted by the General Assembly of Virginia:

That § 54.1-2957.19 of the *Code of Virginia* is amended and reenacted as follows:

§ 54.1-2957.19. Genetic counseling; regulation of the practice; license required; licensure; temporary license.

A. The Board shall adopt regulations governing the practice of genetic counseling, upon consultation with the Advisory Board on Genetic Counseling. The regulations shall (i) set forth the requirements for licensure to practice genetic counseling, (ii) provide for appropriate application and renewal fees, (iii) include requirements for licensure renewal and continuing education, (iv) be consistent with the American Board of Genetic Counseling's current job description for the profession and the standards of practice of the National Society of Genetic Counselors, and (v) allow for independent practice.

B. It shall be unlawful for a person to practice or hold himself out as practicing genetic counseling in the Commonwealth without a valid, unrevoked license issued by the Board. No unlicensed person may use in connection with his name or place of business the title "genetic counselor," "licensed genetic counselor," "gene counselor," "genetic consultant," or "genetic associate" or any words, letters, abbreviations, or insignia indicating or implying a person holds a genetic counseling license.

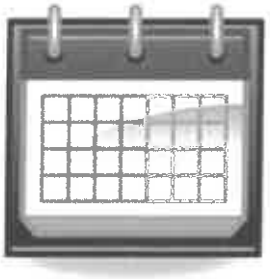
C. An applicant for licensure as a genetic counselor shall submit evidence satisfactory to the Board that the applicant (i) has earned a master's degree from a genetic counseling training program that is accredited by the Accreditation Council of Genetic Counseling, or its predecessor organizations, and (ii) holds a current, valid certificate issued by the American Board of Genetic Counseling or American Board of Medical Genetics to practice genetic counseling.

D. The Board shall waive the requirements of a master's degree and American Board of Genetic Counseling or American Board of Medical Genetics certification for license applicants who (i) apply for licensure before December 31, 2018, or within 90 days of the effective date of the regulations promulgated by the Board pursuant to subsection A, whichever is later; (ii) comply with the Board's regulations relating to the National Society of Genetic Counselors Code of Ethics; (iii) have at least 20 years of documented work experience practicing genetic counseling; (iv) submit two letters of recommendation, one from a genetic counselor and another from a physician; and (v) have completed, within the last five years, 25 hours of continuing education approved by the National Society of Genetic Counselors or the American Board of Genetic Counseling.

E. The Board may grant a temporary license to an applicant who has been granted Active Candidate Status by the American Board of Genetic Counseling and has paid the temporary license fee. Temporary licenses shall be valid for a period of up to one year. ~~An applicant shall not be eligible for temporary license renewal upon expiration of Active Candidate Status as defined by the American Board of Genetic Counseling.~~ A temporary license shall expire twelve months from issuance or upon failure of the American Board of Genetic Counseling examination, whichever comes first. A person practicing genetic counseling under a temporary license shall be supervised by a licensed genetic counselor or physician.

Next Meeting Date of the Executive Committee is

December 7, 2018



Please check your calendars and advise staff of any known conflicts that may affect your attendance.

The travel regulations require that "travelers must submit the Travel Expense Reimbursement Voucher with 30 days after completion of their trip". (CAPP Topic 20335, State Travel Regulations, p.7)

In order for the agency to be in compliance with the state travel regulations, please submit your request for today's meeting no later than

August 31, 2018