Committee of Joint Boards of Nursing and Medicine
and Advisory Committee of the Joint Boards of Nursing and Medicine

Department of Health Professions
Perimeter Center - 9960 Mayland Drive, Conference Center, Suite 201, Henrico, Virginia 23233

Business Meeting Agenda
February 8, 2017 at 9:00 A.M. in Board Room 2

Call To Order - Louise Hershkowitz, CRNA, MSHA; Chair

Establishment of Quorum

Review of Minutes

- December 7, 2016 Business Meeting

Public Comment

Dialogue with Agency Director

Old Business:

- Revision to Guidance Document 90-56 (Practice Agreements) based on Board of Nursing action – Ms. Yeatts/Ms. Douglas
- Board of Medicine FAQ's related to Controlled Substances CE requirements for Nurse Practitioners

New Business

- The Opioid Public Health Crisis and the CARA Act, Implications for Virginia - S. Hughes Melton, MD, MBA, FAAFP, FABAM, Chief Deputy Commissioner, Office of the Commissioner, Virginia Department of Health
- Regulatory Update and 2017 General Assembly Report – Ms. Yeatts
- Emergency Regulations for Nurse Practitioners with Prescriptive Authority: Pain Management, Opioid Treatment, use of Buprenorphine – Ms. Yeatts

Information Only Materials:

- NCSBN CARA Implementation: Educational Opportunities for Meeting Federal Requirements
- DEA Advisory regarding renewal of DEA numbers
- Changes in name of certifying body AANPCP to AANPCB
- NCSBN Annual APRN Certification Examination Report Data
- NCSBN APRN Roundtable Meeting, April 4, 2017, in Rosemont, IL – Ms. Hershkowitz attending
- Veterans Administration APRN Revised Rules

Probable Cause Case Review (Joint Board Members Only)

Adjourn

Our mission is to ensure safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to health care practitioners and the public.

Here you will find a **DRAFT AGENDA** and a **DRAFT PACKET OF SUPPORTING MATERIALS**. This information is in the **DRAFT** form and is subject to change.

DRAFT

VIRGINIA BOARD OF NURSING
COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
MINUTES
December 7, 2016

TIME AND PLACE: The meeting of the Committee of the Joint Boards of Nursing and Medicine was convened at 9:30 A.M., December 7, 2016 in Board Room 4, Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

MEMBERS PRESENT:
Louise Hershkowitz, CRNA. MSHA; Chair
Marie Gerardo, MS, RN, ANP-BC
Rebecca Poston, PhD, RN, CPNP
Wayne Reynolds, DO
Kenneth Walker, MD

MEMBERS ABSENT: Lori D. Conklin, MD

ADVISORY COMMITTEE MEMBERS PRESENT:
Joseph F. Borzelleca, Jr., MD, MPH
Kevin E. Brigle, RN, NP
Mark Coles, RN, BA, MSN, NP-C
Wendy Dotson, CNM, MSN
David A. Ellington, MD
Sarah E. Hobgood, MD
Tom Watters, RN, CRNA

STAFF PRESENT:
Jay P. Douglas, MSM, RN, CSAC, FRE; Executive Director; Board of Nursing
Stephanie Willinger, Deputy Executive Director, Board of Nursing
Huong Vu, Executive Assistant; Board of Nursing

OTHERS PRESENT:
Charis Mitchell, Assistant Attorney General; Board Counsel
David Brown, DC; Director; Department of Health Professions
Elaine Yeatts, Senior Policy Analyst, Department of Health Professions

IN THE AUDIENCE:
Lynn Poole, FNP-BC
Richard Grossman, Virginia Council of Nurse Practitioners (VCNP)
Tyler Cox, Medical Society of Virginia (MSV)
Mary Duggan, American Association of Nurse Practitioners (AANP) State Representative
Caroline Perrin, MWC
Sarah Heisler, Virginia Hospital and Healthcare Association (VHHA)

DIALOGUE WITH AGENCY DIRECTOR:
Opioid Crisis – Dr. Brown reported that the State Health Commissioner, Dr. Marrisa Levine, declared the Virginia opioid addiction crisis a public health emergency and issued a standing order that allows all Virginians to obtain the drug Naloxone that is used to treat narcotic overdoses in emergency situations.

Dr. Brown noted that in 2015, there were 809 fatalities from opioid overdose, up from 515 in 2007. He added that the projected fatal overdose from opioid in 2016 is over 1000.

Dr. Brown said that through Prescription Monitoring Program (PMP), DHP has made it harder for doctor shopping to occur in order to obtain opioids. He added that data from PMP is used to identify outlier prescribers and criteria to be used in disciplinary cases.

Dr. Brown stated that last General Assembly, the law was passed to require Board of Medicine (BOM) to identify licensees with prescriptive authority that should complete two continuing education hours in controlled substance prescribing. He added that BOM has developed a Task Force focuses on assisting practitioners on how to properly treat opioid addiction with buprenorphine products in the context of medication-assisted therapy.

Dr. Brown commented that Board of Medicine is moving forward with regulations on the use of buprenorphine.

Dr. Brown left the meeting.

ESTABLISHMENT OF A QUORUM:

Ms. Hershkowitz called the meeting to order and established a quorum was present. Ms. Hershkowitz welcomed Dr. Ellington acknowledging this was his first meeting.

INTRODUCTIONS: Committee members, Advisory Committee members and staff members introduced themselves.

REVIEW OF MINUTES:

The minutes of June 8, 2016 and October 12, 2016 were reviewed. Dr. Reynolds moved to accept the minutes as presented. The motion was seconded and carried unanimously.

PUBLIC COMMENT: There was no one present that wished to address the Board.

OLD BUSINESS: **Consideration of elimination of separate licenses for Nurse Practitioners and Prescriptive Authority (PA):**

Ms. Douglas stated that at the last meeting, the Board asked for information obtained related to the question that was raised regarding if a separate prescriptive authority license is needed. Ms. Douglas noted that if a licensee wishes to have the Prescriptive Authority, he/she must first obtain the Registered Nurse (RN) license or holds a multi-state privilege from a compact state. Then applies for a Nurse Practitioner (NP) license and if wishes to execute prescriptive authority, must apply for a third license. Ms. Douglas stated for the past two years, $126,000 and $143,000 in revenue was generated by prescriptive authority licensees and noted that Board of Nursing current budget balance is healthy. Ms.

Douglas shared information from National Council of State Board of Nursing indicating the majority of 27 states do have some mechanism for a separate process for obtaining authorization for prescriptive authority, not necessarily a separate license. Ms. Douglas reported that the total numbers of licensed nurse practitioners (LNPs) as of November 29, 2016 is 9,272 of which 6,325 LNPs have prescriptive authority. There are 1,951 Certified Registered Nurse Anesthetists (CRNAs) who do not have prescriptive authority and 996 LNPs without prescriptive authority that are licensed in categories other than CRNA.

The Committee generally discussed the advantages and disadvantages of a separate license. Dr. Reynolds stated that he supports the combined license. He commented that it is an administrative burden and burdensome and confusing for nurse practitioners (NPs) to apply for the third license. Ms. Gerardo expressed agreement with Dr. Reynolds. Dr. Hobgood asked if NPs are trained about prescriptive authority during their education program.

Ms. Douglas noted that if use of a separate license was discontinued, there could still be a mechanism to differentiate through the licensure database and the website those with prescriptive authority. She commented that as NP education has advanced over the years, basic NP education now includes pharmacology.

Dr. Reynolds motioned to move forward with the recommendation to combine NP and PA. The motion was seconded and passed unanimously.

Ms. Douglas said that the next step is for Ms. Mitchell, Board Counsel, to review the Code to identify any statutory barriers. Staff will further assess fiscal and operational factors and seek any necessary DHP approval.

Consideration of BOM rationale for amendment to Guidance Document (GD) 90-56 (Practice Agreements):

Ms. Yeatts reviewed the GD 90-56 which was adopted by the Board of Nursing (BON) in July. She added that it was presented to the Board of Medicine (BOM) for adoption because Licensed Nurse Practitioners (LNPs) are jointly regulated by BON and BOM. She noted that in August the BOM modified the GD to delete inclusion of "authorization to write DNR orders" for practice agreement for an LNP in the category of CNM. She said that it was presented to the BON in September, the BON stayed with its original decision, and asked staff to request the BOM to provide rational for their action.

Ms. Yeatts noted that the OB/GYNs on the BOM stated that they would not usually write DNR orders since the patient is co-managed by primary physician. She stated that there are two options to consider:

- The appropriateness of DNR for CNM to write; and
- Separating sections in GD 90-56 to differentiate between "should" and "may" activities for inclusion in a practice agreement.

Ms. Dotson commented that it is not needed or appropriate for a CNM. Dr. Borzelleca and Mr. Coles noted that certain situations in hospitalized patient where the CNM might have the primary relationship with the patients and therefore the ability to write the DNR order would be appropriate.

Ms. Yeatts noted that an omission of something in a GD does not prohibit the activity. Ms. Mitchell added that if something is not referenced in GD, it does not prevent CNM to have it included in a practice agreement.

Dr. Walker moved to delete "authorization to write DNR orders" in the practice agreement for an LNP in the category of CNM. The motion was seconded and passed unanimously.

Dr. Reynolds moved to revise the GD to differentiate between "should" and "may" sections. The motion was seconded and passed unanimously.

Ms. Yeatts said the revision of the GD will be forwarded to the BON and BOM for approval after staff make the changes. All agreed.

RECESS: The Board recessed at 10:34 A.M.

RECONVENTION: The Board reconvened at 10:49 A.M.

NEW BUSINESS: **Nominations for Replacement of Physician and Nurse Practitioner Advisory Committee Members:**

Ms. Douglas reviewed the regulations indicating the Committee of the Joint Boards and the Advisory Committee composition.

A recommendation for the vacant physician position on the Advisory Committee was submitted by Dr. Hobgood for Thokozeni Lipato. In addition, Stuart Mackler had previously indicated his interest in serving on the Advisory Committee once his Board of Medicine term was completed, but has not submitted his CV for review. Dr. Reynolds and Dr. Walker spoke in support of Dr. Mackler. Dr. Hobgood spoke in support of Dr. Lipato.

Ms. Hershkowitz asked for the hand vote in favor of Dr. Lipato. There was one vote of yes out of six.

Ms. Hershkowitz asked for the hand vote in favor of Dr. Mackler. There were four votes of yes out of six.

Recommendation for a nurse practitioner to replace Dr. Watters on Advisory Committee was submitted by the VANA for Cathy Harrison, CRNA.

Ms. Dotson left the meeting.

Dr. Watters recommended Dr. Harrison highly.

Ms. Hershkowitz asked for the hand vote in favor of Dr. Harrison. There were five votes of yes out six.

Committee Members discussed the need for Advisory Committee Members in the future and encouraged Dr. Lipato to reapply. Ms. Hershkowitz thanked Mr. Watters for his years of service.

Review of Comprehensive Addiction and Recovery Act (CARA); implications for Nurse Practitioners with prescriptive authority:
Ms. Douglas noted that this is provided as information only and no action is needed. She then referred the Committee to Sec. 303 of the law and noted that there will be more discussion between agencies regarding this section and DHP has not taken any position on this matter. Ms. Douglas added that NPs would need to comply with federal requirements in order to be qualified providers.

Recommendation from BON regarding licensure renewal continued competency requirements related to pharmacology. Should there be a requirement that includes course content in Substance Abuse Disorders and Opioid prescribing?:
Ms. Douglas stated that a 2016 new law now requires all licensees who prescribe to complete two hours of continuing education (CE) on the topics related to pain management, the responsible prescribing of controlled substances, and the diagnosis and management of addiction. Ms. Douglas added that this requirement includes NPs who have Prescriptive Authority. She noted that she was made aware of the notification that Dr. Harp, BOM Executive Director, plans to send by e-mails to all licensees who prescribe. She commented that there is not action needed at this time. The Committee agreed that this addresses the suggestion made by the BON.

Nurse Practitioner Licensure Update:
Ms. Willinger reported the following:

- There have been no complaints received recently from NPs;
- Complaints in the prior few months allowed for identification of issues and solutions for more efficient communication internally/externally and better management of application supporting documents;
- Solutions included:
  - process in place to track applications and to record the national certificate numbers and expiration dates in licensing database which also populates in the Prescriptive Authority license record which is helpful for renewal and audit purposes;
  - Applications and instructions were revised and streamlined to route supporting information to the correct email address closely monitored by licensing staff, inclusion of table in "paper" application with corresponding specialties, clarification of

process/requirements for NP exam and endorsement applications and for those current licensees adding specialties, inclusion of hyperlinks to applicable regulations and RN requirements and more concise online "checklist" viewed by online applicants;

- Licensing staff education regarding other states'/certifying agency's licensure/certification requirements and methods of verifying supporting information; and
- Data tracking of affirmative application answers for questions related to military service.

Regulatory Update:
Ms. Yeatts stated that there are no regulations outstanding for NPs and nothing additional to report.

Review of 2017 Joint Boards meeting dates:
Ms. Hershkowitz stated that a copy of the 2017 Joint Boards has been provided to all members. She noted that the next meeting is scheduled for Wednesday, February 8, 2017.

RECESS: The Board recessed at 11:25 A.M. Ms. Yeatts and Advisory Committee members left the meeting.

RECONVENTION: The Board reconvened at 11:30 A.M.

CONSIDERATION OF AGENCY SUBORDINATE RECOMMENDATION:

CLOSED MEETING: Dr. Poston moved that the Committee of the Joint Board of Nursing and Medicine convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 11:30 A.M., for the purpose of consideration of agency subordinate recommendation. Additionally, Dr. Poston moved that Ms. Douglas, Ms. Vu and Ms. Mitchell attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and carried unanimously.

RECONVENTION: The Board reconvened in open session at 11:45 A.M.

Dr. Poston moved that the Committee of the Joint Board of Nursing and Medicine certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded and carried unanimously.

Kimberly Maigi, LNP 0024-171831; Prescriptive Authority 0017-142639 (Virginia RN license 0001-254913)
Ms. Maigi did not appear.

Dr. Poston moved that the Committee of the Joint Board of Nursing and Medicine modify the recommended decision of the agency subordinate to delete reprimand and to impose monetary penalty of $100.00 to pay within 60 days from entry of the Order. The motion was seconded and carried unanimously.

Ms. Hershkowitz reminded available Board Members that assistance was needed with probable cause review following the meetings.

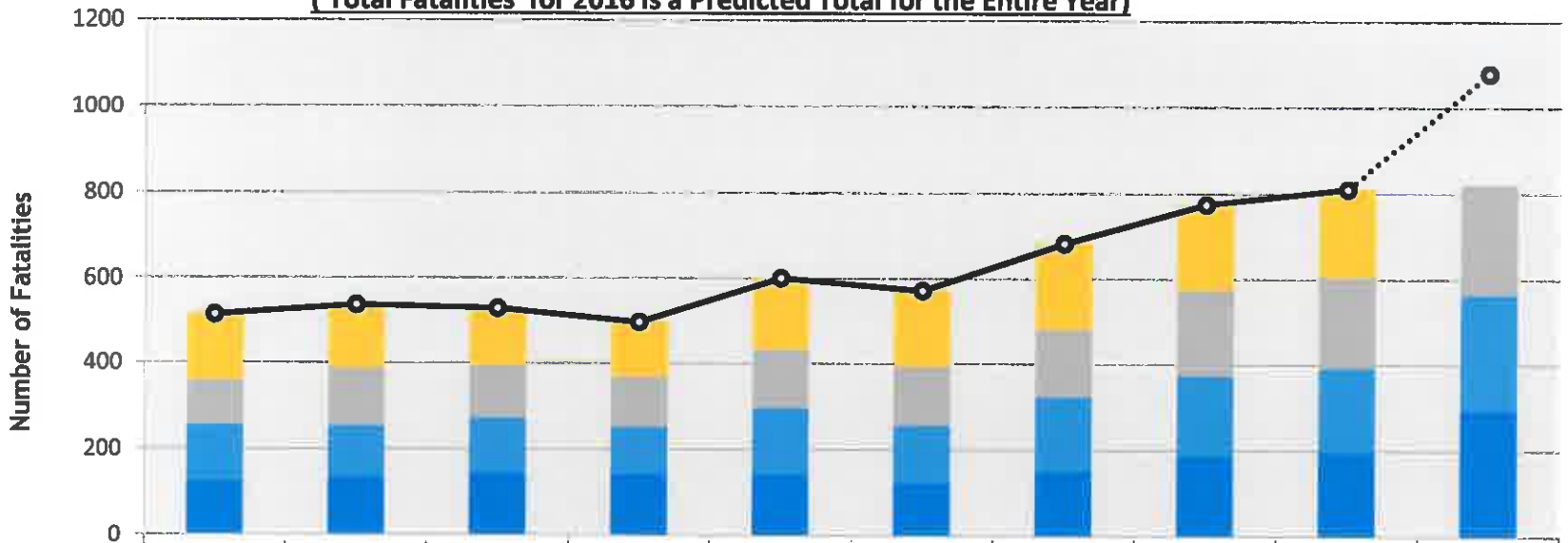
ADJOURNMENT: As there was no additional business, the meeting was adjourned at 11:46 A.M.

Jay P. Douglas, MSM, RN, CSAC, FRE
Executive Director

VIRGINIA
Department of Health Professions

VIRGINIA OPIOID OVERDOSE DEATHS

Total Number of Fatal Opioid Overdoses by Quarter and Year of Death, 2007-2016
('Total Fatalities' for 2016 is a Predicted Total for the Entire Year)



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016*
Q4	156	151	136	131	168	179	202	201	207	
Q3	104	134	122	116	136	137	158	202	213	259
Q2	130	120	128	109	156	134	173	185	195	270
Q1	125	133	144	142	141	122	150	187	196	293
Total Fatalities	515	538	530	498	601	572	683	775	811	1079

[1] 'All Opioids' include all versions of fentanyl, heroin, prescription opioids, and opioids unspecified
[2] 'Opioids Unspecified' are a small category of deaths in which the determination of heroin and/or one or more prescription opioids cannot be made due to specific circumstances of the death. Most commonly, these circumstances are a result of death several days after an overdose, in which the OCME cannot test for toxicology because the substances have been metabolized out of the decedent's system.
[3] Fatal opioid numbers have changed slightly from past reports due to the removal of fentanyl from the category of prescription opioids, as well as the addition of buprenorphine, levorphanol, meperidine, pentazocine, propoxyphene, and tapentadol added to the list of prescription opioids.

Guidance Document 90-56 (Practice Agreement)

Time Line

July 19, 2016 → Board of Nursing adopted GD 90-56 with changes to conform with 2016 changes in law.

August 5, 2016 → Board of Medicine modified to delete inclusion of "authorization to write DNR orders" in the guidance for practice agreement for LNP in the category of CNM.

September 20, 2016 → Board of Nursing rejected the modification, referred to the Joint Boards, and asked for Board of Medicine rationale for changes.

December 7, 2016 → Joint Boards revised changes in format and deleted reference to CNM's and DNR orders.

January 24, 2017 → Board of Nursing heard the public comment and further amended the GD. This version is to be presented for consideration by the Joint Boards at the February 8, 2017 meeting.

Guidance document: 90-56

Practice Agreement Requirements for Licensed Nurse Practitioners

Rejected by the Board of Nursing – January 24, 2017
Adopted by the Board of Medicine –

In the *Regulations Governing the Licensure of Nurse Practitioners, 18VAC 90-30-10 et seq.*, "Practice agreement" is defined as:

"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 nurse practitioners licensed in the category of certified nurse midwives, the practice agreement is a statement jointly developed with the consulting physician(s)."

A practice agreement is not required for nurse practitioners licensed in the category of certified registered nurse anesthetists.

The practice agreement for a licensed nurse practitioner (LNP) other than a certified nurse midwife (CNM) should include:

- A description of the procedures that the licensed nurse practitioner (LNP) will perform in accordance with his or her specialty training;
- Provisions for 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;
- Provisions for appropriate physician input in complex clinical cases and patient emergencies and for referrals;
- Categories of drugs and devices that may be prescribed;
- Guidelines for availability and ongoing communications that provide for and define consultation among the collaborating parties and the patient that address, at a minimum, the availability of the collaborating physician proportionate to such factors as practice setting, acuity, and geography;
- Provisions for periodic joint evaluation of services provided and review of patient care outcome;.
- Provisions for periodic review and revision of the practice agreement; and
- Written or electronic signature of the LNP(s) and the physician(s) or the name of the patient care team physician who has entered into the agreement with the licensed nurse practitioner.

The practice agreement may also include, but not be limited to:

- Authorization for the LNP's for signatures, certifications, stamps, verifications, affidavits and endorsements consistent with 18VAC90-30-122;
- Authorization to refer patients for physical therapy in accordance with § 54.1-3482; and
  Authorization to write DNR orders.

The LNP should consider identifying a back-up collaborating physician in the event of the unexpected departure of the patient care team physician. The practice agreement should either state the name or include the signature of the physician who will serve in the role of an alternative team physician in the event the primary team physician is no longer available for collaboration and consultation.

The practice agreement for an LNP in the category of CNM should include:.

- ~~A description of the procedures that the CNM will perform in accordance with his or her specialty training;~~
- ~~Provisions for appropriate physician input in complex clinical cases and patient emergencies and for referrals;~~
- Categories of drugs and devices that may be prescribed, if prescribing Schedule II through V drugs;
- Guidelines for availability and ongoing communications that provide for and define consultation and the availability of the physician for routine and urgent consultation on patient care;
- Provisions for periodic review and revision of the practice agreement; and
- Written or electronic signature of the CNM(s) and the physician(s) who has entered into the agreement.

The practice agreement may also include, but not be limited to:

- Authorization for the CNM's for signatures, certifications, stamps, verifications, affidavits and endorsements consistent with 18VAC90-30-122; and
- Authorization to refer patients for physical therapy in accordance with § 54.1-3482;

The CNM should consider identifying a back-up physician in the event of the unexpected departure of the consulting physician. The practice agreement should either state the name or include the signature of the physician who will serve in the role of an alternative consulting physician in the event the primary physician is no longer available for consultation.

The LNP is required to:

- Maintain the practice agreement.
- Make the practice agreement available for review by the Board of Nursing.
- Have a practice agreement with a patient care team physician (or for certified nurse midwives, a consulting physician) that includes the setting or settings in which the nurse practitioner is actively practicing.

It is not a requirement that a copy of the practice agreement be submitted to the Board of Nursing to obtain or renew the professional license.

Board of Medicine FAQ's related to Controlled Substances CE Requirements

Controlled Substances CE Requirements

Who has to complete this CE requirement?

The requirement to obtain 2 hours of Type 1 CE is applicable to all licensees of the Board of Medicine with prescriptive authority regardless of whether a licensee is engaged in clinical medicine, administration, or any other category of practice. However, interns and residents holding a training license are not required to complete this CE.

When do I have to complete the 2 hours of CE?

MD's, DO's, DPM's, PA's and NP's must complete 2 hours of Type 1 CE prior in the 24 months prior to your next renewal.

How will the Board know that I have taken the CE?

There will be a question in the renewal process to attest to having obtained the 2 hours of CE on controlled substances in the prior 24 months. For MD's, DO's, and DPM's, the question will appear when you renew your license in 2018. PA's renewing in the first 6 months of 2017 will not be expected to have completed the 2 hours of CE. However, those scheduled to renew in July through December of 2017 will see the question in the renewal process. Likewise, NP's renewing in the first 6 months of 2017 will not be expected to complete the 2 hours of CE, but those renewing July 2017 or later are expected to do so.

Do I have to submit evidence of my CE to the Board?

You are not required to submit evidence of your CE unless you receive an audit letter from the Board of Medicine.

What if I have done CE hours on pain management, proper prescribing of controlled substances, and the diagnosis and management of addiction previously?

The requirement is to obtain 2 hours of controlled substances CE in the next biennium, and the Board is interpreting that to be the 24 months prior to your next license renewal. The law went into effect July 1, 2016. So any CE on controlled substances taken on July 1, 2016 or thereafter will count towards the 2-hour requirement for the next biennium, as long as they fall within the 24-month timeframe.

Are these 2 hours of CE part of the required 30 Type 1 hours, or are they extra?

The 2 hours of controlled substances CE may be part of the 30 hours of Type 1 (CAT I).

Will the Board accept CE that I take to satisfy my licensure in another state?

Virginia licensees who live and practice in another state can satisfy the 2-hour requirement for controlled substances by obtaining Type 1 (CAT I) hours as long as it is done in the 24 months prior to your next license renewal.

Can I get an exemption?

There is no exemption from this CE requirement for doctors of medicine, osteopathy, podiatry, physician assistants, and nurse practitioners who hold active licenses. Retirement and lack of DEA registration do not exempt a licensee.

What if I have an inactive Virginia license?

Licensees with an inactive license are not required to obtain the 2 hours of controlled substances CE, because an inactive license does not confer prescriptive authority. However, if a licensee wishes to activate the license, he/she must attest to obtaining 2 hours of controlled substances CE in the 24 months prior to activation.

Can the Board send more links to other Type 1 (CAT I) CE courses/hours?

It is the responsibility of the licensee to find and complete the required hours of CE. The Board suggested that links to some CE resources be included in the notice describing this new requirement. The links include Type 1 and Type 2 activities which have useful information for all providers. However, the Type 2 activities do not meet the requirement of the law. Other opportunities to satisfy the requirement for Type 1 CE can be searched online.

VIRGINIAN'S PLAN FOR WELL-BEING MEASURES

VISION

By 2020, the percent of adults who report positive well-being increases (metric under development)

AIM 1 » Healthy, Connected Communities

Goal 1.1: VIRGINIA'S FAMILIES MAINTAIN ECONOMIC STABILITY

By 2020, the percent of Virginia high school graduates enrolled in an institute of higher education within 16 months after graduation increases from 70.9% to 75.0%

By 2020, the percent of cost-burdened households in Virginia (more than 30% of monthly income spent on housing costs) decreases from 31.4% to 29.0%

By 2020, the Consumer Opportunity Profile score in Virginia increases from 81.8% to 83.7%

By 2020, the Economic Opportunity Profile Score in Virginia increases from 70.7% to 73.7%

Goal 1.2: VIRGINIA'S COMMUNITIES COLLABORATE TO IMPROVE THE POPULATION'S HEALTH

By 2020, the percent of Virginia health planning districts that have established an on-going collaborative community health planning process increases from 43% to 100%

AIM 2 » Strong Start for Children

Goal 2.1: VIRGINIANS PLAN THEIR PREGNANCIES

By 2020, Virginia's teen pregnancy rate decreases from 27.9 to 25.1 pregnancies per 1,000 females ages 15 to 19 years

Goal 2.2: VIRGINIA'S CHILDREN ARE PREPARED TO SUCCEED IN KINDERGARTEN

By 2020, the percent of children in Virginia who do not meet the PALS K benchmarks in the fall of kindergarten and require literacy interventions decreases from 12.7% to 12.2%

By 2020, the percent of third graders in Virginia who pass the Standards of Learning third grade reading assessment increases from 69% to 80%

Goal 2.3: THE RACIAL DISPARITY IN VIRGINIA'S INFANT MORTALITY RATE IS ELIMINATED

By 2020, Virginia's Black Infant Mortality Rate equals the White Infant Mortality Rate

AIM 3 » Preventive Actions

Goal 3.1: VIRGINIANS FOLLOW A HEALTHY DIET AND LIVE ACTIVELY

By 2020, the percent of Virginia adults who did not participate in any physical activity during the past 30 days decreases from 23.5% to 20.0%

By 2020, the percent of Virginia adults who are overweight or obese decreases from 64.7% to 63.0%

By 2020, the percent of Virginia households that are food insecure for some part of the year decreases from 11.9% to 10.0%

Goal 3.2: VIRGINIA PREVENTS NICOTINE DEPENDENCY

By 2020, the percent of adults aged 18 years and older in Virginia who report using tobacco decreases from 21.9% to 12.0%

VIRGINIAN'S PLAN FOR WELL-BEING MEASURES

Goal 3.3: VIRGINIANS ARE PROTECTED AGAINST VACCINE-PREVENTABLE DISEASES

By 2020, the percent of adults in Virginia who receive an annual influenza vaccine increases from 48.2% to 70%

By 2020, the percent of girls aged 13-17 in Virginia who receive three doses of HPV vaccine increases from 35.9% to 80%

By 2020, the percent of boys aged 13-17 in Virginia who receive three doses of HPV vaccine increases from 22.5% to 80%

Goal 3.4: CANCERS ARE PREVENTED OR DIAGNOSED AT THE EARLIEST STAGE POSSIBLE

By 2020, the percent of adults aged 50 to 75 years in Virginia who receive colorectal cancer screening increases from 69.1% to 85.0%

Goal 3.5: VIRGINIANS HAVE LIFE-LONG WELLNESS

By 2020, the average years of disability-free life expectancy for Virginians increases from 66.1 years to 67.3 years

By 2020, the percent of adults in Virginia who report adverse childhood experiences decreases (metric under development)

AIM 4 » System of Health Care

Goal 4.1: VIRGINIA HAS A STRONG PRIMARY CARE SYSTEM LINKED TO BEHAVIORAL HEALTH CARE, ORAL HEALTH CARE, AND COMMUNITY SUPPORT SYSTEMS

By 2020, the percent of adults in Virginia who have a regular health care provider increases from 69.3% to 85.0%

By 2020, the rate of avoidable hospital stays for ambulatory care sensitive conditions in Virginia decreases from 1,294 to 1,100 per 100,000 persons

By 2020, the rate of avoidable deaths from heart disease, stroke, or hypertensive disease in Virginia decreases from 50 to 40 per 100,000 persons

By 2020, the rate of adult mental health and substance use disorder hospitalizations in Virginia decreases from 668.5 to 635.1 per 100,000 adults

By 2020, the percent of adults in Virginia who report having one or more days of poor health that kept them from doing their usual activities decreases from 19.5% to 18.0%

Goal 4.2: VIRGINIA'S HEALTH IT SYSTEM CONNECTS PEOPLE, SERVICES, AND INFORMATION TO SUPPORT OPTIMAL HEALTH OUTCOMES

By 2020, the percent of health-care providers in Virginia who have implemented a certified electronic health record increases from 70.6% to 90.0%

By 2020, the number of entities in Virginia connected through Connect Virginia HIE Inc., the electronic health information exchange, and the national e-Health Exchange increases from 3,800 to 7,600

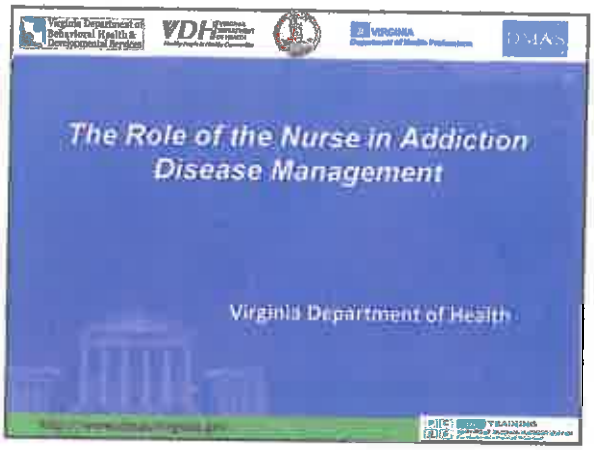
By 2020, the number of Virginia's local health districts that have electronic health records and connect to community providers through Connect Virginia increases from 0 to 35

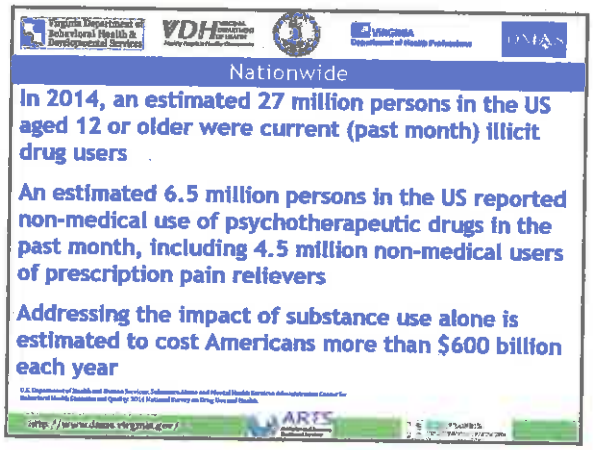
Goal 4.3: HEALTH CARE-ASSOCIATED INFECTIONS ARE PREVENTED AND CONTROLLED IN VIRGINIA

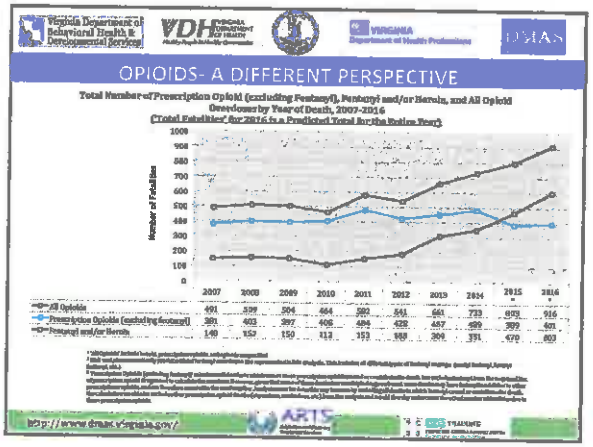
By 2020, the percentage of hospitals in Virginia meeting the state goal for prevention of hospital-onset Clostridium difficile infections increases from 38.5% to 100%

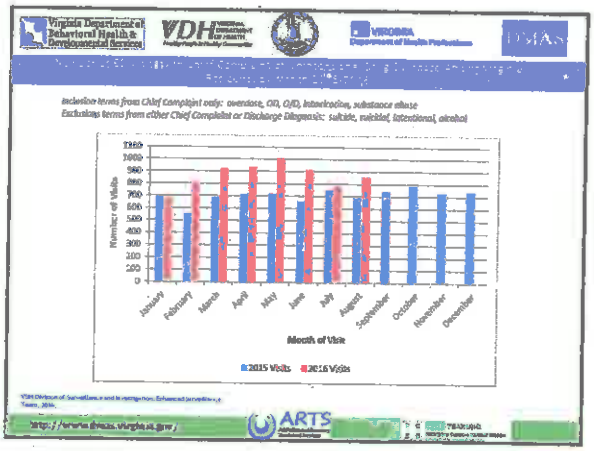
Virginia's Plan For Well-Being Measures*		2020 GOAL	2015 Baseline	2017 Update	Trend
AIM 1 = Healthy, Connected Communities	Percent of High School Graduates Enrolled in an Institution of Higher Education Within 16 Months After Graduation	75.0%	70.9%	72.6%	↑
	Percent of Cost-Burdened Households (More Than 30% of Monthly Income Spent on Housing Costs)	29.0%	31.4%	31.9%	↑
	Consumer Opportunity Profile	102.7	91.8	93.6	•
	Economic Opportunity Profile	77.7	70.7	72.2	•
	Percent of Health Planning Districts That Have Established an On-going Collaborative Community Health Planning Process	100.0%	43.8%	62.5%	↑
AIM 2 = Strong Start for Children	Pregnancies Per 1,000 Females Ages 15 to 19 Years Old	25.3	27.7	24.7	↓
	Percent of Children Who Do Not Meet the PALS-K Benchmarks in the Fall of Kindergarten and Require Literacy Interventions	12.3%	12.7%	13.0%	↑
	Percent of Third Graders Who Pass the Standards of Learning Third Grade Reading Assessment	80.0%	69.8%	75.4%	↑
	Black Infant Deaths Per 1,000 Black Live Births	9.2	12.2	11.2	↓
AIM 3 = Preventive Actions	Percent of Adults Who Did Not Participate In Any Physical Activity During the Past 30 Days	20.0%	22.5%	25.1%	↑
	Percent of Adults Who Are Overweight or Obese	61.0%	64.7%	64.1%	↓
	Percent of Households That Are Food Insecure For Some Part of the Year	10.0%	11.8%	11.8%	↓
	Percent of Adults Who Currently Use Tobacco	12.8%	21.4%	19.4%	↓
	Percent of Adults Who Receive an Annual Influenza Vaccine	50.0%	48.2%	44.6%	↓
	Percent of Adolescent Girls (13-17 Years Old) Who Receive Three Doses of HPV Vaccine	80.0%	38.9%	38.6%	↑
	Percent of Adolescent Boys (13-17 Years Old) Who Receive Three Doses of HPV Vaccine	80.0%	22.5%	25.7%	↑
	Percent of Adults Ages 50-75 Years Old Who Receive Colorectal Cancer Screening	85.0%	69.1%	70.2%	•
	Average Years of Disability-Free Life Expectancy	67.1	64.1	64.0	↓
AIM 4 = System of Health Care	Percent of Adults Who Have a Regular Health-care Provider	85.0%	69.3%	71.1%	↑
	Avoidable Hospital Stays for Ambulatory Care Sensitive Conditions Per 100,000 Persons	1,100	1,294	1,276	•
	Avoidable Deaths from Heart Disease, Stroke or Hypertensive Disease Per 100,000 Persons	40.0	47.9	46.1	↓
	Mental Health and Substance Use Disorder Hospitalizations Per 100,000 Adults	634.1	668.5	697.0	↑
	Percent of Adults Who Report Having One or More Days of Poor Health That Kept Them From Doing Their Usual Activities During the Past 30 Days	12.0%	19.5%	19.0%	↓
	Percent of Heath-care Providers Who Have Implemented a Certified Electronic Health Record	90.0%	20.4%	23.4%	↑
	Number of Entities Connected Through Connect Virginia HIE Inc., and the Electronic Health Information Exchange, and the National e-Health Exchange	7,500	3,800	4,832	↑
	Number of Local Health Districts That Have Electronic Health Records and Connect to Community Providers Through Connect Virginia	35	0	0	↔
	Percent of Hospitals That Meet the State Goal for Prevention of Hospital-onset *Clostridium difficile* Infections	100%	38.5%	38.5%	↓

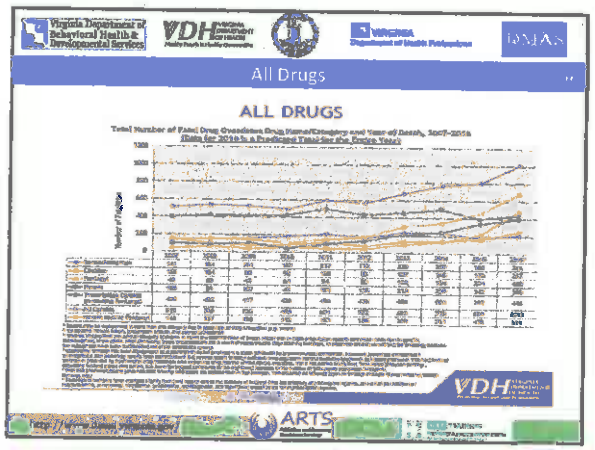
Virginia's Plan for Well-Being 2016–2020 and Technical Report can be found online at* ***http://virginiawellbeing.com/* *under Measures.*

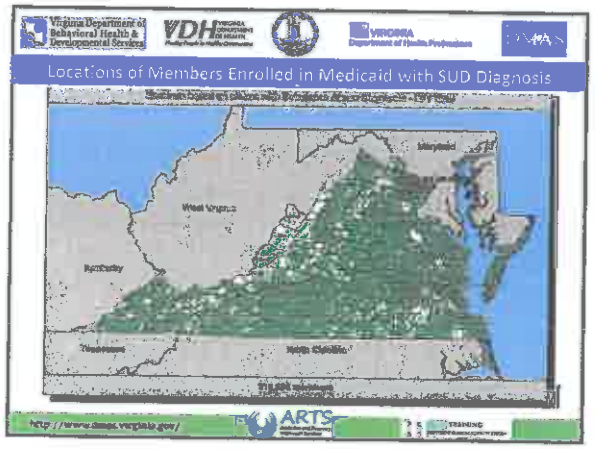

The Role of the Nurse in Addiction Disease Management
Virginia Department of Health

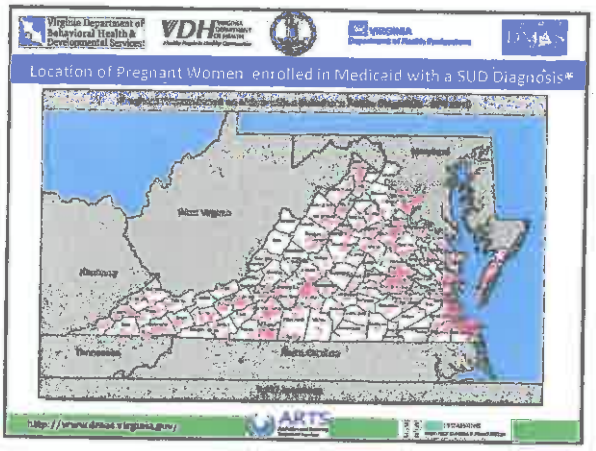

Nationwide
In 2014, an estimated 27 million persons in the US aged 12 or older were current (past month) illicit drug users
An estimated 6.5 million persons in the US reported non-medical use of psychotherapeutic drugs in the past month, including 4.5 million non-medical users of prescription pain relievers
Addressing the impact of substance use alone is estimated to cost Americans more than $600 billion each year

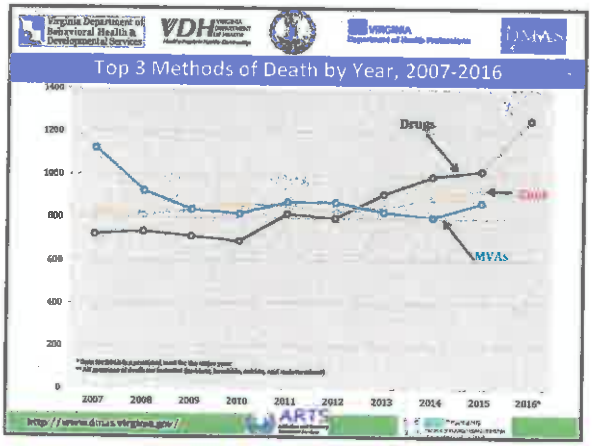

OPIOIDS- A DIFFERENT PERSPECTIVE

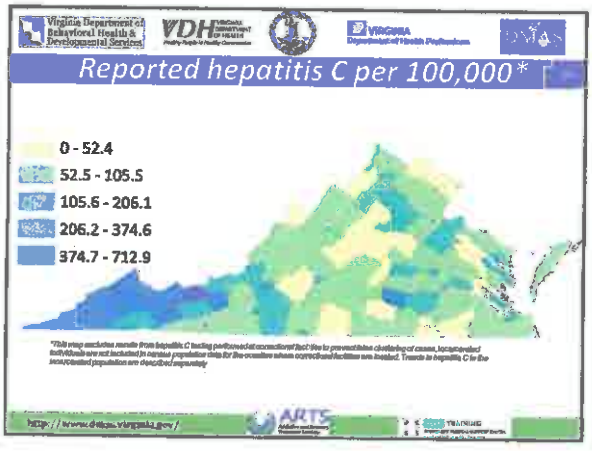

Inclusive terms from Chief Complaint only: overdose, OD, O/D, intoxication, substance abuse
Exclusive terms from other Chief Complaint or Discharge Diagnosis: suicide, suicidal, intentional, alcohol
Number of Visits
Month of Visit
January
February
March
April
May
June
July
August
September
October
November
December
2015 Visits
2016 Visits
ARTS

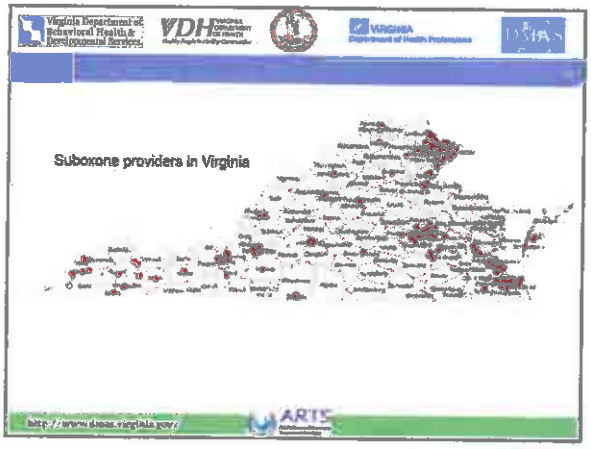

All Drugs
ALL DRUGS
ARTS


Locations of Members Enrolled in Medicaid with SUD Diagnosis
Maryland
West Virginia
Kentucky
Tennessee
North Carolina
ARTS


Location of Pregnant Women enrolled in Medicaid with a SUD Diagnosis*


Top 3 Methods of Death by Year, 2007-2016
Drugs
MVAs
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016*


Reported hepatitis C per 100,000*
0 - 52.4
52.5 - 105.5
105.6 - 206.1
206.2 - 374.6
374.7 - 712.9



Addiction is similar to other chronic illnesses because:

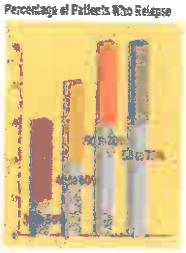
- Biological and behavioral components, both of which must be addressed during treatment
- Recovery (protracted abstinence and restored functioning) – is a long-term process requiring repeated episodes of treatment
- Relapse can occur during or after treatment – a signal for treatment adjustment or reinstatement
- Participation in support programs during and following treatment can be helpful in sustaining long-term recovery

What is Addiction Disease Management?

"A patient-centered model of care that involves longitudinal care delivery; integrated, and coordinated primary medical and specialty care; patient and clinician education; explicit evidence-based care plans; and expert care availability. The model, incorporating mental health and specialty addiction care, holds promise for improving care for patients with substance dependence who often receive no care or fragmented ineffective care".

Addiction as Chronic Disease: Treatment Works

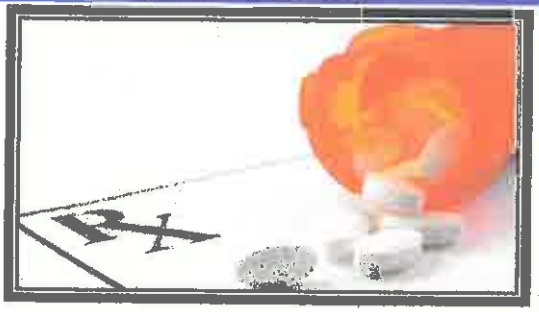
- Reduces drug use by 40-70%
- Addiction treatment is as successful as treatment of diabetes, asthma, and hypertension
- Strongest predictor of recovery is retention in treatment

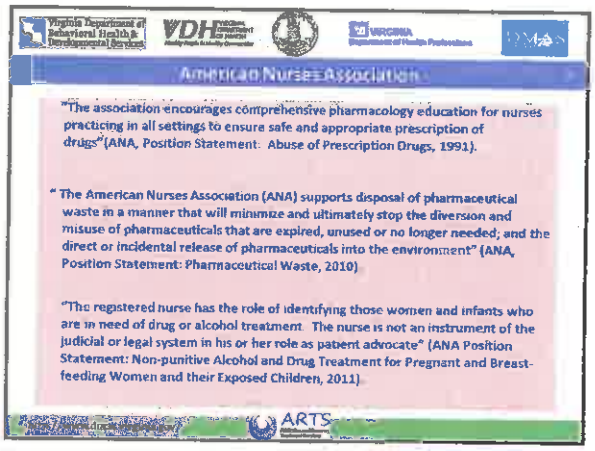


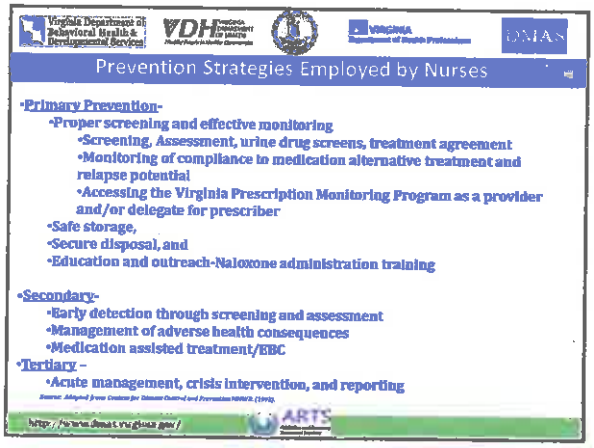
Reluctance to Prescribe Medications for Opioid Use Disorders

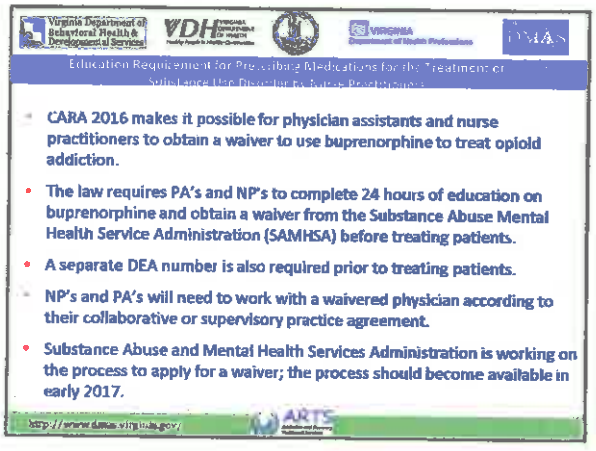
- Lack of available prescribing providers/Nurse Practitioners
- Lack of support network for payment
- Concerns about psychological issues: over-reliance on medications
- Concerns about "enabling"
- Concerns about medication safety and diversion

Prevention: The Nurse's Role

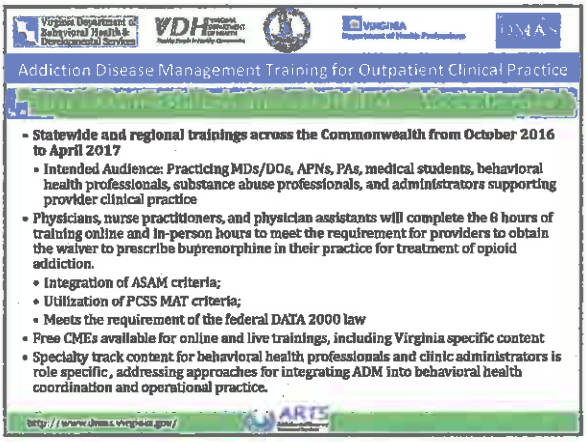


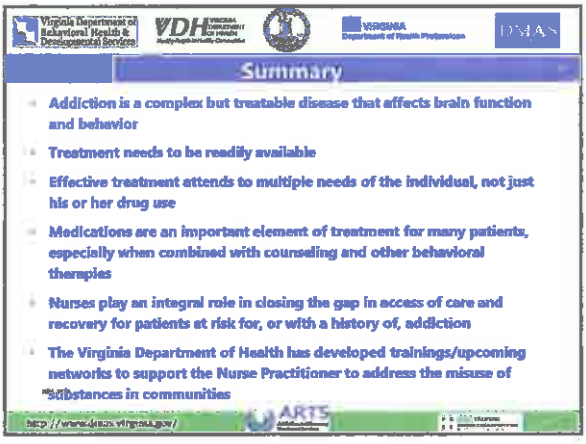

American Nurses Association
"The association encourages comprehensive pharmacology education for nurses practicing in all settings to ensure safe and appropriate prescription of drugs" (ANA, Position Statement: Abuse of Prescription Drugs, 1991).
" The American Nurses Association (ANA) supports disposal of pharmaceutical waste in a manner that will minimize and ultimately stop the diversion and misuse of pharmaceuticals that are expired, unused or no longer needed; and the direct or incidental release of pharmaceuticals into the environment" (ANA, Position Statement: Pharmaceutical Waste, 2010)
"The registered nurse has the role of identifying those women and infants who are in need of drug or alcohol treatment. The nurse is not an instrument of the judicial or legal system in his or her role as patient advocate" (ANA Position Statement: Non-punitive Alcohol and Drug Treatment for Pregnant and Breast-feeding Women and their Exposed Children, 2011).
ARTS


Prevention Strategies Employed by Nurses
•Primary Prevention-
•Proper screening and effective monitoring
•Screening, Assessment, urine drug screens, treatment agreement
•Monitoring of compliance to medication alternative treatment and relapse potential
•Accessing the Virginia Prescription Monitoring Program as a provider and/or delegate for prescriber
•Safe storage,
•Secure disposal, and
•Education and outreach-Naloxone administration training
•Secondary-
•Early detection through screening and assessment
•Management of adverse health consequences
•Medication assisted treatment/EBC
•Tertiary –
•Acute management, crisis intervention, and reporting
ARTS


Education Requirement for Prescribing Medications for the Treatment of
CARA 2016 makes it possible for physician assistants and nurse practitioners to obtain a waiver to use buprenorphine to treat opioid addiction.
The law requires PA's and NP's to complete 24 hours of education on buprenorphine and obtain a waiver from the Substance Abuse Mental Health Service Administration (SAMHSA) before treating patients.
A separate DEA number is also required prior to treating patients.
NP's and PA's will need to work with a waivered physician according to their collaborative or supervisory practice agreement.
Substance Abuse and Mental Health Services Administration is working on the process to apply for a waiver; the process should become available in early 2017.
ARTS


Registered Nursing Interventions
Care management
Monitoring both physical and emotional changes
Emergency interventions
Hygiene
Administration of MAT
Effective management of acute and chronic physiological and psychological state
Ineffective coping reversal
Health education/stress management/relapse prevention
Screening/brief intervention/referral to treatment
Health hazard and adverse health consequence education (abscess from injectable use)
Collection of family history
Confidentiality/privacy integrity


Addiction Disease Management Training for Outpatient Clinical Practice
Statewide and regional trainings across the Commonwealth from October 2016 to April 2017
Intended Audience: Practicing MDs/DOs, APNs, PAs, medical students, behavioral health professionals, substance abuse professionals, and administrators supporting provider clinical practice
Physicians, nurse practitioners, and physician assistants will complete the 8 hours of training online and in-person hours to meet the requirement for providers to obtain the waiver to prescribe buprenorphine in their practice for treatment of opioid addiction.
Integration of ASAM criteria;
Utilization of PCSS MAT criteria;
Meets the requirement of the federal DATA 2000 law
Free CMEs available for online and live trainings, including Virginia specific content
Specialty track content for behavioral health professionals and clinic administrators is role specific, addressing approaches for integrating ADM into behavioral health coordination and operational practice.


Summary
Addiction is a complex but treatable disease that affects brain function and behavior
Treatment needs to be readily available
Effective treatment attends to multiple needs of the individual, not just his or her drug use
Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies
Nurses play an integral role in closing the gap in access of care and recovery for patients at risk for, or with a history of, addiction
The Virginia Department of Health has developed trainings/upcoming networks to support the Nurse Practitioner to address the misuse of substances in communities

Committee of the Joint Boards of Nursing and Medicine

HB 1541 Board of Nursing; powers and duties.

Chief patron: Robinson

Summary as introduced:
Board of Nursing; powers and duties. Authorizes the Board of Nursing to deny or withdraw approval from training programs for failure to meet prescribed standards. Under current law, the Board has such power for educational programs.

01/19/17 House: Read second time and engrossed
01/20/17 House: Read third time and passed House BLOCK VOTE (92-Y 0-N)
01/20/17 House: VOTE: BLOCK VOTE PASSAGE (92-Y 0-N)
01/23/17 Senate: Constitutional reading dispensed
01/23/17 Senate: Referred to Committee on Education and Health

HB 1609 Nurse practitioner as expert witness; scope of activities.

Chief patron: Leftwich

Summary as introduced:
Nurse practitioner as expert witness; scope of activities. References the specific Code section outlining the scope of a nurse practitioner's activities in the context of the current provision that authorizes a nurse practitioner to testify as an expert witness within the scope of his activities.

01/03/17 House: Prefiled and ordered printed; offered 01/11/17 17101624D
01/03/17 House: Referred to Committee for Courts of Justice
01/13/17 House: Assigned Courts sub: Civil Law
01/25/17 House: Subcommittee recommends reporting (10-Y 0-N)
01/27/17 House: Reported from Courts of Justice (21-Y 0-N)

HB 1885 Opioids; limit on amount prescribed, extends sunset provision.

Chief patron: Hugo

Summary as introduced:
Prescription of opioids; limits. Provides that a prescriber who prescribes a controlled substance containing an opioid to a patient shall not prescribe an amount greater than a seven-day supply unless (i) in the professional medical judgment of the prescriber, more than a seven-day supply of the controlled substance containing an opioid is required to stabilize the patient's acute medical condition, or (ii) the prescription is for the management of pain associated with cancer, use in palliative or hospice care, or management of chronic pain not associated with cancer. The bill also requires a prescriber to obtain information from the Prescription Monitoring Program at the time of initiating a new course of treatment that includes the prescribing of opioids anticipated to last more than seven consecutive days. Currently, a prescriber must request such information when a course of opioid treatment is expected to last more than 14 consecutive days.

01/26/17 House: Impact statement from VDH (HB1885H1)
01/27/17 House: Read first time
01/30/17 House: Read second time
01/30/17 House: Committee substitute agreed to 17104611D-H1
01/30/17 House: Engrossed by House - committee substitute HB1885H1

HB 2119 Laser hair removal; limits practice.

Chief patron: Keam

Summary as introduced:
Practice of laser hair removal. Limits the practice of laser hair removal to a person licensed to practice medicine or osteopathic medicine or to a properly trained person under the direction and supervision of a licensed doctor of medicine or osteopathic medicine.

01/10/17 House: Prefiled and ordered printed; offered 01/11/17 17102330D
01/10/17 House: Referred to Committee on Health, Welfare and Institutions
01/16/17 House: Impact statement from DPB (HB2119)
01/17/17 House: Assigned HWI sub: Subcommittee #3

HB 2153 Durable Do Not Resuscitate Orders; reciprocity.

Chief patron: Rasoul

Summary as introduced:
Durable Do Not Resuscitate Orders; reciprocity. Provides that a Durable Do Not Resuscitate order or other order regarding life-sustaining treatment executed in accordance with the laws of another state in which such order was executed shall be deemed to be valid and shall be given full effect in the Commonwealth.

01/23/17 House: Read second time and engrossed
01/24/17 House: Read third time and passed House BLOCK VOTE (97-Y 0-N)
01/24/17 House: VOTE: BLOCK VOTE PASSAGE (97-Y 0-N)
01/25/17 Senate: Constitutional reading dispensed
01/25/17 Senate: Referred to Committee on Education and Health

HB 2164 Drugs of concern; drug of concern.

Chief patron: Pillion

Summary as introduced:
Drugs of concern; gabapentin. Adds any material, compound, mixture, or preparation containing any quantity of gabapentin, including any of its salts, to the list of drugs of concern.

EMERGENCY

01/30/17 House: Read second time
01/30/17 House: Committee amendment agreed to

01/30/17 House: Emergency clause added
01/30/17 House: Engrossed by House as amended HB2164E

HB 2401 Virginia Freedom of Information Act; minutes of closed meetings required, audio recordings.

Chief patron: Morris

Summary as introduced:
Virginia Freedom of Information Act; minutes of closed meetings required; audio recordings. Provides that a public body shall (i) take closed meeting minutes, (ii) also make an audio recording of the entirety of every meeting that is closed to the public, and (iii) use a means of recording that fully captures and can clearly reproduce all statements made during a closed meeting. The bill provides that the minutes or recordings made shall not be subject to the disclosure provisions of FOIA.

01/18/17 House: Presented and ordered printed 17103944D
01/18/17 House: Referred to Committee on General Laws
01/23/17 House: Assigned GL sub: Subcommittee #2

HB 2470 Drug Control Act; Schedule II and Schedule V.

Chief patron: Jones

Summary as introduced:
Drug Control Act; Schedule II and Schedule V. Adds thiafentanil to Schedule II of the Drug Control Act and Brivaracetam to Schedule V of the Drug Control Act.

01/23/17 House: Impact statement from VCSC (HB2470)
01/24/17 House: Impact statement from VDH (HB2470)
01/26/17 House: Reported from Health, Welfare and Institutions (22-Y 0-N)
01/26/17 House: Referred to Committee on Appropriations
01/27/17 House: Assigned App. sub: Public Safety

SB 848 Naloxone; dispensing for use in opioid overdose reversal, etc.

Chief patron: Wexton

Summary as introduced:
Dispensing of naloxone. Allows a person who is authorized by the Department of Behavioral Health and Developmental Services to train individuals on the administration of naloxone for use in opioid overdose reversal and who is acting on behalf of an organization that provides substance abuse treatment services to individuals at risk of experiencing opioid overdose or training in the administration of naloxone for overdose reversal and that has obtained a controlled substances registration from the Board of Pharmacy pursuant to § 54.1-3423 to dispense naloxone to a person who has completed a training program on the administration of naloxone for opioid overdose reversal, provided that such dispensing is (i) pursuant to a standing order issued by a prescriber,(ii) in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health, and (iii) without charge or compensation. The bill also provides that a person who dispenses naloxone shall not be liable for civil damages of ordinary negligence for acts or omissions resulting from the rendering of such treatment if he acts in good faith and that a person to whom naloxone has been dispensed pursuant to the

provisions of the bill may possess naloxone and may administer naloxone to a person who is believed to be experiencing or about to experience a life-threatening opioid overdose.

EMERGENCY

01/30/17 Senate: Read second time
01/30/17 Senate: Reading of substitute waived
01/30/17 Senate: Committee substitute agreed to 17103883D-S1
01/30/17 Senate: Emergency clause added
01/30/17 Senate: Engrossed by Senate - committee substitute SB848S1

SB 922 Dept of Professional and Occupational Regulation and Department of Health Professions; licensure.

Chief patron: Petersen

Summary as introduced:
Department of Professional and Occupational Regulation and Department of Health Professions; licensure, certification, registration, and permitting. Provides that certain powers of the Department of Professional and Occupational Regulation, the Department of Health Professions, and health regulatory boards and certain requirements of persons regulated by such entities apply, inclusively, to permits as well as licenses, certifications, and registrations and to holders of permits as well as holders of such licenses, certifications, and registrations.

01/16/17 Senate: Read second time and engrossed
01/17/17 Senate: Read third time and passed Senate (40-Y 0-N)
01/30/17 House: Placed on Calendar
01/30/17 House: Read first time
01/30/17 House: Referred to Committee on Health, Welfare and Institutions

SB 972 Requests for information by members of the General Assembly; responses not subject to redaction.

Chief patron: DeSteph

Summary as introduced:
Requests for information by members of the General Assembly; responses not subject to redaction. Requires all departments, agencies, and institutions of the Commonwealth and staff and employees thereof to respond to a request for information made by a member of the General Assembly. The bill further provides that notwithstanding the Virginia Freedom of Information Act (§ 2.2-3700 et seq.), a response to a request for information made by a member of the General Assembly shall not be subject to redaction.

01/03/17 Senate: Prefiled and ordered printed; offered 01/11/17 17100582D
01/03/17 Senate: Referred to Committee on Rules
01/26/17 Senate: Impact statement from DPB (SB972)

SB 981 Charity health care services; liability protection for administrators.

Chief patron: Stanley

Summary as introduced:
Charity health care services; liability protection for administrators. Provides that persons who administer, organize, arrange, or promote the rendering of services to patients of certain clinics shall not be liable for any civil damages for any act or omission resulting from the rendering of such services unless the act or omission was the result of such persons' or the clinic's gross negligence or willful misconduct.

01/18/17 Senate: Passed Senate (40-Y 0-N)
01/18/17 Senate: Printed as engrossed 17101302D-E
01/30/17 House: Placed on Calendar
01/30/17 House: Read first time
01/30/17 House: Referred to Committee for Courts of Justice

SB 1009 Telemedicine, practice of; prescribing controlled substances.

Chief patron: Dunnavant

Summary as introduced:
Practice of telemedicine; prescribing. Provides that a health care practitioner who performs or has performed an appropriate examination of the patient, either physically or by the use of instrumentation and diagnostic equipment, for the purpose of establishing a bona fide practitioner-patient relationship may prescribe Schedule II through VI controlled substances to the patient, provided that the prescribing of such controlled substance is in compliance with federal requirements for the practice of telemedicine. The bill also authorizes the Board of Pharmacy to register an entity at which a patient is treated by the use of instrumentation and diagnostic equipment for the purpose of establishing a bona fide practitioner-patient relationship and is prescribed Schedule II through VI controlled substances to possess and administer Schedule II through VI controlled substances when such prescribing is in compliance with federal requirements for the practice of telemedicine and the patient is not in the physical presence of a practitioner registered with the U.S. Drug Enforcement Administration.

EMERGENCY

01/16/17 Senate: Engrossed by Senate - committee substitute SB1009S1
01/17/17 Senate: Read third time and passed Senate (40-Y 0-N)
01/30/17 House: Placed on Calendar
01/30/17 House: Read first time
01/30/17 House: Referred to Committee on Health, Welfare and Institutions

SB 1020 Peer recovery specialists and qualified mental health professionals; registration.

Chief patron: Barker

Summary as introduced:
Registration of peer recovery specialists and qualified mental health professionals. Authorizes the registration of peer recovery specialists and qualified mental health professionals by the Board of Counseling. The bill defines "qualified mental health professional" as a person who by education and experience is professionally qualified and registered by the Board of Counseling to provide collaborative mental health services for adults or children. The bill requires that a qualified mental health professional

provide such services as an employee or independent contractor of a mental health service provider licensed by the Department of Behavioral Health and Developmental Services. The bill defines "registered peer recovery specialist" as a person who by education and experience is professionally qualified and registered by the Board of Counseling to provide collaborative services to assist individuals in achieving sustained recovery from the effects of addiction or mental illness, or both. The bill requires that a registered peer recovery specialist provide such services as an employee or independent contractor of the Department of Behavioral Health and Developmental Services, a mental health service provider licensed by the Department of Behavioral Health and Developmental Services, a practitioner licensed by or holding a permit issued from the Department of Health Professions, or a facility licensed by the Department of Health. The bill adds qualified mental health professionals and registered peer recovery specialists to the list of mental health providers that are required to take actions to protect third parties under certain circumstances and notify clients of their right to report to the Department of Health Professions any unethical, fraudulent, or unprofessional conduct. The bill directs the Board of Counseling and the Board of Behavioral Health and Developmental Services to promulgate regulations to implement the provisions of the bill within 280 days of its enactment.

01/30/17 Senate: Impact statement from VDH (SB1020S1)
01/30/17 Senate: Read second time
01/30/17 Senate: Reading of substitute waived
01/30/17 Senate: Committee substitute agreed to 17104802D-S1
01/30/17 Senate: Engrossed by Senate - committee substitute SB1020S1

SB 1024 Doctor of medicine, etc.; reporting disabilities of drivers to DMV, not subject to civil liability.

Chief patron: Dunnavant

Summary as introduced:
Health care practitioners; reporting disabilities of drivers. Provides that any doctor of medicine, osteopathy, chiropractic, or podiatry, any nurse practitioner, or any physician assistant who reports to the Department of Motor Vehicles the existence, or probable existence, of a mental or physical disability or infirmity of any person licensed to operate a motor vehicle which the reporting individual believes affects such person's ability to operate a motor vehicle safely is not subject to civil liability unless he has acted in bad faith or with malicious intent.

01/23/17 Senate: Engrossed by Senate - committee substitute SB1024S1
01/24/17 Senate: Read third time and passed Senate (28-Y 12-N)
01/31/17 House: Placed on Calendar
01/31/17 House: Read first time
01/31/17 House: Referred to Committee on Health, Welfare and Institutions

SB 1027 Cannabidiol oil and THC-A oil; permitting of pharmaceutical processors to manufacture and provide.

Chief patron: Marsden

Summary as introduced:
Cannabidiol oil and THC-A oil; permitting of pharmaceutical processors to manufacture and provide. Authorizes a pharmaceutical processor, after obtaining a permit from the Board of Pharmacy (the Board) and under the supervision of a licensed pharmacist, to manufacture and provide cannabidiol

oil and THC-A oil to be used for the treatment of intractable epilepsy. The bill sets limits on the number of permits that the Board may issue and requires that the Board adopt regulations establishing health, safety, and security requirements for permitted processors. The bill provides that only a licensed practitioner of medicine or osteopathy who is a neurologist or who specializes in the treatment of epilepsy may issue a written certification to a patient for the use of cannabidiol oil or THC-A oil. The bill also requires that a practitioner who issues a written certification for cannabidiol oil or THC-A oil, the patient issued such certification, and, if the patient is a minor or incapacitated, the patient's parent or legal guardian register with the Board. The bill requires further that a pharmaceutical processor shall not provide cannabidiol oil or THC-A oil to a patient or a patient's parent or legal guardian without first verifying that the patient, the patient's parent or legal guardian if the patient is a minor or incapacitated, and the practitioner who issued the written certification have registered with the Board. Finally, the bill provides an affirmative defense for agents and employees of pharmaceutical processors in a prosecution for the manufacture, possession, or distribution of marijuana. This bill contains an emergency clause.

EMERGENCY

01/23/17 Senate: Read second time and engrossed
01/24/17 Senate: Read third time and passed Senate (40-Y 0-N)
01/30/17 House: Placed on Calendar
01/30/17 House: Read first time
01/30/17 House: Referred to Committee on Health, Welfare and Institutions

SB 1178 Buprenorphine without naloxone; prescription limitation.

Chief patron: Chafin

Summary as introduced:
Prescription of buprenorphine without naloxone; limitation. Provides that buprenorphine mono or products containing buprenorphine without naloxone shall be issued only for a patient who is pregnant.

01/24/17 Senate: Impact statement from VDH (SB1178E)
01/24/17 Senate: Read third time and passed Senate (39-Y 0-N)
01/31/17 House: Placed on Calendar
01/31/17 House: Read first time
01/31/17 House: Referred to Committee on Health, Welfare and Institutions

SB 1180 Opioids and buprenorphine; Boards of Dentistry and Medicine to adopt regulations for prescribing.

Chief patron: Chafin

Summary as introduced:
Boards of Dentistry and Medicine; regulations for the prescribing of opioids and buprenorphine. Directs the Boards of Dentistry and Medicine to adopt regulations for the prescribing of opioids and products containing buprenorphine. The bill contains an emergency clause.

EMERGENCY

01/24/17 Senate: Impact statement from VDH (SB1180E)
01/24/17 Senate: Read third time and passed Senate (39-Y 0-N)

01/30/17 House: Placed on Calendar
01/30/17 House: Read first time
01/30/17 House: Referred to Committee on Health, Welfare and Institutions

SB 1230 Opiate prescriptions; electronic prescriptions.

Chief patron: Dunnavant

Summary as introduced:
Opiate prescriptions; electronic prescriptions. Requires a prescription for any controlled substance containing an opiate to be issued as an electronic prescription and prohibits a pharmacist from dispensing a controlled substance that contains an opiate unless the prescription is issued as an electronic prescription, beginning July 1, 2020. The bill defines electronic prescription as a written prescription that is generated on an electronic application in accordance with federal regulations and is transmitted to a pharmacy as an electronic data file. The bill requires the Secretary of Health and Human Resources to convene a work group to review actions necessary for the implementation of the bill's provisions and report on the work group's progress to the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health by November 1, 2017 and a final report to such Chairmen by November 1, 2018.

01/24/17 Senate: Impact statement from DPB (SB1230E)
01/24/17 Senate: Read third time and passed Senate (39-Y 0-N)
01/31/17 House: Placed on Calendar
01/31/17 House: Read first time
01/31/17 House: Referred to Committee on Health, Welfare and Institutions

SB 1232 Opioids; limit on amount prescribed, extends sunset provision.

Chief patron: Dunnavant

Summary as introduced:
Limits on prescription of controlled substances containing opioids. Prohibits a prescriber providing treatment for a patient in an emergency department of a corporation, facility, or institution licensed, owned, or operated by the Commonwealth to provide health care from prescribing a controlled substance containing an opioid in a quantity greater than a three-day supply, as determined in accordance with the prescriber's directions for use. The bill also prohibits a pharmacist from dispensing a controlled substance containing an opioid pursuant to a prescription issued by a prescriber providing treatment to a patient in the emergency department of a corporation, facility, or institution licensed, owned, or operated by the Commonwealth to provide health care unless the prescription complies with the requirements of the bill. The bill has an expiration date of July 1, 2020.

01/30/17 Senate: Impact statement from VDH (SB1232S1)
01/30/17 Senate: Read second time
01/30/17 Senate: Reading of substitute waived
01/30/17 Senate: Committee substitute agreed to 17104640D-S1
01/30/17 Senate: Engrossed by Senate - committee substitute SB1232S1

SB 1298 Marijuana; possession or distribution for medical purposes, affirmative defense for treatment.

Chief patron: Vogel

Summary as introduced:
Possession or distribution of marijuana for medical purposes; affirmative defense for treatment of certain conditions. Provides an affirmative defense to prosecution for possession of marijuana if a person has a valid written certification issued by a practitioner for cannabidiol oil or THC-A oil for treatment of, or to alleviate the symptoms of, cancer, glaucoma, human immunodeficiency virus, acquired immune deficiency syndrome, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, Alzheimer's disease, nail patella, cachexia or wasting syndrome, multiple sclerosis, or complex regional pain syndrome. Under current law, only the treatment of intractable epilepsy is covered by the affirmative defense.

01/25/17 Senate: Read second time and engrossed
01/26/17 Senate: Read third time and passed Senate (29-Y 11-N)
01/31/17 House: Placed on Calendar
01/31/17 House: Read first time
01/31/17 House: Referred to Committee for Courts of Justice

SB 1327 Doctors; licensure of medical science.

Chief patron: Carrico

Summary as introduced:
Licensure of doctors of medical science. Establishes criteria for license as a doctor of medical science and establishes the Advisory Board on Doctors of Medical Science.

01/10/17 Senate: Prefiled and ordered printed; offered 01/11/17 17102807D
01/10/17 Senate: Referred to Committee on Education and Health
01/24/17 Senate: Impact statement from VDH (SB1327)

SB 1403 Cannabidiol; Board of Pharmacy to deschedule or reschedule upon certain publication.

Chief patron: Dunnavant

Summary as introduced:
Board of Pharmacy to deschedule or reschedule cannabidiol upon publication of an interim final rule. Directs the Board of Pharmacy to initiate action to deschedule or reschedule cannabidiol or any product containing cannabidiol that has been approved as a prescription medication by the U.S. Food and Drug Administration pursuant to 21 U.S.C. § 360bb and 21 U.S.C. § 355 within 90 days of publication in the Federal Register of an interim final rule.

01/23/17 Senate: Engrossed by Senate - committee substitute SB1403S1
01/24/17 Senate: Read third time and passed Senate (39-Y 1-N)
01/31/17 House: Placed on Calendar
01/31/17 House: Read first time
01/31/17 House: Referred to Committee on Health, Welfare and Institutions

SB 1484 Prescription Monitoring Program; disclosure of information to certain physicians or pharmacists.

Chief patron: Hanger

Summary as introduced:
Prescription Monitoring Program. Requires the information in the possession of the Prescription Monitoring Program disclosed by the Director of Health Professions about a specific recipient who is a member of a Virginia Medicaid managed care program to a physician or pharmacist employed by the Virginia Medicaid managed care program to be provided via electronic access to the Prescription Monitoring Program in real time. The bill requires such electronic access to be identical to that provided to a prescriber or a dispenser who receives information in the possession of the Prescription Monitoring Program from the Director. The bill provides that such physicians or pharmacists employed by the Virginia Medicaid managed care program may delegate their authority to access such information and may be licensed in a jurisdiction other than the Commonwealth.

01/30/17 Senate: Impact statement from VDH (SB1484S1)
01/30/17 Senate: Read second time
01/30/17 Senate: Reading of substitute waived
01/30/17 Senate: Committee substitute agreed to 17104669D-S1
01/30/17 Senate: Engrossed by Senate - committee substitute SB1484S1

SB 1557 Community health workers; VDH to establish work group to examine risks, etc.

Chief patron: Barker

Summary as introduced:
Department of Health Professions; community health workers. Directs the Department of Health to establish a work group of interested stakeholders to examine the risks and benefits of having community health workers in the Commonwealth. The bill directs the Department to submit a report on the work group's findings and recommendations to the Governor and Chairmen of the House Appropriations and Senate Finance Committees by October 15, 2017.

01/20/17 Senate: Presented and ordered printed 17104205D
01/20/17 Senate: Referred to Committee on Rules

Agenda Item: Regulatory Action on Pain Management and Prescribing of Buprenorphine

Staff notes:

- On November 21, 2016, the Commission of Health declared a statewide Public Health Emergency for Virginia as a result of the opioid addiction epidemic
- On January 6, 2017, the Board of Medicine convened a Regulatory Advisory Panel (RAP) with 4 addiction specialists to draft regulations for prescribing of opioids and buprenorphine
- On January 27, 2017, the Legislative Committee convened to consider the RAP draft and additional comment on opioid and buprenorphine prescribing
- The draft amendments to prescriptive authority regulations which are included in the Committee's agenda package are virtually identical to the regulations recommended by the Legislative Committee which will be adopted as emergency regulations by the BOM on February 23rd.

Included in your agenda package are:

A copy of draft regulations

A copy of Administrative Process Act showing authority to adopt by emergency action

A copy of legislation passed in the 2017 General Assembly (HB2165 is identical to SB1180)

Proposed Action:

Recommendation to the Boards of Nursing and Medicine for adoption of proposed amendments to 18VAC90-40-10 et seq., Regulations for Prescriptive Authority for Nurse Practitioners

Administrative Process Act

§ 2.2-4011. Emergency regulations; publication; exceptions.

A. Regulations that an agency finds are necessitated by an emergency situation may be adopted by an agency upon consultation with the Attorney General, which approval shall be granted only after the agency has submitted a request stating in writing the nature of the emergency, and the necessity for such action shall be at the sole discretion of the Governor.

B. Agencies may also adopt emergency regulations in situations in which Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation be effective in 280 days or less from its enactment and the regulation is not exempt under the provisions of subdivision A 4 of § 2.2-4006. In such cases, the agency shall state in writing the nature of the emergency and of the necessity for such action and may adopt the regulations. Pursuant to § 2.2-4012, such regulations shall become effective upon approval by the Governor and filing with the Registrar of Regulations.

C. All emergency regulations shall be limited to no more than 18 months in duration. During the 18-month period, an agency may issue additional emergency regulations as needed addressing the subject matter of the initial emergency regulation, but any such additional emergency regulations shall not be effective beyond the 18-month period from the effective date of the initial emergency regulation. If the agency wishes to continue regulating the subject matter governed by the emergency regulation beyond the 18-month limitation, a regulation to replace the emergency regulation shall be promulgated in accordance with this article. The Notice of Intended Regulatory Action to promulgate a replacement regulation shall be filed with the Registrar within 60 days of the effective date of the emergency regulation and published as soon as practicable, and the proposed replacement regulation shall be filed with the Registrar within 180 days after the effective date of the emergency regulation and published as soon as practicable.

D. In the event that an agency concludes that despite its best efforts a replacement regulation cannot be adopted before expiration of the 18-month period described in subsection C, it may seek the prior written approval of the Governor to extend the duration of the emergency regulation for a period of not more than six additional months. Any such request must be submitted to the Governor at least 30 days prior to the scheduled expiration of the emergency regulation and shall include a description of the agency's efforts to adopt a replacement regulation together with the reasons that a replacement regulation cannot be adopted before the scheduled expiration of the emergency regulation. Upon approval of the Governor, provided such approval occurs prior to the scheduled expiration of the emergency regulation, the duration of the emergency regulation shall be extended for a period of no more than six months. Such approval shall be in the sole discretion of the Governor and shall not be subject to judicial review. Agencies shall notify the Registrar of Regulations of the new expiration date of the emergency regulation as soon as practicable.

E. Emergency regulations shall be published as soon as practicable in the Register.

17101154D

SENATE BILL NO. 1180

Senate Amendments in [ ] — January 23, 2017

A BILL to amend the Code of Virginia by adding in Article 1 of Chapter 27 of Title 54.1 a section numbered 54.1-2708.4 and by adding in Article 2 of Chapter 29 of Title 54.1 a section numbered 54.1-2928.2, relating to Board of Dentistry and Medicine; regulations for the prescribing of opioids and buprenorphine.

Patrons Prior to Engrossment—Senators Chafin, Dunnavant, Ebbin and Mason

Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Article 1 of Chapter 27 of Title 54.1 a section numbered 54.1-2708.4 and by adding in Article 2 of Chapter 29 of Title 54.1 a section numbered 54.1-2928.2 as follows:

§ 54.1-2708.4. Board to adopt regulations related to prescribing of opioids.

The Board shall adopt regulations for the prescribing of opioids, which shall include guidelines for:

1. The treatment of acute pain, which shall include (i) requirements for an appropriate patient history and evaluation, (ii) limitations on dosages or day supply of drugs prescribed, (iii) requirements for appropriate documentation in the patient's health record, and (iv) a requirement that the prescriber request and review information contained in the Prescription Monitoring Program in accordance with § 54.1-2522.1;

2. The treatment of chronic pain, which shall include, in addition to the requirements for treatment of acute pain set forth in subdivision 1, requirements for (i) development of a treatment plan for the patient, (ii) an agreement for treatment signed by the provider and the patient that includes permission to obtain urine drug screens, and (iii) periodic review of the treatment provided at specific intervals to determine the continued appropriateness of such treatment; and

3. Referral of patients to whom opioids are prescribed for substance abuse counseling or treatment, as appropriate.

§ 54.1-2928.2. Board to adopt regulations related to prescribing of opioids and buprenorphine.

The Board shall adopt regulations for the prescribing of opioids and products containing buprenorphine. Such regulations shall include guidelines for:

1. The treatment of acute pain, which shall include (i) requirements for an appropriate patient history and evaluation, (ii) limitations on dosages or day supply of drugs prescribed, (iii) requirements for appropriate documentation in the patient's health record, and (iv) a requirement that the prescriber request and review information contained in the Prescription Monitoring Program in accordance with § 54.1-2522.1;

2. The treatment of chronic pain, which shall include, in addition to the requirements for treatment of acute pain set forth in subdivision 1, requirements for (i) development of a treatment plan for the patient, (ii) an agreement for treatment signed by the provider and the patient that includes permission to obtain urine drug screens, and (iii) periodic review of the treatment provided at specific intervals to determine the continued appropriateness of such treatment; and

3. The use of buprenorphine in the treatment of addiction, including a requirement for referral to or consultation with a provider of substance abuse counseling in conjunction with treatment of opioid dependency with products containing buprenorphine.

2. That an emergency exists and this act is in force from its passage.

[3. That the Prescription Monitoring Program at the Department of Health Professions shall annually provide a report to the Joint Commission on Health Care on the prescribing of opioids and benzodiazepines in the Commonwealth that includes data on reporting of unusual patterns of prescribing or dispensing of a covered substance by an individual prescriber or dispenser or on potential misuse of a covered substance by a recipient, pursuant to §54.1-2523.1.]

Commonwealth of Virginia

REGULATIONS
FOR
PRESCRIPTIVE AUTHORITY FOR NURSE PRACTITIONERS

VIRGINIA BOARD OF NURSING
VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18 VAC 90-40-10 et seq.

Statutory Authority: §§ 54.1-2400 and 54.1-2957.01 of the *Code of Virginia*

Revised Date:

9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

(804) 367-4515 (TEL)
(804) 527-4455 (FAX)
email: nursebd@dhp.virginia.gov

Part I. General Provisions.

18VAC90-40-10. Definitions.

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

"Acute pain" shall mean pain that occurs within the normal course of a disease or condition or as the result of surgery for which controlled substances may be prescribed for no more than three months.

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

"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.

"Chronic pain" shall mean non-malignant pain that goes beyond the normal course of a disease or condition for which controlled substances may be prescribed for a period greater than three months.

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

"Controlled substance" shall mean drugs listed in The Drug Control Act of the Code of Virginia in Schedules II through IV.

"FDA" shall mean the U. S. Food and Drug Administration.

"MME" shall mean morphine milligram equivalent.

"Nonprofit health care clinics or programs" means a clinic organized in whole or in part for the delivery of health care services without charge or when a reasonable minimum fee is charged only to cover administrative costs.

"Nurse practitioner" means a registered nurse who has met the requirements for licensure as a nurse practitioner as stated in 18VAC90-30-10 et seq.

"Practice agreement" means a written or electronic agreement jointly developed by the patient care team physician and the nurse practitioner for the practice of the nurse practitioner that 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.

"Prescription Monitoring Program" shall mean the electronic system within the Department of Health Professions that monitors the dispensing of certain controlled substances.

Part V. Management of Acute Pain.

18VAC90-40-150. Evaluation of the patient for acute pain.

A. The requirements of this part shall not apply to:

1. The treatment of acute pain related to cancer, a patient in hospice care or a patient in palliative care

2. The treatment of acute pain during an inpatient hospital admission, in a nursing home or an assisted living facility that uses a sole source pharmacy; or

3. A patient enrolled in a clinical trial as authorized by state or federal law.

B. Non-pharmacologic and non-opioid treatment for pain shall be given consideration prior to treatment with opioids. If an opioid is considered necessary for the treatment of acute pain, the practitioner shall give a short-acting opioid in the lowest effective dose for the fewest possible days.

C. Prior to initiating treatment with a controlled substance for a complaint of acute pain, the prescriber shall perform a history and physical examination appropriate to the complaint, query the Prescription Monitoring Program as set forth in the § 54.1-2522.1 of the Code of Virginia and conduct an assessment of the patient's history and risk of substance abuse as a part of the initial evaluation.

18VAC90-40-170. Treatment of acute pain with opioids.

A. Initiation of opioid treatment for patients shall be with short-acting opioids.

1. A prescriber providing treatment for a patient shall not prescribe a controlled substance containing an opioid in a quantity that exceeds a seven-day supply as determined by the manufacturer's directions for use, unless extenuating circumstances are clearly documented in the medical record. This shall also apply to prescriptions of a controlled substance containing an opioid upon discharge from an emergency department.

2. An opioid prescribed as part of treatment for a surgical procedure shall be for no more than 14 consecutive days in accordance with manufacturer's direction and within the immediate perioperative period, unless extenuating circumstances are clearly documented in the medical record.

B. Initiation of opioid treatment for all patients shall include the following:

1. The practitioner shall carefully consider and document in the medical record the reasons to exceed 50 MME/day.

2. Prior to exceeding 120 MME/day, the practitioner shall document in the medical record the reasonable justification for such doses or refer to consult with a pain management specialist.

3. Naloxone shall be prescribed for any patient when risk factors of prior overdose, substance abuse, doses in excess of 120 MME/day, or concomitant benzodiazepine are present.

C. Due to a higher risk of fatal overdose when opioids are used with benzodiazepines, sedative hypnotics, carisoprodol, and tramadol, the prescriber shall only co-prescribe these substances when there are extenuating circumstances and shall document in the medical record a tapering plan to achieve the lowest possible effective doses if these medications are prescribed.

D. Buprenorphine is not indicated for acute pain in the outpatient setting.

18VAC90-40-180. Medical records for acute pain.

The medical record shall include a description of the pain, a presumptive diagnosis for the origin of the pain, an examination appropriate to the complaint, a treatment plan and the medication prescribed to include the date, type, dosage, and quantity prescribed.

Part VI. Management of Chronic Pain.

18VAC90-40-190. Evaluation of the chronic pain patient.

A. The requirements of this part shall not apply to:

1. The treatment of chronic pain related to cancer, a patient in hospice care or a patient in palliative care

2. The treatment of chronic pain during an inpatient hospital admission, in a nursing home or an assisted living facility that uses a sole source pharmacy; or

3. A patient enrolled in a clinical trial as authorized by state or federal law.

B. Prior to initiating management of chronic pain with a controlled substance, a medical history and physical examination to include a mental status examination and shall be performed and documented in the medical record, including:

1. The nature and intensity of the pain;

2. Current and past treatments for pain;

3. Underlying or coexisting diseases or conditions;

4. The effect of the pain on physical and psychological function, quality of life and activities of daily living;

5. Psychiatric, addiction and substance abuse history of the patient and any family history of addiction or substance abuse;

6. A urine drug screen;

7. A query the Prescription Monitoring Program as set forth in § 54.1-2522.1 of the Code of Virginia;

8. An assessment of the patient's history and risk of substance abuse; and

9. A request for prior applicable records.

B. Prior to initiating opioid analgesia for chronic pain, the practitioner shall discuss with the patient the known risks and benefits of opioid therapy and the responsibilities of the patient during treatment. The practitioner shall also discuss with the patient an exit strategy for the discontinuation of opioids in the event they are not effective.

18VAC90-40-200. Treatment of chronic pain with opioids.

A. Non-pharmacologic and non-opioid treatment for pain shall be given consideration prior to treatment with opioids.

B. Initiation of opioid treatment for all patients shall be with short-acting opioids.

C. In initiating opioid treatment for all patients, the practitioner shall:

1. Carefully consider and document in the medical record the reasons to exceed 50 MME/day;

2. Prior to exceeding 120 MME/day, the practitioner shall document in the medical record the reasonable justification for such doses or refer to or consult with a pain management specialist.

3. Prescribe naloxone for any patient when risk factors of prior overdose, substance abuse, doses in excess of 120 MME/day, or concomitant benzodiazepine are present; and

4. Document the rational to continue opioid therapy every three months.

D. Due to a higher risk of fatal overdose when buprenorphine is given with other opioids, benzodiazepines, sedative hypnotics, carisoprodol, and tramadol, the prescriber shall only co-prescribe these substances when there are extenuating circumstances and shall document in the medical record a tapering plan to achieve the lowest possible effective doses if these medications are prescribed.

E. The practitioner shall regularly screen for opioid use disorder and shall initiate specific treatment for opioid use disorder or refer the patient for evaluation for treatment if indicated.

18VAC90-40-210. Treatment plan for chronic pain.

A. The medical record shall include a treatment plan that states measures to be used to determine progress in treatment, including but not limited to pain relief and improved physical and psychosocial function, quality of life, and daily activities.

B. The treatment plan shall include further diagnostic evaluations and other treatment modalities or rehabilitation that may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

C. The prescriber shall record in the medical records the presence or absence of any indicators for medication misuse, abuse or diversion and take appropriate action.

18VAC90-40-220. Informed consent and agreement for treatment of chronic pain.

A. The prescriber shall document in the medical record informed consent, to include risks, benefits and alternative approaches, prior to the initiation of opioids for chronic pain.

B. There shall be a written treatment agreement in the medical record that addresses the parameters of treatment, including those behaviors which will result in a cessation of treatment or dismissal from care.

C. The treatment agreement shall include, but not be limited to permission for the practitioner to:

1. Obtain urine or serum medication levels, when requested;

2. Query and receive reports from the Prescription Monitoring Program; and

3. Consult with other prescribers or dispensing pharmacists for the patient.

D. Expected outcomes shall be documented in the medical record including improvement in pain relief and function or simply in pain relief. Limitations and side effects of chronic opioid therapy shall be documented in the medical record.

18VAC90-40-230. Opioid therapy for chronic pain.

A. The prescriber shall review the course of pain treatment and any new information about the etiology of the pain or the patient's state of health at least every three months.

B. Continuation of treatment with controlled substances shall be supported by documentation of continued benefit from the prescribing. If the patient's progress is unsatisfactory, the prescriber shall assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

C. Practitioners shall check the Prescription Monitoring Program at the initiation of treatment with opioids that will extend beyond 14 days, and a least every three months thereafter.

D. Practitioner shall order and review a urine drug screen or serum medication levels at the initiation of chronic pain management and at least every three months thereafter.

E. The practitioner shall regularly screen for opioid use disorder and shall initiate specific treatment for opioid use disorder or refer the patient for evaluation for treatment if indicated.

18VAC90-40-240. Additional consultation.

A. When necessary to achieve treatment goals, the prescriber shall refer the patient for additional evaluation and treatment.

B. When a practitioner makes the diagnosis of opioid use disorder, treatment for opioid use disorder shall be initiated or the patient shall be referred for evaluation and treatment.

18VAC90-40-250. Medical records.

A. The prescriber shall keep current, accurate and complete records in an accessible manner and readily available for review to include:

1. The medical history and physical examination;

2. Past medical history;

3. Applicable records from prior treatment providers and/or any documentation of attempts to obtain;

4. Diagnostic, therapeutic and laboratory results;

5. Evaluations and consultations;

6. Treatment goals;

7. Discussion of risks and benefits;

8. Informed consent and agreement for treatment;

9. Treatments;

10. Medications (including date, type, dosage and quantity prescribed and refills).

11. Patient instructions; and

12. Periodic reviews.

Part VII. Prescribing of Buprenorphine.

18VAC90-40-260. General provisions.

A. Prescribers engaged in office-based opioid addiction treatment with buprenorphine shall have obtained a waiver from the Substance Abuse Mental Health Services Administration and the appropriate Drug Enforcement Administration registration.

B. Prescribers shall abide by all federal and state laws and regulations governing the prescribing of buprenorphine for the treatment of opioid addiction.

C. Nurse practitioners shall only prescribe buprenorphine for opioid addiction pursuant to a practice agreement with a waivered doctor of medicine or osteopathic medicine.

D. Practitioners engaged in medication-assisted treatment shall refer the patient to a licensed mental health professional for counseling or provide counseling in their practice and document such in the medical record.

18VAC90-40-270. Patient assessment and treatment planning.

A. A practitioner shall perform and document an assessment that includes a comprehensive medical and psychiatric history, substance abuse history, family history and psychosocial supports, appropriate physical examination, urine drug screen, pregnancy test for women of childbearing age, a check of the Prescription Monitoring Program, and, when clinically indicated, infectious disease testing for HIV, Hepatitis B, Hepatitis C and TB.

B. The treatment plan shall include the practitioner's rationale for selecting medication assisted treatment, patient education, written informed consent, how counseling will be accomplished, and a signed treatment agreement that outlines the responsibilities of the patient and the prescriber.

18VAC90-40-280. Treatment with buprenorphine.

A. Buprenorphine without naloxone (buprenorphine mono-product) shall not be prescribed except:

1. When a patient is pregnant; or

2. When converting a patient from methadone to buprenorphine containing naloxone for a period not to exceed seven days.

B. Buprenorphine mono-product tablets may be administered directly to patients in federally licensed opiate treatment programs (OTPs), but only the buprenorphine product containing naloxone shall be prescribed or dispensed for use offsite from the program.

C. The evidence for the decision to use buprenorphine mono-product shall be fully documented in the medical record.

D. Buprenorphine mono-products in formulations including transdermal patches, mucosal adhesives, implantable devises, shall only be administered or prescribed for indications approved by the FDA.

E. Due to a higher risk of fatal overdose when buprenorphine is prescribed with other opioids, benzodiazepines, sedative hypnotics, carisoprodol, and tramadol, the prescriber shall only co-prescribe these substances when there are extenuating circumstances and shall document in the medical record a tapering plan to achieve the lowest possible effective doses if these medications are prescribed.

F. Prior to starting medication-assisted treatment, the practitioner shall perform a check of the Prescription Monitoring Program.

G. During the induction phase, except for medically indicated circumstances as documented in the medical record, patients should be started on a dosage of 4 mg. of buprenorphine per day, and a dosage during induction shall not exceed 8 mg. of buprenorphine per day. The patient shall be seen by the prescriber at least once a week.

H. During the stabilization phase, the prescriber shall increase the daily dosage of buprenorphine in safe and effective increments to achieve the lowest dose that avoids intoxication, withdrawal, or significant drug craving.

I. Practitioners shall take steps to reduce the chances of buprenorphine diversion by using the lowest effective dose, appropriate frequency of office visits, urine drug screens or serum medication levels, pill counts and checks of the Prescription Monitoring Program.

J. Documentation of the rationale for prescribed doses exceeding 16 mg. of buprenorphine per day shall be placed in the medical record. Dosages exceeding 24 mg. of buprenorphine per day are not FDA approved and shall not be prescribed.

K. The practitioner shall incorporate relapse prevention strategies into counseling or assure that they are addressed by a licensed mental health professional.

18VAC90-40-290. Special populations.

A. Pregnant women shall be treated with the buprenorphine mono-product, usually 16 mg. per day or less.

B. Patients under the age of 16 years shall not be prescribed buprenorphine for addiction treatment unless such treatment is approved by the FDA.

C. The progress of patients with chronic pain shall be assessed by reduction of pain and functional objectives which can be identified, quantified and independently verified.

D. Practitioners shall evaluate patients with medical comorbidities by history, physical exam, appropriate laboratory studies, and be aware of interactions of buprenorphine with other prescribed medications.

E. Practitioners shall not undertake buprenorphine treatment with a patient who has psychiatric comorbidities and is not stable. The patient should be referred for psychiatric evaluation and treatment prior to initiating medication-assisted treatment.

18VAC90-40-300. Medical records for opioid addiction treatment.

A. Records shall be timely, accurate, legible, complete, and readily accessible for review.

B. The treatment agreement and informed consent shall be maintained in the medical record.

C. Confidentiality requirements of 42 CFR, Part 2 which prohibits release of records, re-disclosure or other information without the patient's consent or a court order, or in cases of a bona fide medical emergency, or in the mandatory reporting of child abuse, shall be followed.

18VAC90-30-220. Grounds for Disciplinary Action Against the License of a Licensed Nurse Practitioner.

The boards may deny licensure or relicensure, revoke or suspend the license, or take other disciplinary action upon proof that the nurse practitioner:

1. Has had a license or multistate privilege to practice nursing in this Commonwealth or in another jurisdiction revoked or suspended or otherwise disciplined;

2. Has directly or indirectly represented to the public that the nurse practitioner is a physician, or is able to, or will practice independently of a physician;

3. Has exceeded the authority as a licensed nurse practitioner;

4. Has violated or cooperated in the violation of the laws or regulations governing the practice of medicine, nursing or nurse practitioners;

5. Has become unable to practice with reasonable skill and safety to patients as the result of a physical or mental illness or the excessive use of alcohol, drugs, narcotics, chemicals or any other type of material;

6. Has violated or cooperated with others in violating or attempting to violate any law or regulation, state or federal, relating to the possession, use, dispensing, administration or distribution of drugs; ~~or~~

7. Has failed to comply with continuing competency requirements as set forth in 18VAC90-30-105;

8. Has willfully or negligently breached the confidentiality between a practitioner and a patient. A breach of confidentiality that is required or permitted by applicable law or beyond the control of the practitioner shall not be considered negligent or willful.

9. Has engaged in unauthorized use or disclosure of confidential information received from the Prescription Monitoring Program.

From: Maureen Cahill <MCahill@ncsbn.org>
Date: January 30, 2017 at 2:02:44 PM EST
To: MB Executive Officers <execoffs@ncsbn.org>
Cc: Advanced Practice Knowledge Network <AdvancedPracticeKnowledgeNetwork@ncsbn.org>
Subject: C.A.R.A. implementation

Educational opportunities for meeting the requirements to apply for a medication assisted therapy waiver through SAMHSA:
Below are the objectives for meeting the educational requirements of the nurse practitioner application to SAMHSA for a Medication Assisted Therapy waiver.
https://www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/cara-learning-objectives-11017.pdf

The Society of Addiction Medicine and the American Association of Nurse Practitioners have partnered to offer the additional 16 hours of required education [in addition to the 8 hours now offered on the SAMHSA website]. https://www.samhsa.gov/medication-assisted-treatment/qualify-nps-pas-waivers

https://aanp.inreachce.com/SearchResults?searchType=1&category=e5f98b0f-eafe-4f64-9779-383732cd8a10 AANP has the full 24 hours of education available as well:

"This CE activity provides two training sessions that must be completed to fulfill the 24-hour continuing education training requirements outlined in the Comprehensive Addiction and Recovery Act (CARA). Participants must complete both activities to qualify for the waiver application. Those who complete this educational activity must allow a week for their information to be reported and then will be able to apply for the waiver to prescribe buprenorphine for patients with opioid addiction. ASAM, AANP and AAPA have formed a collaborative to provide the 24-hour waiver training for nurse practitioners and physician assistants. Educational content has been identified and/or created to satisfy the 24-hour requirement as described in the Comprehensive Addiction and Recovery Act (CARA). "

" 8-hour Activity Overview: Part I: The ASAM Treatment of Opioid Use Disorder Course: Includes Waiver Qualifying Requirements - will ensure that participants are exposed to the highest quality, evidence-based practices when using buprenorphine to treat opioid use disorders."
"16-hour Activity Overview: Part II: NP/PA 16-Hour Waiver Training - The 16-hour product developed includes all additional education required by the Comprehensive Addiction and Recovery Act (CARA) for nurse practitioners to successfully apply for a waiver to prescribe buprenorphine for office-based treatment of opioid use disorders."
"This activity was planned in accordance with AANP Accreditation Standards and Policies in collaboration with ASAM, and AAPA to provide the 24 hours of required education. Planner, faculty, and all other relevant disclosures are listed on the ASAM website. The collaborative of ASAM, AANP and AAPA identified and reviewed this content to provide the NP/PA training required by CARA. The NP/PA 24-Hour Waiver Training is available for free through 2017 in part by an unrestricted educational grant from Indivior."
"To complete the CE for this activity, successfully complete all content and posttests on the partner site, and then submit the online program evaluation in the AANP CE Center. "
"For questions about this online CE activity, or more information concerning the AANP CE Center, contact the AANP CE Center Manager at CECenter@aanp.org." AANP member site

The only thing that you do not have here is confirmation from SAMHSA that this education fulfills the requirements [though it certainly is implied]. Elliot and I will follow up with them and report back. SAMHSA has previously stated that CNPs could begin with the existing 8 hours and they state:

"For the additional 16 hours, SAMHSA will also offer the training for free through the PCSS-MAT once it has been developed. NPs and PAs who have completed the required training and seek to become DATA-waiver for up to 30 patients will be able to apply to do so beginning in early 2017. For more information on the upcoming launch of the application and SAMHSA-sponsored training opportunities, sign up (link is external) for the Buprenorphine Waiver Management email list." SAMHSA 1/25/2017
https://www.samhsa.gov/medication-assisted-treatment

Maureen
Maureen Cahill [Senior Policy Advisor] 312.525.3646 (D) mcahill@ncsbn.org
National Council of State Boards of Nursing (NCSBN) 111 E. Wacker Drive, Ste 2900, Chicago, IL 60601-4277 312.279.1032 (F) www.ncsbn.org
Our Mission – NCSBN, Leading in nursing regulation

Qualify for NP and PA Waivers

samhsa.gov/medication-assisted-treatment/qualify-nps-pas-waivers

Learn how nurse practitioners (NPs) and physician assistants (PAs) can train and apply to become DATA-waiver practitioners.

On July 22, 2016, President Obama signed the Comprehensive Addiction and Recovery Act (CARA) into law as Public Law 114-198. One of CARA's important provisions expands access to substance use treatment services and overdose reversal medications—including the full spectrum of services from prevention to medication-assisted treatment (MAT) and recovery support—by extending the privilege of prescribing buprenorphine in office-based settings to qualifying nurse practitioners (NPs) and physician assistants (PAs) until Oct. 1, 2021.

Proposed Learning Objectives

CARA requires that NPs and PAs complete 24 hours of training to be eligible for a prescribing waiver. SAMHSA has created a list of recommended learning objectives for the trainings. While we cannot require that the organizations listed in the CARA Act use these learning objectives, we are sharing them with the stakeholders. Access the Proposed Learning Objectives for the NP and PA Waiver Training – 2017 (PDF | 196 KB).

Sign Up for Courses

NPs and PAs may take the eight-hour DATA-waiver course for treatment of opioid use disorder, designed by national experts, that physicians currently take. The course is offered for free by SAMHSA through the Providers' Clinical Support System for Medication Assisted Treatment (PCSS-MAT) (link is external).

For the additional 16 hours, SAMHSA will also offer the training for free through the PCSS-MAT once it has been developed. NPs and PAs who have completed the required training and seek to become DATA-waiver for up to 30 patients will be able to apply to do so beginning in early 2017. For more information on the upcoming launch of the application and SAMHSA-sponsored training opportunities, sign up (link is external) for the Buprenorphine Waiver Management email list.

Proposed Learning Objectives for the Nurse Practitioner and Physician Assistant Waiver Training

Medical withdrawal management and maintenance

General understanding

- Describe the epidemiology of opioid use disorder (OUD)
- Discuss the U.S. Food and Drug Administration (FDA)-approved pharmacological treatments for OUD
- List the benefits of using medication-assisted treatment (MAT) and recovery services for OUD
- Discuss the neurobiology of addiction and the roles genetics and environmental factors play in addiction
- Present the process of medication induction as well as stabilization, maintenance, and treatment termination (when indicated)
- Define safety concerns and drug interactions
- Explain the regulatory oversight for pharmacological treatments for OUD
- Describe minimum standards of care
- Discuss informed consent procedures and treatment agreements when providing MAT for OUD
- Identify how to determine the adequate level of psychosocial treatment and frequency of pharmacotherapy visits when providing MAT
- Explain the importance of evidenced-based practices (EBPs) for substance use disorders (SUDs)
- Demonstrate understanding of the basic principle of EBPs to enhance MAT outcomes:
    - Cognitive behavioral therapy
    - Acceptance and commitment therapy
    - Motivational interviewing
    - 12-step facilitation
    - Community reinforcement approach
    - Community reinforcement and family training approach
- Identify skills from each EPB to be used in a variety of treatment settings
- Demonstrate how to increase understanding of SUD mutual-help groups
- Describe the importance of trauma-informed care in providing a safe setting

Increasing access to MAT

- Describe major barriers to access to and utilization of MAT
- Demonstrate understanding of the vital role of the medical community in ensuring the adoption of MAT and other evidence-based treatments for OUD
- Present the evolution of MAT for OUD

Treating OUD in pregnant women

- Discuss the epidemiology of SUDs (OUD in particular) in pregnant women
- Understand both maternal and fetal/infant risks of OUD during pregnancy and the postpartum period
- Identify screening approaches to OUD during pregnancy
- List MAT options for pregnant women with OUD
- Discuss behavioral treatment options for management of OUD in pregnant women
- Present approaches to management of infants born to mothers with OUD

Appropriate clinical use of FDA-approved medications for OUD treatment

Choosing the most appropriate pharmacological strategy for treatment of individuals with OUD

***Buprenorphine* (e.g., buprenorphine/naloxone combination formulations and buprenorphine monoproduct formulations)**

- Discuss the process of buprenorphine induction
- Present stabilization and maintenance techniques

***Naltrexone* (e.g., extended-release injectable and oral formulations)**

- Describe the process to select the most appropriate patients for treatment with naltrexone
- Determine pharmacological strategies to initiate treatment with naltrexone
- Identify clinical challenges encountered during treatment with naltrexone
- Explain how to implement naltrexone in SUD treatment

Methadone

- Discuss the unique characteristics of opioid treatment programs (OTPs)
- Identify OTPs as part of the continuum of care
- Assess the infrastructure available to support medication management in OTPs
- Identify challenges to and opportunities for integrating all three MAT medications (methadone, buprenorphine, and naltrexone) into OTP settings
- Discuss clinical and operational issues related to medication choice in OTP settings

Benzodiazepines interactions

- Present the basic pharmacology of benzodiazepines
- List the hazards of combining benzodiazepines with buprenorphine or methadone
- Identify alternatives for the treatment of anxiety in the patient with OUD

Initial and periodic patient assessments (e.g., substance use monitoring)

General patient assessment

- Describe the relevant elements of patient history and medical/psychiatric evaluation (including physical examination)
- Identify appropriate screening tools to detect SUDs
- Determine the severity of SUD and patient factors to guide treatment
- Describe the components of a brief intervention
- Present ways to engage patients in achieving and maintaining good physical and mental health
- Explain how to schedule appropriate follow-up appointments and referrals as needed

Urine drug testing (UDT)

- Explain UDT methodology
- Describe the differences between qualitative and quantitative UDT
- Discuss drug metabolism
- Explain a sample integrity check
- Describe best UDT clinical practices

Screening adolescents

- Describe how to quickly screen for symptoms of mental illness among adolescents to identify the most common psychiatric problems
- Explain how to incorporate both mental health and substance use screening into routine pediatric settings

- Define treatment options for adolescents with co-occurring OUD and psychiatric disorders

Addressing overdose, co-occurring disorders, and pain management

Overdose

- Explain the epidemiology of overdose
- Describe the effects of opioids on respiratory function
- Provide the rationale for and scope of overdose education and naloxone distribution (OEND) programs
- Describe how to incorporate OEND into MAT settings:
    - Educate patients about overdose risk reduction
    - Prescribe FDA-approved naloxone rescue kits

Co-occurring disorders

- List psychiatric illnesses and SUDs that commonly co-occur
- Describe how to screen for and identify comorbid psychiatric disorders
- Discuss the distinction between independent psychiatric illness and substance-induced disorders
- Demonstrate how to develop treatment plans when comorbidities are identified

Pain management

- Describe the epidemiology of pain among individuals with OUD and factors that influence the overlap
- Compare patient and provider perspectives on pain management
- Explain the management of pain in special populations (e.g., adolescents, pregnant women, those with chronic medical conditions)
- Discuss general principles of and different approaches to acute and chronic pain management in patients with OUD receiving methadone, buprenorphine, or naltrexone treatment including alternatives to Opiates for acute and long term pain management
- Have familiarity with the Centers for Disease Control and Prevention's Guideline for Prescribing Opioids for Chronic Pain

Counseling and recovery support services

General understanding

- Identify the four key components of a behavioral treatment protocol
- Provide examples of each component
- Describe the elements of a standard medication-management approach

Motivational interviewing

- Describe the fundamental principles of motivational interviewing
- Explain how to use specific motivational interviewing techniques to engage patients in treatment
- Define motivational enhancement and the stages of change

Diversion control

- Define the scope of the problem of healthcare facility drug diversion in the United States
- Describe methods of diversion
- Become familiar with monitoring strategies for signs of diversion and misuse such as state prescription drug monitoring programs

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CE Center

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Home » Buprenorphine Waiver Course » Product Details

NP/PA 16-Hour Waiver Training: Part II Only

Part II ONLY

Credit(s): 16 CE; 12 of which may be applied towards Pharmacology

Register Now

Description Credits Faculty Materials

Category: Buprenorphine Waiver Course, Complimentary, Controlled Substances, Pharmacology, Recent Additions (show less)

Other: Addiction, Chronic Pain, Controlled Substances, Pain Management, Pharmacology, Substance Abuse (show less)

This training course is for the practitioner who has already COMPLETED the 8-hours training activity for use of buprenorphine to treat opioid use disorders and ONLY REQUIRES the additional 16 hours to request the waiver to prescribe buprenorphine.

If you have *not* completed the 8-hour training, register for and complete *NP/PA 24-Hour Waiver Training* in the AANP CE Center to meet the requirements for the waiver.

Release Date: January 17, 2017

Once you have REGISTERED this course in the AANP CE Center, under Download Materials, review the instructions for completing this activity.

- Participants must complete, in full, both parts of this educational requirement to be waivered (see below)
  - 8-Hour Training: Part I: The ASAM Treatment of Opioid Use Disorder Course: Includes Waiver Qualifying Requirements
  - 16-Hour Training: Part II: NP/PA 16-Hour Waiver Training
- Learners will be directed to a partner site for content, and re-directed back to the AANP CE Center to complete the requirements for CE and obtain the CE Certificate. **Learners must log on in the Partner site and and Register this course on their site to continue.**
- Those who complete this educational activity must allow approximately a week for their information to be reported to Center for Substance Abuse Treatment (CSAT). They will then be able to apply for the waiver to prescribe buprenorphine to their patients with opioid use disorders.
- Monitor the SAMHSA website regarding the NP waiver application form: The information regarding the application process will come from the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA has stated their plans to open the application process for NPs/PAs in early 2016. Updates on the waiver application will be available at http://www.samhsa.gov/medication-assisted-treatment

Reference Number: 16122474-A

Overview

This CE activity provides the PART II training session that must be completed to fulfill the 24-hour continuing education training requirements outlined in the Comprehensive Addiction and Recovery Act (CARA). Participants must complete both the 8-hour session and this 16-hour session to qualify for the waiver application. Those who complete this educational activity must allow a week for their information to be reported and then will be able to apply for the waiver to prescribe buprenorphine for patients with opioid addiction.

ASAM, AANP and AAPA have formed a collaborative to provide the 24-hour waiver training for nurse practitioners and physician assistants. Educational content has been identified and/or created to satisfy the 24-hour requirement as described in the Comprehensive Addiction and Recovery Act (CARA).

8-hour Activity Overview (completed previous to this activity): Part I: The ASAM Waiver Course: Treatment of Opioid Use Disorder - will ensure that participants are exposed to the highest quality, evidence-based practices when using buprenorphine to treat opioid use disorders.

16-hour Activity Overview: Part II: NP/PA 16-Hour Waiver Training (this activity)- The 16-hour product developed includes all additional education required by the Comprehensive Addiction and Recovery Act (CARA) for nurse practitioners to successfully apply for a waiver to prescribe buprenorphine for office-based treatment of opioid use disorders.

Objectives

At the completion of this presentation Learners will be able to:

- Apply for a waiver to prescribe buprenorphine to their patients with opioid use disorders
- Identify and assess patients who are appropriate for treatment with medications
- Have specific knowledge concerning the use of medications to manage patients with addiction involving opioid use
- Discuss the psychiatric and medical co-morbidities associated with opioid addiction

Content Developers and Speakers

- Daniel P. Alford, MD, MPH, FACP, DFASAM
- Sarah Bagley, MD
- Jeffrey Baxter, MD
- Adam Bisaga, MD

- Timothy K. Brennan, MD, MPH
- Theordore Cicero, PhD
- Captain Jennifer Fan, PharmD, JD
- James W. Finch, MD, DFASAM
- Debra Houry, MD, MPH
- Brian Hurley, MD, MBA, DFASAM
- Magaret A. Jarvis, MD, DFASAM
- Karol Kaltenbach, PhD
- Kyle Kampman, MD
- Colleen Labelle, BSN, RN-BC, CARN
- Lorenzo Leggio, MD, PhD, MSc
- Sharon Levy, MD, MPH
- Raye Z. Litten, PhD,
- Paula Lum, MD, MPH, FASAM
- Barbara Mason, PhD
- David Mee-Lee, MD, FASAM
- Yngvild K. Olsen, MD, MPH, FASAM
- Ricardo Restrepo, MD, MPH,
- Richard N. Rosenthal, MD, FASAM
- Kelley Saia, MD
- Edwin A. Salsitz, MD, DFASAM
- Andrew Saxon, MD, FASAM
- Mark Sullivan, MD, PhD,
- Frank J. Vocci, PhD,
- R. Corey Waller, MD, MS, DFASAM,
- Alexander Y. Walley, MD, MSc, FASAM,
- Timothy J. Weigand, MD, DABAM, FACMT, FAACT
- Tricia Wright, MD, MS, FACOG, FASAM
- Tricia E. Wright, MD, MS, FACOD, FASAM
- Stephen A. Wyatt, DO, FASAM

Disclosure
This activity was planned in accordance with AANP Accreditation Standards and Policies in collaboration with ASAM, and AAPA to provide the 24 hours of required education. Planner, faculty, and all other relevant disclosures are listed on the ASAM website.

The collaborative of ASAM, AANP and AAPA identified and reviewed this content to provide the NP/PA training required by CARA. The NP/PA 24-Hour Waiver Training is available for free through 2017 in part by an unrestricted educational grant from Indivior.

This educational activity may contain opinions of the speakers from their personal experience. The activity may contain discussion of published and/or investigational uses of agents that are not indicated by the FDA. Please refer to the official prescribing information for each product for discussion of approved indications, contraindications, and warnings. Further, attendees/participants should appraise the information presented critically and are encouraged to consult appropriate resources for any product or device mentioned in this program.

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Home » Buprenorphine Waiver Course » Product Details

NP/PA 24-Hour Waiver Training

Credit(s): 24 CE; 18 of which may be applied towards Pharmacology

Register Now

Description Credits Faculty Materials

Category: Buprenorphine Waiver Course, Complimentary, Controlled Substances, Pharmacology, Recent Additions (show less)

Other: Addiction, Assessment, Controlled Substances, Mental Health, Opioids, Pharmacology, Substance Abuse, Treatment Plan (show less)

Release Date: January 17, 2017

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- Monitor the SAMHSA website regarding the NP waiver application form: The information regarding the application process will come from the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA has stated their plans to open the application process for NPs/PAs in early 2016. Updates on the waiver application will be available at http://www.samhsa.gov/medication-assisted-treatment.

Reference Number: 16122474

Overview

This CE activity provides two training sessions that must be completed to fulfill the 24-hour continuing education training requirements outlined in the Comprehensive Addiction and Recovery Act (CARA). Participants must complete both activities to qualify for the waiver application. Those who complete this educational activity must allow a week for their information to be reported and then will be able to apply for the waiver to prescribe buprenorphine for patients with opioid addiction.

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Vu, Huong (DHP)

From: Maureen Cahill <MCahill@ncsbn.org>
Sent: Wednesday, January 11, 2017 8:58 AM
To: Advanced Practice Knowledge Network
Subject: DEA renewal change

The DEA has reversed its plan to alter the process for DEA renewal and the latest advisory can be found here:

https://www.deadiversion.usdoj.gov/drugreg/index.html.
/ https://apps.deadiversion.usdoj.gov/webforms/jsp/regapps/common/renewalAppLogin.jsp

Maureen

Maureen Cahill [Senior Policy Advisor] 312.525.3646 (D) mcahill@ncsbn.org
National Council of State Boards of Nursing (NCSBN) 111 E. Wacker Drive, Ste 2900, Chicago, IL 60601-4277
312.279.1032 (F) www.ncsbn.org
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U.S. DEPARTMENT OF JUSTICE ★ DRUG ENFORCEMENT ADMINISTRATION

DIVERSION CONTROL DIVISION

REGISTRATION

Applications
Tools
Resources
CMEA Required Training & Self-Certification
Quota Applications

Renewal Applications Online

REVISED ANNOUNCEMENT REGARDING RENEWAL APPLICATIONS

Starting January 2017, DEA will no longer send its second renewal notification by mail. Instead, an electronic reminder to renew will be sent to the email address associated with the DEA registration.

At this time, DEA will otherwise retain its current policy and procedures with respect to renewal and reinstatement of registration. This policy is as follows:

- If a renewal application is submitted in a timely manner prior to expiration, the registrant may continue operations, authorized by the registration, beyond the expiration date until final action is taken on the application.
- DEA allows the reinstatement of an expired registration for one calendar month after the expiration date. If the registration is not renewed within that calendar month, an application for a new DEA registration will be required.
- Regardless of whether a registration is reinstated within the calendar month after expiration, federal law prohibits the handling of controlled substances or List 1 chemicals for any period of time under an expired registration.

DEA Form 224a – Retail Pharmacy, Hospital/Clinic, Practitioner, Teaching Institution, or Mid-Level Practitioner
DEA Form 225a – Manufacturer, Distributor, Researcher, Analytical Laboratory, Importer, Exporter
DEA Form 363a – Narcotic Treatment Programs
DEA Form 510a – Domestic Chemical

New Applications Online

DEA Form 224 – Retail Pharmacy, Hospital/Clinic, Practitioner, Teaching Institution, or Mid-Level Practitioner
DEA Form 225 – Manufacturer, Distributor, Researcher, Canine Handler, Analytical Laboratory, Importer, Exporter
DEA Form 363 – Narcotic Treatment Programs
DEA Form 510 – Domestic Chemical

To Apply for New Applications for Registration through the U.S. Postal Service

Researcher - Schedule I Only

Researchers with Schedule I drugs only must submit DEA 225 PDF application and the protocol found in **21 CFR 1301.18.** You cannot apply online for your initial application.

Registration Tools

Chain Renewals

Duplicate Certificates

This form is not for change of address or matters pertaining to the renewal of your registration. For these matters call **1-800-882-9539**; for change of address, use the **Address Changes** Form.

Duplicate Receipt of Registration Application

Online Pharmacy Modifications

- Modify business activity from Retail Pharmacy to Retail Online Pharmacy
- Modify business activity from Retail Online Pharmacy to Retail Pharmacy
- Modify existing Retail Online Pharmacy Information

Official Order Forms

NOTICE: Modification to the "Mailing Address" section of the DEA Form 222

Large Volume Order Forms (DEA Form 222)

Q & A - DEA Form 222 - Official Order Forms

Registration Changes - Use for the following Registration Changes:

Name Changes | Schedule Changes | Drug Code Changes | Address Changes - ***Do not submit this until you have an approved state license for the new address. Please note that these changes will become effective immediately upon DEA approval.***

Registration for Disposal of Controlled Substances

- Modify eligible DEA registration to collect pharmaceutical controlled substances from ultimate users (e.g., patients)
- Modify DEA registration to stop being a collector
- Modify existing collector registration information

Search for an Authorized Collector Location

Registration Validation

Registration Resources

Registration Procedures

Registration Categories and Fees

Customer Service Plan for Registrants (January 2010)

Pharmacist's Manual

Practitioner's Manual

Practitioner's License Requirements

Mid-Level Practitioners (MLP) Authorization by State

Questions & Answers

Reinstated and Retired Registrant List

A complete listing of all active DEA registration numbers can be obtained from the U.S. Department of Commerce National Technical Information Service (NTIS) Web Site at **http://www.ntis.gov/products/dea.aspx**. For your convenience and the most accurate information of a Registrant's status, please use the **Registration Validation Tool**. For further information, contact **DEA.Registration.Help@usdoj.gov**

Registrant Population (Active)

Summary | Active Registrants by State | Active Registrants by Business Activity | Active Chemical Handler Registrants

State Licensing Boards

2012 Fee Rule

Controlled Substances and List I Chemical Registration and Reregistration Fees (March 15, 2012)

Supporting and Related Material:

New Registrant Fee Schedule Calculations - Diversion Control Fee Account (PDF) (March 12, 2012)

ECONOMIC IMPACT ANALYSIS of Final Rule on Controlled Substances and List I Chemical Registration and Reregistration Fees, DEA-346 (PDF) (March 12, 2012)

DEA Registrant Letter (PDF) (March 12, 2012)

Registration Fees Fact Sheet (PDF) (March 12, 2012)

New DEA Number Series

DEA is announcing that, *effective immediately*, DOD personal service contractors will be issued a **new DEA registration number that begins with the letter "G"**. This new first character will be in addition to the current first characters A, B, F of the DEA registration for practitioners. The G series DEA registration number will be listed in the database provided to NTIS and available on the DEA website validation query system.

Registrant type (first letter of DEA Number):

A/B/F/G – Hospital/Clinic/Practitioner/Teaching Institution/Pharmacy

M – Mid-Level Practitioner (NP/PA/OD/ET, etc.)

P/R – Manufacturer/Distributor/Researcher/Analytical Lab/Importer/Exporter/Reverse Distributor/Narcotic Treatment Program

Registration Help

Contact DEA Registration Service Center at **1-800-882-9539**

Email **DEA.Registration.Help@usdoj.gov** - Be sure to include your DEA Registration number in your email

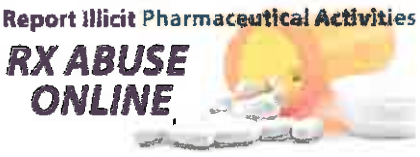
Locate Field Office Registration Program Specialist

CMEA (Combat Meth Epidemic Act)

CMEA Required Training & Self-Certification

Monthly Self Certification List (Electronically downloadable formatted list of person who have self-certified)

Quota Applications



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Title 21 USC Codified CSA

DIVERSION CONTROL DIVISION

U.S. DEPARTMENT OF JUSTICE • DRUG ENFORCEMENT ADMINISTRATION
Diversion Control Division • 8701 Morrissette Drive • Springfield, VA 22152 • 1-800-882-9539

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U.S. DEPARTMENT OF JUSTICE ★ DRUG ENFORCEMENT ADMINISTRATION

DIVERSION CONTROL DIVISION

Renewal Application for Registration Under Controlled Substances Act of 1970

ONLY USE THIS FORM TO:

1. **RENEW YOUR DEA REGISTRATION** (Do not use for NEW Registrations or if you have already mailed in a paper form).
2. **OBTAIN A RECEIPT for recent renewal submitted via this on-line form.**

ON-LINE RENEWAL CONSISTS OF SIX (6) SECTIONS. You will need information from your **current renewal notice and/or registration certificate** in order to login. Please have the following information available **before** you begin the application:

Section 1. Personal/Business Information

Review current information. If changed: Address, phone number. If not previously provided: SSN or Tax ID.

Section 2. Activity

If changed: Drug Schedule information. **In addition** - Certain registrants for forms 225 and 510 will need to provide specific drug codes and/or chemical codes related to their operations.

Section 3. State License(s)

It is mandatory to provide State medical and/or controlled substance licenses/registrations. Failure to provide VALID and ACTIVE state licenses will be cause to declare the application as defective and it will be withdrawn **WITHOUT refund.**

Section 4. Background Information

Information pertaining to controlled substances in the applicant's background.

Section 5. Payment

Payment, via this on-line application, must be made with a Visa or MasterCard, American Express, or Discover. **Application fees are not refundable.**

Section 6. Confirmation

Applicants will confirm the entered information, make corrections if needed, and electronically submit the application and a submission confirmation will be presented. Applicants will be able to print copies for their records.

WARNING: 21 USC 843(d), states that any person who knowingly or intentionally furnishes false or fraudulent information in the application is subject to a term of imprisonment of not more than 4 years, and a fine under Title 18 of not more than $250,000, or both.

DEA Registration Renewal Form Login:

[ ] **DEA Number (Required** - Not Case Sensitive)

[ ] **Last Name or Business Name (Required** - Not Case Sensitive) As it appears on your registration. Example: If "Smith, John Q MD" is on your registration, then enter: **Smith** If "Smith's, Pharmacy" is on your registration, then enter: **Smith's** If "Smith's Pharmacy" (no comma) is on your registration, then enter: **Smith's Pharmacy**

[ ] **First Name** (Optional - Not Case Sensitive)
As it appears on your registration. Example: If "Smith, John MD" is on your registration, then enter: **John MD** If "Smith's, Pharmacy" is on your registration, then enter: **Pharmacy** If "Smith's Pharmacy" (no comma) is on your registration, then enter nothing

[ ] **SSN (Required** if given on previous application)

[ ] **Tax ID (Required** if given on previous application)

[-Month-] [-Day-] [-Year-] **Current Expiration Date (Required**. Listed on registration certificate. In most cases, must be less than 60 days from today's date.)

[-State-] **State (from registered address) (Required).**

[ ] **Zip (from registered address) (Required).**

Please do not use your browser's BACK and FORWARD buttons while navigating this form.

Login

ADDITIONAL INFORMATION

Form 224A *Approved OMB Form No. 1117-0014 Expires: 04/30/2019 (12 minutes)*
Form 225A *Approved OMB Form No. 1117-0012 Expires: 07/31/2018 (15 minutes)*
Form 510A *Approved OMB Form No. 1117-0031 Expires: 05/31/2019 (15 minutes)*
Form 363A *Approved OMB Form No. 1117-0015 Expires: 06/30/2018 (15 minutes)*

1. No registration will be issued unless a completed application form has been received (21 CFR 1301.13).
2. In accordance with the Paperwork Reduction Act of 1995, no person is required to respond to a collection of information unless it displays a valid OMB control number. The OMB number for this collection is (See Above). Public reporting burden for this collection of information is estimated to average (See Above) per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information.
3. The Debt Collection Improvements Act of 1996 (31 U.S.C. §7701) requires that you furnish your Taxpayer Identification Number (TIN) or Social Security Number (SSN) on this application. This number is required for debt collection procedures if your fee is not collectible.
4. **PRIVACY ACT NOTICE:**
   Providing information other than your SSN or TIN is voluntary; however, failure to furnish it will preclude processing of the application. The authorities for collection of this information are §§302 and 303 of the Controlled Substances Act (CSA) (21 U.S.C. §§822 and 823). The principle purpose for which the information will be used is to register applicants pursuant to the CSA. The information may be disclosed to other Federal law enforcement and regulatory agencies for law enforcement and regulatory purposes, State and local law enforcement and regulatory agencies for law enforcement and regulatory purposes, and person registered under the CSA for the purpose of verifying registration. For further guidance regarding how your information may be used or disclosed, and a complete list of the routine uses of this collection, please see the DEA System of Records Notice "Controlled Substances Act Registration Records" (DEA-005), 52 FR 47208, December 11, 1987, as modified.

DIVERSION CONTROL PRIVACY POLICY

From: Maureen Cahill <MCahill@ncsbn.org>
Date: January 4, 2017 at 8:38:23 AM CST
To: MB Executive Officers <execoffs@ncsbn.org>
Subject: Annual Certification Survey

Good morning everyone and Happy New Year! Please find attached the annual NCSBN APRN role and population certification survey reports. The current reporting period is for the year 2015. You will find a letter explaining the surveys and intended use of the materials. Also attached is a breakdown of 1st time and repeat pass rates by certification program and role type. I also present trending data on 1st time exam writers by year and by role.

The following news update was submitted:

Effective January 2017, the *American Academy of Nurse Practitioners National Certification Board, Inc.* changed its business name from the **American Academy of Nurse Practitioners Certification Program (AANPCP)** to the **American Academy of Nurse Practitioners Certification Board (AANPCB).** The updated name, acronym, and logo will appear on all official AANPCB documents and materials. We expect to complete these updates within the next few weeks.

Although these are minor changes, **Certification Board** more accurately represents our official incorporation name (American Academy of Nurse Practitioners National Certification Board, Inc. 1999) and reflects the full scope of the organization since we offer multiple certification programs. While our name and logo have changed, our website domain www.aanpcert.org and contact information remain the same Certification@aanpcert.org.

In addition, AANPCB launched the Emergency NP specialty certification by examination for certified FNPs yesterday. The ENP examination meets the requirements of the Consensus Model for both specialty certification and APRN role/population focused competencies.

Once you have reviewed the information, if you have any questions or clarifications, please let me know. We will shortly be adding these documents to the members only portion of the APRN webpage.

Maureen

Maureen Cahill [Senior Policy Advisor] 312.525.3646 (D) mcahill@ncsbn.org
National Council of State Boards of Nursing (NCSBN) 111 E. Wacker Drive, Ste 2900, Chicago, IL 60601-4277 312.279.1032 (F) www.ncsbn.org
Our Mission – NCSBN, Leading in nursing regulation

NCSBN Annual APRN Certification Examination Report Data

December 16, 2016

Executive Summary

Each year in September and October, NCSBN conducts a survey of the APRN role certification programs. These accredited exams are used as one of the elements of eligibility for APRN licensure or recognition in states and jurisdictions. The survey offers information on the number of tests administered by examination type as well as information about accreditation of the exams. Previous surveys are available on the member's only section on NCSBN.org website/APRN Consensus. Survey data always represents the previous calendar year.

This information is intended to supplement Member Board's own criteria as they consider the suitability of certification exams for use in licensure decisions.

Certification exams were changed to better align with The APRN Consensus Model. Exams are available for each of the four APRN roles and for most populations (the Women's Health CNS does not have an exam). Gerontology content and wellness concepts have been incorporated into exams, as required by the APRN Consensus Model. The certification programs have indicated they will maintain their old credentials through continuing education or other means.

The American Association of Colleges of Nursing surveyed APRN programs in 2015 to learn whether they were aligned with the APRN role and population changes that are outlined in the APRN Consensus Model. It was learned that only a handful of programs had any remaining students in non-aligned programs. The retirement of non-aligned exams was postponed to allow for an examination to be available to such students. Graduates are expected to sit for a certification examination that tests adult/gerontology and wellness concepts, and, in the case of pediatric and adult/gerontology nurse practitioners, tests the focus of acute or primary care. *Please note that several exams will be discontinued at the end of this calendar year and several (that are not fully aligned) will be discontinued in 2017. Boards of Nursing will need to determine whether those to-be-discontinued exams can be used in their state as an element of licensure eligibility.*

I have provided, *purely for interest sake*, on the following page, trending data of all first time test takers by role, from 2005 – 2015.

Please send any questions, comments, or requests to Maureen Cahill 312-525-3646. Have a very safe and happy holiday season!

Maureen

Maureen Cahill [Associate] 312.525.3646 (D) mcahill@ncsbn.org
National Council of State Boards of Nursing (NCSBN) 111 E. Wacker Drive, Ste 2900, Chicago, IL 60601-4277 312.279.1032 (F) www.ncsbn.org
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Organization/Examination and Credential Granted Data is always 1 full year behind. Pertains to 2015 data	Credential Granted	How many times in 2015 did you make exceptions?	Number of first time writers:	Pass rate if first time writers:	Number of repeat writers:	Pass rate of repeat writers:	ABNS	NCCA	Exam retirement date
American Association of Critical Care Nursing (AACN) Pediatric Clinical Nurse Specialist wellness through acute care	ACCNS-P	0	12	100%	0	NA	1/1/2012-1/1/2017	4/1/2015 to 3/31/2020	NA
American Association of Critical Care Nursing (AACN) Adult-Gerontology Clinical Nurse Specialist wellness through acute care	ACCNS-AG	0	126	88%	12	50%	1/1/2012-1/1/2017	4/1/2015 to 3/31/2020	NA
American Association of Critical Care Nursing (AACN) Adult-Gero Acute Care Nurse Practitioner	ACNP-AG	0	174	76.4%	49	30.6%	1/1/2012-1/1/2017	4/1/2015 to 3/31/2020	NA
American Association of Critical Care Nursing (AACN)* Adult Acute Care Nurse Practitioner	ACNPC	0	10	60%	3	33%	6/1/2014-3/1/2019	NCCA accreditation was extended through the last day of testing for the retired exams so that all candidates had the opportunity to take a fully accredited certification exam.	This exam has been retired effective 08/31/2015.

American Association of Critical Care Nursing (AACN)* Acute/Critical Care Clinical Nurse Specialist Neonatal	CCNS - N	0	1	100%	0	NA	3/1/2014-3/1/2019	NCCA accreditation was extended through the last day of testing for the retired exams so that all candidates had the opportunity to take a fully accredited certification exam.	This exam has been retired effective 08/31/2015.
American Association of Critical Care Nursing (AACN)* Acute/Critical Care Clinical Nurse Specialist Pediatric	CCNS - P	0	2	50%	0	NA	1/1/2012-1/1/2017	NCCA accreditation was extended through the last day of testing for the retired exams so that all candidates had the opportunity to take a fully accredited certification exam.	This exam has been retired effective 08/31/2015.
American Association of Critical Care Nursing (AACN) Acute/Critical Care Clinical Nurse Specialist – Adult	CCNS - A	0	72	81%	6	33%	1/1/2012-1/1/2017	4/1/2015 to 3/31/2020	NA
American Nurses Credentialing Center (ANCC); Pediatric Primary Care Nurse Practitioner	PPCNP-BC	0	92	79.35%	20	45.96%	1/1/2012-1/1/2017	8/1/2014-7/31/2019	NA
American Nurses Credentialing Center (ANCC); Psychiatric-Mental Health Nurse Practitioner {across the life-span}	PMHNP-BC	0	1,168	87.67%	211	48.04%	1/1/2012-1/1/2017	8/1/2014-7/31/2019	NA

American Nurses Credentialing Center (ANCC); Family Nurse Practitioner	FNP-BC	1; ineligible determination was overturned as result of an appeal.	4,689	75.41%	920	39.97%	1/1/2012-1/1/2017	8/1/2014-7/31/2019	NA
American Nurses Credentialing Center (ANCC); Adult-Gerontology Primary Care Nurse Practitioner	AGPCNP-BC	0	1,340	78.73%	186	37.73%	6/1/2014-3/1/2019	8/1/2014-7/31/2019	NA
American Nurses Credentialing Center (ANCC); Adult-Gerontology Acute Care Nurse Practitioner	AGACNP-BC	0	1,778	86.28%	268	57.86%	3/1/2014-3/1/2019	8/1/2014-7/31/2019	NA
American Nurses Credentialing Center (ANCC); Gerontological Nurse Practitioner	GNP-BC	0	31	77.42%	35	40.36%	1/1/2012-1/1/2017	4/6/1996 (first accredited) to 1/31/2017	12/31/2017
American Nurses Credentialing Center (ANCC); Adult Nurse Practitioner	ANP-BC	0	167	71.86%	155	38.07%	1/1/2012-1/1/2017	4/6/1996 (first accredited) to 1/31/2017	12/31/2016
American Nurses Credentialing Center (ANCC); Adult Psychiatric-Mental Health Nurse Practitioner	PMHNP-BC	0	69	69.57%	115	37.37	1/1/2012-1/1/2017	2012 to 2017	12/31/2016
American Nurses Credentialing Center (ANCC); Acute Care Nurse Practitioner	ACNP-BC	0	97	81.44%	44	40.63%	1/1/2012-1/1/2017	2014 to 2019	12/31/2016

American Nurses Credentialing Center (ANCC); Pediatric Clinical Nurse Specialist	PCNS-BC	0	28	75.00%	16	37.27%	11/1/2012 - 11/1/2017	2012 to 2017	10/31/2017
American Nurses Credentialing Center (ANCC); Child/Adolescent Psychiatric-Mental Health Clinical Nurse Specialist	PMHCNS-BC	0	7	85.71%	4	50.00%	11/1/2012 - 11/1/2017	2012 to 2017	10/31/2017
American Nurses Credentialing Center (ANCC); Adult Psychiatric-Mental Health Clinical Nurse Specialist	PMHCNS-BC	0	41	82.93%	19	20.56%	11/1/2012 - 11/1/2017	Jun 2017	10/31/2017
American Nurses Credentialing Center (ANCC); Adult Clinical Nurse Specialist	ACNS-BC	0	171	70.18%	74	33.43%	N/A	3/31/2020	10/31/2017
American Nurses Credentialing Center (ANCC); Adult-Gerontology Clinical Nurse Specialist	AGCNS-BC	0	241	87.14%	27	43.96%	N/A	In process	
Pediatric Nursing Certification Board/Primary Care Pediatric Nurse Practitioner (PNCB)	CPNP-PC	0	936	92%	117	63%	N/A	1/31/2022	

Pediatric Nursing Certification Board/Acute Care Pediatric Nurse Practitioner (PNCB)	CPNP-AC	0	260	77%	64	63%	2012 to 2017	1/31/2022	
American Academy of Nurse Practitioners Certification Program (AANPCP)/Adult Nurse Practitioner ANP-C	ANP-C	0	143	75.50%	75	40%	2013 to 2018	11/30/2017	
American Academy of Nurse Practitioners Certification Program (AANPCP)/Adult-Gerontology Primary Care Nurse Practitioner A-GNP-C	A-GNP-C	0	2,266	81.70%	291	64.3%	2012 to 2017	1/31/2019	
American Academy of Nurse Practitioners Certification Program (AANPCP)/Family Nurse Practitioner FNP-C	FNP-C	0	12,301	81.40%	1748	58.1%	2012 to 2017	11/30/2017	
National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA) grants CRNA credential	CRNA	1 Individual requested take the National Certification Examination beyond the two year testing policy.	2440	85.00%	553	65.1%	pending	4/30/2017	

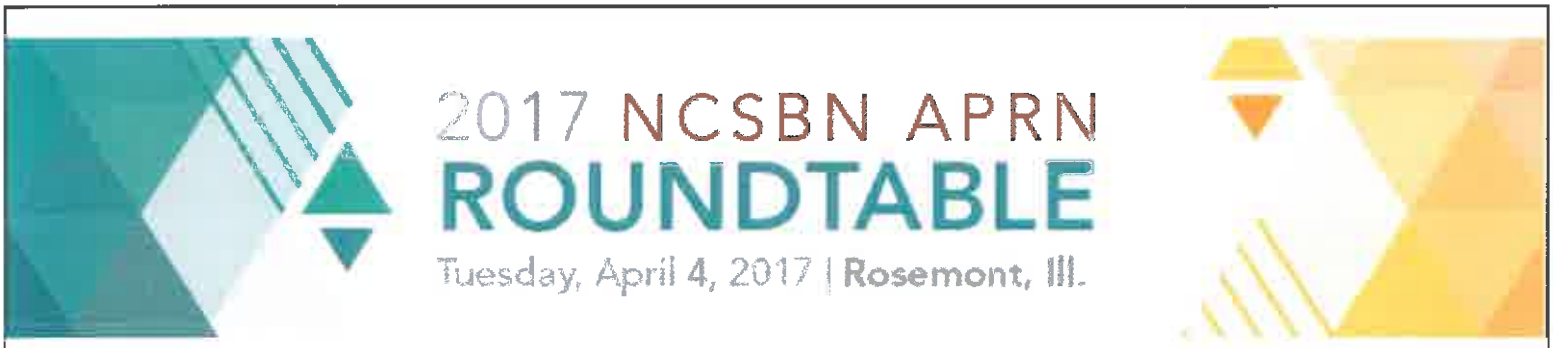
The National Certification Corporation for the Obstetric, Gynecologic & Neonatal Specialties: Women's Health Care NP (NCC)	WHNP-BC	0	641	87.80%	1	0%	Through 03/31/2020		
The National Certification Corporation for the Obstetric, Gynecologic & Neonatal Specialties: Neonatal NP (NCC)	NNP-BC	0	331	87.90%	1	0%	Through 03/31/2020		
American Midwifery Certification Board (AMCB) grants the CNM credential	CNM	0	561	93.20%	37	75.5%		Through 12/31/2016	NA

*AACN – retired exam credentials are maintained as renewal as long as certificate holders require them to continue to practice as APRNs. Renewal by testing is possible for those who cannot meet practice requirements.

Vu, Huong (DHP)

From: Vu, Huong (DHP) on behalf of Douglas, Jay P. (DHP)
Sent: Thursday, January 05, 2017 11:38 AM
To: Vu, Huong (DHP)
Subject: FW: Registration Open for the 2017 NCSBN APRN Roundtable

From: NCSBN Meetings [mailto:meetingsregistration@ncsbn.org]
Sent: Thursday, January 05, 2017 11:20 AM
To: Douglas, Jay P. (DHP)
Subject: Registration Open for the 2017 NCSBN APRN Roundtable



The NCSBN APRN Roundtable is an opportunity for advanced practice registered nurse (APRN) stakeholders to discuss common issues/concerns regarding APRNs.

The roundtable is intended for professionals, educators, professional societies, credentialing agencies and others interested in the grassroots work of moving toward the unified elements of The 2008 Consensus Model for APRN Regulation.

OBJECTIVES
1. Detail the application of grandfathering to those whose roles or populations were affected when APRN Consensus was put in place.
2. Identify lessons to be learned from closed claims involving APRN providers as they relate to diagnosis, APRN preparation, and appropriate referral.
3. Identify the challenges for Boards of Nursing regarding APRNs whose practice is misaligned with education and certification.
4. Describe the most common legal challenges to APRN practice.

Accommodations for the roundtable are provided by Hyatt Regency O'Hare.

Registration is complimentary to approved attendees. It includes sessions, continental breakfast, lunch and refreshment breaks.

When Tuesday, April 4, 2017 9:00 am - 3:30 pm
Central Time

Where Hyatt Regency O'Hare
9300 Bryn Mawr Avenue, Rosemont, Illinois 60018, USA

Dress Code	Business Casual
Fees	View Event Fees View Event Summary View Event Agenda
Registration Deadline	Tuesday, March 21, 2017

Please respond by clicking one of the buttons below

YES NO

NCSBN
National Council of State Boards of Nursing

Having trouble with the link? Simply copy and paste the entire address listed below into your web browser:
http://www.cvent.com/d/q5uiUWAKxUOSZx6fx_2cmQ/njsd/P1/1Q?

If you no longer want to receive emails from NCSBN Meetings please click the link below.
Opt-Out

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AGENDA

Subject to change.

Tuesday, April 4, 2017

8:00 am - 9:00 am	**Continental Breakfast**
8:00 am - 9:00 am	**Registration**
9:00 am - 9:15 am	**The Many Lanes of APRN Roles and Populations** Maureen Cahill, MSN, RN, APN-CNS Senior Policy Advisor, NCSBN
9:15 am - 10:10 am	**Diagnostic Timeliness, Accuracy and Closed Claims** Penny Greenburg, MS, RN, CPPS Senior Program Director, CRICO Strategies
10:10 am - 10:30 am	**Break**
10:30 am - 11:00 am	**APRN Alignment of Practice with Education and Certification in a Role & Population** Lisa Emrich, MSN, RN, FRE Program Manager, Practice, Education and Administration, Ohio Board of Nursing
11:00 am - 12:00 pm	**Defending Your Lane, the Misaligned APRN** Carolyn Buppert, MSN, JD Health Care Attorney
12:00 pm - 1:00 pm	**Lunch**
1:00 pm - 2:00 pm	**Panel Discussion: Changing Lanes - APRNs Adding a Focus or Population** Robin Bissinger PhD, APRN, NNP-BC, FAAN Executive Director, National Certification Corporation Bruce Schoneboom, CRNA, BSN, MHS, PhD Senior Director, Educational and Professional Development, American Association of Nurse Anesthetists Suzanne Staebler, DNP, FAANP, Associate Professor, Nell Hodgson Woodruff School of Nursing at Emory University and President of the National Certification Corporation Anne Thomas, PhD, ANP-BC, GNP, FAANP Associate Dean for Academic Affairs, College of Nursing, Michigan State University
2:00 pm - 2:20 pm	**Break**
2:20 pm - 3:00 pm	**Panel Discussion: What Attaining and Maintaining Certification Means** Panelists: Peg Harrison, MS, RN, CPNP-PC, CAE CEO, Pediatric Nursing Certification Board Carol Hartigan, MA, RN Certification and Policy Strategist, American Association of Critical-Care Nurses Richard F. Meadows, MS, RN, NP-C, FAANP Chief Executive Officer, American Academy of Nurse Practitioners National Certification Program Diane Thompkins, MS, RN Manager, Accreditation, Certification Department, American Nurses Credentialing Center

3:30 pm	**Closing Remarks**