Committee of Joint Boards of Nursing and Medicine Regulatory Advisory Ad Hoc Committee

HB 793 Nurse Practitioners

May 17, 2018

Department of Health Professions
Perimeter Center - 9960 Mayland Drive
Conference Center, Board Room 2
Henrico, Virginia 23233

Committee of Joint Boards of Nursing and Medicine
Regulatory Advisory Ad Hoc Committee HB 793 Nurse Practitioners

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Meeting Agenda
May 17, 2018 at 9:00 A.M. to 2:00 P.M. in Board Room 2

Call to Order - Louise Hershkowitz, CRNA, MSHA Chair

Welcome and Introductions/Overview of purpose of the meeting - L. Hershkowitz

Ordering of the agenda - L. Hershkowitz

Public Comments - L. Hershkowitz

Review of HB 793 - E. Yeatts

Review of timeline and topics for consideration - L. Hershkowitz

Review of written public comments - E. Yeatts

Discussion of possible regulatory language -L. Hershkowitz/E. Yeatts

Identification of next steps

Adjourn

Attachments:

1. Tentative Timeline/Topics for Consideration in Adoption of Regulations to Amend Chapter 30 (Nurse Practitioner Licensure) and Chapter 40 (Prescriptive Authority)
2. HB 793
3. Public Comments on Promulgation of Regulations for Implementation of HB 793 – Autonomous Practice for Nurse Practitioners
4. Nurse Practitioner Licensing Categories
5. Nurse Practitioner Core Competencies Content
   Source: National Organization of Nurse Practitioner Faculties (NONPF)

Implementation of HB793
(Autonomous practice for certain nurse practitioners)

Tentative Timeline:

04/11/18 Discussion of legislation and plan for promulgation of emergency regulations which must be effective by 1/9/19

05/17/18 Committee of Joint Boards to receive public comment, consider draft regulations, and make recommendations

06/?/18 Additional meeting of Joint Boards if necessary to complete recommended regulations

07/17/18 Board of Nursing to adopt emergency regulations/NOIRA

08/3/18 Board of Medicine to adopt emergency regulations/NOIRA

Implementation upon effective date of regulation.

Topics for consideration in adoption of regulations to amend Chapters 30 (NP Licensure) and 40 (Prescriptive Authority):

- **Equivalent of at least five years of full-time clinical experience**
- **Routinely practiced in a practice area included within the category for which the NP was certified and licensed**
- **Requirements for an attestation**
- **Fee associated with submission of attestation and issuance of autonomous designation**
- **Acceptance of "other evidence" demonstrating that the applicant met the requirements**
- **Endorsement of experience in other states**
- **Unprofessional conduct – falsification of attestation**

VIRGINIA ACTS OF ASSEMBLY — CHAPTER

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

[H 793]

Approved

Be it enacted by the General Assembly of Virginia:

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

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

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

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

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

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

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

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

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

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

department patients who is employed by or engaged by the facility where the death occurred; (vi) the physician who performed an autopsy upon the decedent; or (vii) an individual to whom the physician has delegated authority to complete and sign the certificate, if such individual has access to the medical history of the case and death is due to natural causes.

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

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

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

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

§ 32.1-282. Medical examiners.

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

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

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

§ 54.1-2901. Exceptions and exemptions generally.

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

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

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

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

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

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

6. Any practitioner licensed or certified by the Board from delegating to personnel supervised by

118 him, such activities or functions as are nondiscretionary and do not require the exercise of professional
119 judgment for their performance and which are usually or customarily delegated to such persons by
120 practitioners of the healing arts, if such activities or functions are authorized by and performed for such
121 practitioners of the healing arts and responsibility for such activities or functions is assumed by such
122 practitioners of the healing arts;
123 7. The rendering of medical advice or information through telecommunications from a physician
124 licensed to practice medicine in Virginia or an adjoining state, or from a licensed nurse practitioner, to
125 emergency medical personnel acting in an emergency situation;
126 8. The domestic administration of family remedies;
127 9. The giving or use of massages, steam baths, dry heat rooms, infrared heat or ultraviolet lamps in
128 public or private health clubs and spas;
129 10. The manufacture or sale of proprietary medicines in this Commonwealth by licensed pharmacists
130 or druggists;
131 11. The advertising or sale of commercial appliances or remedies;
132 12. The fitting by nonitinerant persons or manufacturers of artificial eyes, limbs or other apparatus or
133 appliances or the fitting of plaster cast counterparts of deformed portions of the body by a nonitinerant
134 bracemaker or prosthetist for the purpose of having a three-dimensional record of the deformity, when
135 such bracemaker or prosthetist has received a prescription from a licensed physician, licensed nurse
136 practitioner, or licensed physician assistant directing the fitting of such casts and such activities are
137 conducted in conformity with the laws of Virginia;
138 13. Any person from the rendering of first aid or medical assistance in an emergency in the absence
139 of a person licensed to practice medicine or osteopathy under the provisions of this chapter;
140 14. The practice of the religious tenets of any church in the ministration to the sick and suffering by
141 mental or spiritual means without the use of any drug or material remedy, whether gratuitously or for
142 compensation;
143 15. Any legally qualified out-of-state or foreign practitioner from meeting in consultation with legally
144 licensed practitioners in this Commonwealth;
145 16. Any practitioner of the healing arts licensed or certified and in good standing with the applicable
146 regulatory agency in another state or Canada when that practitioner of the healing arts is in Virginia
147 temporarily and such practitioner has been issued a temporary authorization by the Board from
148 practicing medicine or the duties of the profession for which he is licensed or certified (i) in a summer
149 camp or in conjunction with patients who are participating in recreational activities, (ii) while
150 participating in continuing educational programs prescribed by the Board, or (iii) by rendering at any
151 site any health care services within the limits of his license, voluntarily and without compensation, to
152 any patient of any clinic which is organized in whole or in part for the delivery of health care services
153 without charge as provided in § 54.1-106;
154 17. The performance of the duties of any active duty health care provider in active service in the
155 army, navy, coast guard, marine corps, air force, or public health service of the United States at any
156 public or private health care facility while such individual is so commissioned or serving and in
157 accordance with his official military duties;
158 18. Any masseur, who publicly represents himself as such, from performing services within the scope
159 of his usual professional activities and in conformance with state law;
160 19. Any person from performing services in the lawful conduct of his particular profession or
161 business under state law;
162 20. Any person from rendering emergency care pursuant to the provisions of § 8.01-225;
163 21. Qualified emergency medical services personnel, when acting within the scope of their
164 certification, and licensed health care practitioners, when acting within their scope of practice, from
165 following Durable Do Not Resuscitate Orders issued in accordance with § 54.1-2987.1 and Board of
166 Health regulations, or licensed health care practitioners from following any other written order of a
167 physician not to resuscitate a patient in the event of cardiac or respiratory arrest;
168 22. Any commissioned or contract medical officer of the army, navy, coast guard or air force
169 rendering services voluntarily and without compensation while deemed to be licensed pursuant to
170 § 54.1-106;
171 23. Any provider of a chemical dependency treatment program who is certified as an "acupuncture
172 detoxification specialist" by the National Acupuncture Detoxification Association or an equivalent
173 certifying body, from administering auricular acupuncture treatment under the appropriate supervision of
174 a National Acupuncture Detoxification Association certified licensed physician or licensed acupuncturist;
175 24. Any employee of any assisted living facility who is certified in cardiopulmonary resuscitation
176 (CPR) acting in compliance with the patient's individualized service plan and with the written order of
177 the attending physician not to resuscitate a patient in the event of cardiac or respiratory arrest;
178 25. Any person working as a health assistant under the direction of a licensed medical or osteopathic

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doctor within the Department of Corrections, the Department of Juvenile Justice or local correctional facilities;

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

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

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

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

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

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

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

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

§ 54.1-2903. What constitutes practice.

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

abbreviation or designation or language that identifies the type of practice for which he is licensed.

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

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

A. As used in this section:

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

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

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

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

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

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

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

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

nurse practitioner's clinical privileges or the electronic or written delineation of duties and responsibilities in collaboration and consultation with a patient care team physician.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 54.1-3300. Definitions.

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

"Board" means the Board of Pharmacy.

"Collaborative agreement" means a voluntary, written, or electronic arrangement between one pharmacist and his designated alternate pharmacists involved directly in patient care at a single physical location where patients receive services and (i) any person licensed to practice medicine, osteopathy, or podiatry together with any person licensed, registered, or certified by a health regulatory board of the Department of Health Professions who provides health care services to patients of such person licensed

to practice medicine, osteopathy, or podiatry; (ii) a physician's office as defined in § 32.1-276.3, provided *that* such collaborative agreement is signed by each physician participating in the collaborative practice agreement; (iii) any licensed physician assistant working under the supervision of a person licensed to practice medicine, osteopathy, or podiatry; or (iv) any licensed nurse practitioner working ~~as part of a patient care team as defined in § 54.1-2900~~ *in accordance with the provisions of § 54.1-2957*, involved directly in patient care which authorizes cooperative procedures with respect to patients of such practitioners. Collaborative procedures shall be related to treatment using drug therapy, laboratory tests, or medical devices, under defined conditions or limitations, for the purpose of improving patient outcomes. A collaborative agreement is not required for the management of patients of an inpatient facility.

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

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

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

"Pharmacy intern" means a student currently enrolled in or a graduate of an approved school of pharmacy who is registered with the Board for the purpose of gaining the practical experience required to apply for licensure as a pharmacist.

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

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

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

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

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

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

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

484 pharmacists or by documenting the same on the patient's prescription.
485 Collaborative agreements may include the implementation, modification, continuation, or
486 discontinuation of drug therapy pursuant to written or electronic protocols, provided implementation of
487 drug therapy occurs following diagnosis by the prescriber; the ordering of laboratory tests; or other
488 patient care management measures related to monitoring or improving the outcomes of drug or device
489 therapy. No such collaborative agreement shall exceed the scope of practice of the respective parties.
490 Any pharmacist who deviates from or practices in a manner inconsistent with the terms of a
491 collaborative agreement shall be in violation of § 54.1-2902; such violation shall constitute grounds for
492 disciplinary action pursuant to §§ 54.1-2400 and 54.1-3316.
493 Collaborative agreements may only be used for conditions which have protocols that are clinically
494 accepted as the standard of care, or are approved by the Boards of Medicine and Pharmacy. The Boards
495 of Medicine and Pharmacy shall jointly develop and promulgate regulations to implement the provisions
496 of this section and to facilitate the development and implementation of safe and effective collaborative
497 agreements between the appropriate practitioners and pharmacists. The regulations shall include
498 guidelines concerning the use of protocols, and a procedure to allow for the approval or disapproval of
499 specific protocols by the Boards of Medicine and Pharmacy if review is requested by a practitioner or
500 pharmacist.
501 Nothing in this section shall be construed to supersede the provisions of § 54.1-3303.
502 **§ 54.1-3301. Exceptions.**
503 This chapter shall not be construed to:
504 1. Interfere with any legally qualified practitioner of dentistry, or veterinary medicine or any
505 physician acting on behalf of the Virginia Department of Health or local health departments, in the
506 compounding of his prescriptions or the purchase and possession of drugs as he may require;
507 2. Prevent any legally qualified practitioner of dentistry, or veterinary medicine or any prescriber, as
508 defined in § 54.1-3401, acting on behalf of the Virginia Department of Health or local health
509 departments, from administering or supplying to his patients the medicines that he deems proper under
510 the conditions of § 54.1-3303 or from causing drugs to be administered or dispensed pursuant to
511 §§ 32.1-42.1 and 54.1-3408, except that a veterinarian shall only be authorized to dispense a
512 compounded drug, distributed from a pharmacy, when (i) the animal is his own patient, (ii) the animal is
513 a companion animal as defined in regulations promulgated by the Board of Veterinary Medicine, (iii) the
514 quantity dispensed is no more than a 72-hour supply, (iv) the compounded drug is for the treatment of
515 an emergency condition, and (v) timely access to a compounding pharmacy is not available, as
516 determined by the prescribing veterinarian;
517 3. Prohibit the sale by merchants and retail dealers of proprietary medicines as defined in Chapter 34
518 (§ 54.1-3400 et seq.) of this title;
519 4. Prevent the operation of automated drug dispensing systems in hospitals pursuant to Chapter 34
520 (§ 54.1-3400 et seq.) of this title;
521 5. Prohibit the employment of ancillary personnel to assist a pharmacist as provided in the
522 regulations of the Board;
523 6. Interfere with any legally qualified practitioner of medicine, osteopathy, or podiatry from
524 purchasing, possessing or administering controlled substances to his own patients or providing controlled
525 substances to his own patients in a bona fide medical emergency or providing manufacturers'
526 professional samples to his own patients;
527 7. Interfere with any legally qualified practitioner of optometry, certified or licensed to use diagnostic
528 pharmaceutical agents, from purchasing, possessing or administering those controlled substances as
529 specified in § 54.1-3221 or interfere with any legally qualified practitioner of optometry certified to
530 prescribe therapeutic pharmaceutical agents from purchasing, possessing, or administering to his own
531 patients those controlled substances as specified in § 54.1-3222 and the TPA formulary, providing
532 manufacturers' samples of these drugs to his own patients, or dispensing, administering, or selling
533 ophthalmic devices as authorized in § 54.1-3204;
534 8. Interfere with any physician assistant with prescriptive authority receiving and dispensing to his
535 own patients manufacturers' professional samples of controlled substances and devices that he is
536 authorized, in compliance with the provisions of § 54.1-2952.1, to prescribe according to his practice
537 setting and a written agreement with a physician or podiatrist;
538 9. Interfere with any licensed nurse practitioner with prescriptive authority receiving and dispensing
539 to his own patients manufacturers' professional samples of controlled substances and devices that he is
540 authorized, in compliance with the provisions of § 54.1-2957.01, to prescribe ~~according to his practice~~
541 ~~setting and a written or electronic agreement with a physician~~;
542 10. Interfere with any legally qualified practitioner of medicine or osteopathy participating in an
543 indigent patient program offered by a pharmaceutical manufacturer in which the practitioner sends a
544 prescription for one of his own patients to the manufacturer, and the manufacturer donates a stock bottle

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545 of the prescription drug ordered at no cost to the practitioner or patient. The practitioner may dispense
546 such medication at no cost to the patient without holding a license to dispense from the Board of
547 Pharmacy. However, the container in which the drug is dispensed shall be labeled in accordance with
548 the requirements of § 54.1-3410, and, unless directed otherwise by the practitioner or the patient, shall
549 meet standards for special packaging as set forth in § 54.1-3426 and Board of Pharmacy regulations. In
550 lieu of dispensing directly to the patient, a practitioner may transfer the donated drug with a valid
551 prescription to a pharmacy for dispensing to the patient. The practitioner or pharmacy participating in
552 the program shall not use the donated drug for any purpose other than dispensing to the patient for
553 whom it was originally donated, except as authorized by the donating manufacturer for another patient
554 meeting that manufacturer's requirements for the indigent patient program. Neither the practitioner nor
555 the pharmacy shall charge the patient for any medication provided through a manufacturer's indigent
556 patient program pursuant to this subdivision. A participating pharmacy, including a pharmacy
557 participating in bulk donation programs, may charge a reasonable dispensing or administrative fee to
558 offset the cost of dispensing, not to exceed the actual costs of such dispensing. However, if the patient
559 is unable to pay such fee, the dispensing or administrative fee shall be waived;
560 11. Interfere with any legally qualified practitioner of medicine or osteopathy from providing
561 controlled substances to his own patients in a free clinic without charge when such controlled substances
562 are donated by an entity other than a pharmaceutical manufacturer as authorized by subdivision 10. The
563 practitioner shall first obtain a controlled substances registration from the Board and shall comply with
564 the labeling and packaging requirements of this chapter and the Board's regulations; or
565 12. Prevent any pharmacist from providing free health care to an underserved population in Virginia
566 who (i) does not regularly practice pharmacy in Virginia, (ii) holds a current valid license or certificate
567 to practice pharmacy in another state, territory, district or possession of the United States, (iii) volunteers
568 to provide free health care to an underserved area of this Commonwealth under the auspices of a
569 publicly supported all volunteer, nonprofit organization that sponsors the provision of health care to
570 populations of underserved people, (iv) files a copy of the license or certificate issued in such other
571 jurisdiction with the Board, (v) notifies the Board at least five business days prior to the voluntary
572 provision of services of the dates and location of such service, and (vi) acknowledges, in writing, that
573 such licensure exemption shall only be valid, in compliance with the Board's regulations, during the
574 limited period that such free health care is made available through the volunteer, nonprofit organization
575 on the dates and at the location filed with the Board. The Board may deny the right to practice in
576 Virginia to any pharmacist whose license has been previously suspended or revoked, who has been
577 convicted of a felony or who is otherwise found to be in violation of applicable laws or regulations.
578 However, the Board shall allow a pharmacist who meets the above criteria to provide volunteer services
579 without prior notice for a period of up to three days, provided the nonprofit organization verifies that the
580 practitioner has a valid, unrestricted license in another state.
581 This section shall not be construed as exempting any person from the licensure, registration,
582 permitting and record keeping requirements of this chapter or Chapter 34 of this title.
583 **§ 54.1-3482. Practice of physical therapy; certain experience and referrals required; physical**
584 **therapist assistants.**
585 A. It shall be unlawful for a person to engage in the practice of physical therapy except as a licensed
586 physical therapist, upon the referral and direction of a licensed doctor of medicine, osteopathy,
587 chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with ~~his~~
588 ~~practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the
589 supervision of a licensed physician, except as provided in this section.
590 B. A physical therapist who has completed a doctor of physical therapy program approved by the
591 Commission on Accreditation of Physical Therapy Education or who has obtained a certificate of
592 authorization pursuant to § 54.1-3482.1 may evaluate and treat a patient for no more than 30 consecutive
593 days after an initial evaluation without a referral under the following conditions: (i) the patient is not
594 receiving care from any licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental
595 surgery, a licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions*
596 *of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician for
597 the symptoms giving rise to the presentation at the time of the presentation to the physical therapist for
598 physical therapy services or (ii) the patient is receiving care from a licensed doctor of medicine,
599 osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in
600 accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant
601 acting under the supervision of a licensed physician at the time of his presentation to the physical
602 therapist for the symptoms giving rise to the presentation for physical therapy services and (a) the
603 patient identifies a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a
604 licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of*
605 *§ 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician from

whom he is currently receiving care; (b) the patient gives written consent for the physical therapist to release all personal health information and treatment records to the identified practitioner; and (c) the physical therapist notifies the practitioner identified by the patient no later than 14 days after treatment commences and provides the practitioner with a copy of the initial evaluation along with a copy of the patient history obtained by the physical therapist. Treatment for more than 30 consecutive days after evaluation of such patient shall only be upon the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician. A physical therapist may contact the practitioner identified by the patient at the end of the 30-day period to determine if the practitioner will authorize additional physical therapy services until such time as the patient can be seen by the practitioner. A physical therapist shall not perform an initial evaluation of a patient under this subsection if the physical therapist has performed an initial evaluation of the patient under this subsection for the same condition within the immediately preceding 60 days.

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

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

E. It shall be unlawful for any licensed physical therapist to fail to immediately refer any patient to a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, or a licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957* when such patient's medical condition is determined, at the time of evaluation or treatment, to be beyond the physical therapist's scope of practice. Upon determining that the patient's medical condition is beyond the scope of practice of a physical therapist, a physical therapist shall immediately refer such patient to an appropriate practitioner.

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

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

§ 54.1-3482.1. Certain certification required.

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

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

667 **2. That the Boards of Medicine and Nursing shall jointly promulgate regulations to implement the**
668 **provisions of this act, which shall govern the practice of nurse practitioners practicing without a**
669 **practice agreement in accordance with the provisions of this act, to be effective within 280 days of**
670 **its enactment.**
671 **3. That the Department of Health Professions shall, by November 1, 2020, report to the General**
672 **Assembly a process by which nurse practitioners who practice without a practice agreement may**
673 **be included in the online Practitioner Profile maintained by the Department of Health Professions.**
674 **4. That the Boards of Medicine and Nursing shall report on data on the implementation of this**
675 **act, including the number of nurse practitioners who have been authorized to practice without a**
676 **practice agreement, the geographic and specialty areas in which nurse practitioners are practicing**
677 **without a practice agreement, and any complaints or disciplinary actions taken against such nurse**
678 **practitioners, along with any recommended modifications to the requirements of this act including**
679 **any modifications to the clinical experience requirements for practicing without a practice**
680 **agreement, to the Chairmen of the House Committee on Health, Welfare and Institutions and the**
681 **Senate Committee on Education and Health and the Chairman of the Joint Commission on Health**
682 **Care by November 1, 2021.**

Comments on Promulgation of Regulations for Implementation of HB793 – Autonomous Practice for Nurse Practitioners

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

Comments on HB 793

1 message

Judy Collins <jebcollins30@gmail.com>
To: elaine.yeatts@dhp.virginia.gov
Fri, May 4, 2018 at 11:50 PM

Dear Ms. Yeatts,

Thank you for the opportunity to provide some comments on the development of the Regulations for HB 793.

I have been a Women's Health Nurse Practitioner (NP) for over 40 years . I have been in practice, on the faculty, educating NPs at MCV/ VCU School of Nursing and in retirement volunteering at CrossOver Health Care providing care to uninsured pregnant patients. During my career, I have also been involved in both certification (NCC Board) and regulation (Virginia Board of Nursing and Joint Board of Nursing and Medicine).

As the regulations for HB 793 are promulgated, I would like to share the following points:
1. Though supportive of a transition to practice for new NP graduates, it is recognized the 5 year year requirement is an outlier from all other states, and will create a problem with a provider workforce leading to further access to care issues. So, it will be especially important not to require an NP who adds another area of specialty , like Psychiatric NP to again repeat a 5 year transition.

2. It will be important to broadly interpret
" other evidence" and a guidance document to demonstrate an NP has met the requirements for transition and attestation.

3. NPs in Virginia already have to provide evidence of completing an accredited educational program and national board certification that meets standards to be clinically competent to be licensed. Therefore, further requirements for both those in transition to practice and those who have been practicing for 5 years, are just having to provide additional evidence of competency to begin providing safe care to patients. As regulations are being developed for HB793, hopefully the requirements will not be burdensome for the NPs or the Boards to compile.

4. Regarding disciplinary standards, both NPs and Physicians should both be held to the same standards for any falsified documentation.

Thanks you so much for letting me share my ideas and concern on Regulations for
HB 793.

Submitted by:
Judith B. Collins, RN, MS, WHNP- BC, FAAN

Sent from my IPad
Judy Collins
804-402-5998 (c)

What you leave behind is not what is engraved in stone monuments, but what is woven into the lives of other-- Pericles

American Academy of Pediatrics

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May 4, 2018

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

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

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

Dear Dr. Harp and Ms. Douglas,

Thank you for the opportunity to provide written public comment on the upcoming regulatory process as we establish guidelines for nurse practitioners transiting to independent practice. The Virginia Chapter, American Academy of Pediatrics believes that "team-based care is a health care model that endorses the partnership of children and families working together with one or more health care providers and other team members across multiple settings to identify, coordinate, and address shared goals that meet the needs of the whole child." We endorse this model and believe it crucial to our success as a Commonwealth that we continue to focus on ensuring that the care we provide to children under this new model is high quality and meets the needs of all children.

To that end, we are asking the Joint Board to please provide further clarification on the specialty of the physician who can practice with a nurse practitioner during their five years of training. It is imperative that nurse practitioners that want to practice independently in pediatrics work with a primary care pediatrician or a family physician that sees a significant number of children in their practice. Every day we encounter situations with our patients that make it starkly clear that children are not mini adults and nowhere is that more apparent than in general pediatric practice.

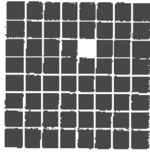
Secondly, we are also asking the Joint Board to develop and establish guidance on the necessary components for the five years of training.

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

We truly appreciate the opportunity to provide the Joint Board with our comments and look forward to testifying further on May 17th. If you have further questions, do not hesitate to contact me or our lobbyist, Aimee Perron Seibert (aimee@commonwealthstrategy.net or 804.647.3140).

Sincerely,

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



Virginia College of Emergency Physicians

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May 4, 2018

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Executive Director
Virginia Board of Medicine

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

RE: Nurse Practitioner Transition to Practice Regulations

Dear Dr. Harp and Ms. Douglas,

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

We appreciate all the technical assistance the Department and Boards provided throughout the legislative process as we all seek to create a clear, standardized and streamlined process for physicians and nurse practitioners on this path to independent practice.

The main points that we believe need to be addressed and clarified during the regulatory process, as outlined in the DHP notice for public comment, fall under the categories of: 1. Five years of clinical experience; 2. Specifications for the specialty of the physician and the license of the nurse practitioner; and 3. Requirements for attestation of practice.

1. We understand that the creation of a pathway for independent practice after five years of clinical practice is new ground for Virginia and the country. What isn't new is the need for uniform benchmarks and standards to ensure that both the nurse practitioner is getting the appropriate training to prepare them for practicing alone and, that the physician is providing the right training to the nurse practitioners, all to protect patients moving forward. We ask that there are standards and/or benchmarks created to ensure that both parties have achievable goals and aligned priorities.

2. As emergency physicians, we believe it is critical to provide further specification in the regulations for the primary/specialty practice area of a physician and the license/certification of the nurse practitioner for the five years they must practice together. We work daily with patients across the spectrum of age and gender, but the care we provide is acute, emergent and episodic. We do not believe that if a family practice nurse practitioner works for five years with an emergency physician, that after five years they can practice as a FNP. Rather, they would be able to practice in an acute care setting. Likewise, we do not believe that a FNP that works for five years in a primary care setting is able to transition to an emergent care setting. Physicians learn specialty specific training during residency which has objective, nationally approved standards, and this type of question must be answered during the regulatory process so there are clear guidelines for both the physicians and the nurse practitioners and expectations are clear from the start.
3. Finally, we encourage the Joint Board to develop a clear and concise process for providing the attestation at the completion of the five years, including measurable objectives that are clear, objective, and reproducible from the beginning of the process. Physicians must complete step examinations prior to licensing, and board certification exams prior to board certification, which provide standardized, objective measures of readiness for independent practice. We support similar standards for NP independent practice to ensure that when independent practice is granted, patient safety is foremost.

To conclude, we appreciate the opportunity to provide written comments today and testimony on May 17th. We look forward to being an active participant in the regulatory process. Do not hesitate to contact me or Aimee Perron Seibert (804.647.3140/aimee@commonwealthstrategy.net) with any questions for concerns.

Respectfully yours,

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

VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION

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

May 4, 2018

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

RE: Public Comment on Emergency Regulations to Implement HB793

Dear Ms. Yeatts:

Thank you for the opportunity to comment on the Boards of Medicine and Nursing promulgation of emergency regulations to implement HB793 (Chapter 776 of the 2018 General Assembly) authorizing nurse practitioners who meet certain qualifications to practice without a practice agreement with a patient care team physician. The Virginia Hospital & Healthcare Association submits the following comments in response to these topics for consideration presented in the general notice:

Equivalent of at least five years of full-time clinical experience
In order to accommodate variation in employer definitions of full-time status, variation in the number of hours worked in shifts and days of the week worked, and leave time, the Board may wish to consider establishing a total number of hours deemed to be commensurate with at least five years of full-time clinical experience. The patient care team physician and nurse practitioner are capable of using available information to calculate the number of hours worked for purposes of completing the attestation.

Routine practice in a practice area included within the category for which the nurse practitioner was certified and licensed
The language of the statute contains sufficient detail to allow the Boards to ascertain whether this requirement has been met. The patient care team physician and nurse practitioner are best situated to determine whether or not the patient care team physician routinely practiced with a patient population and in a practice area included within the category for which the nurse practitioner was certified and licensed for purposes of completing the attestation.

Fee associated with submission of attestation and issuance of autonomous designation
Any fee should be assessed on a one-time basis upon filing of the attestation and in a nominal amount commensurate with other similar fees assessed by the Department of Health Professions.

Acceptance of "other evidence" demonstrating that the applicant met the requirements

The language of the statute contains sufficient detail to allow the Boards to ascertain whether "other evidence" is acceptable to demonstrate that the applicant has met the requirements for practice without a practice agreement. Each one of these requirements could be substantiated with objective evidence and documentation. The Boards could specify on the attestation form, or on an alternative form created for use in instances where the nurse practitioner is unable to obtain the attestation, the types of statements or documentation that would be acceptable to demonstrate that the requirement has been met. The statements or documentation would be verified through the same review process applied to other licensure filings.

Endorsement of experience in other states

The language of the statute provides that "*[a] nurse practitioner to whom a license is issued by endorsement may practice without a practice agreement with a patient care team physician pursuant to subsection I if such application provides an attestation to the Boards that the applicant has completed the equivalent of at least five years of full-time clinical experience, as determined by the Boards, in accordance with the laws of the state in which the nurse practitioner was licensed.*" Accordingly, the application for licensure by endorsement should include the option to provide an attestation that the applicant has completed the equivalent of at least five years of full-time clinical experience. The attestation, combined with verification of licensure in the state in which the practitioner was licensed, should be deemed to be sufficient to meet this requirement.

Unprofessional conduct – falsification of attestation

Falsification of attestation should be treated the same as falsification of any other statement made in licensure filings to the Board. Current law at Va. Code § 54.1-3007 permits the Board to revoke any license for "*[f]raud or deceit in procuring or attempting to procure a license, certificate, or registration.*" Accordingly, further regulations should not be required to address this concern.

Thank you again for this opportunity to comment.

Sincerely,

R. Brent Rawlings
Vice President & General Counsel

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Louise Hershkowitz, CRNA, MSHA
Chair, Joint Boards of Nursing and Medicine
President, Board of Nursing
9960 Mayland Drive
Henrico, VA 23233

May 4, 2018

RE: Public Comment on Promulgation of Regulations to Implement HB793

Dear Chairperson Hershkowitz,

The Medical Society of Virginia (MSV) serves as the voice for more than 30,000 physicians, residents, medical students, physician assistants and physician assistant students, representing all medical specialties in all regions of the Commonwealth. These clinicians deliver health care each day to the millions of residents of the Commonwealth. The MSV appreciates the opportunity to provide comment on House Bill 793.

House Bill 793 will allow nurse practitioners the ability to transition to practice without maintaining a practice agreement with a patient care team physician. Our members work with their nurse practitioner colleagues each day and believe they are valuable members of the patient care team. The MSV believes the regulations must ensure all practitioners are prepared to deliver care that meets Virginia's standard of care requirements. Patients deserve to be assured that every health care provider that practices autonomously has the requisite experience to provide safe and high quality care. With the wide variation in nurse practitioner programs, the regulations must require that a nurse practitioner who seeks to practice autonomously is appropriately prepared and can meet the necessary core competencies. Thus, MSV surveyed physicians and physician assistants across practice settings, practice size, and specialties for feedback.

Physicians and other clinicians provided feedback on the following issues:

- Strongly support matching identical or similar physician specialty to a nurse practitioner specialty;
- Identifying the core competencies, educational requirements, and clinical experience needed for nurse practitioners through the attestation process;
- Statutory requirement on physician relationship for emergencies or referrals; and
- Physician liability for attestation.

Similar specialties and patient care population

First, it is important to note lines 341-344 of the law provide that a nurse practitioner seeking to practice without an agreement must have worked with "*a patient care team physician who routinely practiced with a patient population and in a practice area included within the category for which the nurse practitioner was certified and licensed.*" The medical community believes it is of the utmost importance that the regulatory standards ensure that the physician-nurse practitioner training must require alignment either between similar patient population and/or the national certification category for each practitioner. The MSV has developed a crosswalk for consideration as a basic framework. For those nurse practitioners without a nationally certified specialty, the Joint Boards must create a strong process to consider their educational and practical experience.

Physician	Nurse Practitioner
Family Physician	Family Nurse Practitioner
Pediatrician or Family Physician (treating children)	Pediatric Nurse Practitioner
Internal Medicine	Adult Nurse Practitioner or Geriatric Nurse Practitioner
Psychiatrist or Internal Medicine (providing mental health services)	Psychiatric Nurse Practitioner

We also have concerns that any one physician will be able to provide the requisite training. In the current process of practice agreements, the nurse practitioner practices in a given clinical location where many resources are available and new situations can be immediately addressed by a practicing physician.

Core Competencies

Physicians are prepared to practice autonomously after four years of medical school, five to seven years of a specialized residency program, and standardized national testing that ensures their ability to safely care for patients. Only after rigorous training, testing, and supervision by expert clinical faculty, are physicians permitted to practice independently. Medical school was revolutionized after the Flexner Report[i] in 1910 which found that medical schools as a for-profit enterprise did not yield positive results. Under this model, physicians' level of practice was variable at best, and incompetent and harmful at its worst. This is relevant as we consider the impact of various education models on patient care. The medical community is very concerned about achieving and maintaining a sufficient standard for core competencies for all practitioners who practice autonomously.

Understanding these core competencies such as differential diagnosis, clinical pharmacology, identifying and managing multiple co-morbidities and referral protocol are vital in practicing independently. Further suggestions are attached in Appendix A for your consideration. The medical community requests that you develop a robust standard that defines competencies that should be met and are equivalent of at least five years of full-time clinical experience. It is important that such a knowledge base be determined by the Joint Boards of Medicine and Nursing in order to provide full confidence in public safety. Annual review of hours and monitoring of a nurse practitioner as they move through the attestation process would ensure that their training has met these high standards. This knowledge base and a plan for transition to practice should be specified at the onset of the transition to practice period of training.

To ensure the required clinical experience meets the aforementioned standards, a nurse practitioner at the start of the five year period, should submit to the Joint Boards of Nursing and Medicine a plan that outlines how they will meet the education and training requirements as established in the final regulations.

Emergency Referrals and Liability

Under the current system of care, the patient care team physician and nurse practitioner have an established partnership to address complex cases or emergencies. As individual nurse practitioners transition on their own, they will be required to "establish a plan for referral of complex medical cases and emergencies to physicians or other appropriate health care providers." The MSV strongly supports patients having access to the most appropriate health care provider, especially for complex or emergency issues; there is concern about how this will be accomplished. Physicians are concerned about the management of this relationship. Will they unknowingly be designated as part of a nurse practitioner's plan? Who would be accountable for the care of the patient? Do these physicians have to be readily

available at all times? Is the physician able to review the patient panel and records regularly? These questions all lead to concerns of patients' well-being.

Physicians are also concerned about the potential for liability. As illustrated in the questions above, what legal responsibility are they incurring as a result of being unofficially associated with a nurse practitioner? Further, there are concerns about their potential liability regarding attestation. The attestation must be carefully constructed so that physicians are attesting only to the completion of the required time while being of the same specialty and/or treating the same population; it is the responsibility of the Joint Boards to ensure competency for nurse practitioners. Currently, Virginia statute provides that a physician is not liable solely for being a patient care team physician; the regulations need to extend this same liability protection to physicians for signing off on attestation.

The Medical Society of Virginia appreciates the opportunity to provide comments on this important issue. Should you have questions or need additional information, please do not hesitate to reach out to Ralston King (rking@msv.org).

Sincerely,

Kurtis S. Elward, M.D., M.P.H., FAAFP
President
Medical Society of Virginia

CC:

David Brown, D.C. Director, Department of Health Professions
Barbara Allison-Bryan, M.D., Chief Deputy Department Health Professions
Jay P. Douglas, MSM, RN, CSAC, FRE, Executive Director, Board of Nursing
William L. Harp, M.D., Executive Director, Board of Medicine
Kevin O'Connor, M.D., President, Board of Medicine
Elaine Yeatts, Senior Policy Analyst, Department of Health Professions

Melina Davis-Martin, Executive Vice President, Medical Society of Virginia
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Lauren Bates-Rowe, Assistant Vice President Health Policy, Medical Society of Virginia
Tyler Cox, Government Relations, Medical Society of Virginia
Ralston King, Assistant Vice President Government Affairs, Medical Society of Virginia

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[1] Cooke, M., Irby, D., Sullivan, W., Ludmerer, K. (2006) American Medical Education 100 Years After the Flexner Report. *New England Journal of Medicine, 355:1339-1344.* Retrieved from https://www.nejm.org/doi/full/10.1056/NEJMra055445

Appendix A – Suggested Core Competencies

These are comments from a wide array of physicians who have worked with nurse practitioners and who wished to convey their experience in what skill set affords the ability to provide appropriate patient care.

- Good fund of knowledge, sufficient clinical experience via residency and fellowships, excellent physical exam skills, pharmacology knowledge, managing patients with co-morbidities.
- Differential diagnosis and to be steeped particularly in Internal Medicine which would be helpful as a basic start in any subspecialty.
- In addition to anatomy, pathology, pharmacology, history/physical examination, differential diagnosis, and management of the complex patient, a clinical experience pathway that provides opportunity to distinguish conditions that may rapidly become critical from those conditions that are unlikely to become critical.
- Core knowledge in specialty, knowledge of pharmacotherapy in said specialty, ability to generate a reasonable differential diagnosis and plan of action, the ability to manage several different issues simultaneously, and the ability to know when to refer and who to refer to.
- Experience with diverse patient populations. Background in internal medicine, so a practitioner can make an adequate evaluation and judgment of a condition of a patient.
- Having a broad scope of medicine to handle pharmacology, differential diagnosis, co-morbidities, and how multiple fields of medicine overlap, proper work up, referrals and what their limits are.
- Ability to take comprehensive history and generate differential diagnosis. Understand medication and medication interactions. Also in children understand weight based dosing. Understand community resources and refer appropriately.
- Differential diagnosis referral protocol medical knowledge, including current evidence based medicine. This also will include managing complex patients and their co-morbidities with multiple medications
- The ability to critically think in the areas of history taking, physical examination, diagnostic study and imaging interpretation, pharmacology, differential dx, and having understanding of the patient population and health system/setting that you work in.
- Diagnostic acumen, clinical exam specialty skills, differential diagnosis, managing medications, interpreting lab and radiographic testing, referral sources.
- Diagnostic capabilities with both visual and pathological correlation, ability to prescribe and manage medications in an aging population, appropriate work up and treatment algorithm for both common and rare dermatological conditions.
- Understanding of normal physiology. Understanding pathophysiology of disease states. An ability to compile a comprehensive differential diagnosis list and narrow down this list in an efficient manner. The ability to balance the care of complex patients with a number of comorbid conditions.
- Competent history taking and physical exam. Differential diagnosis; know when to refer and/or ask for consultation.
- Practice-based Learning and Improvement: Show an ability to investigate and evaluate patient care practices, appraise and assimilate scientific evidence, and improve the practice of medicine.
- Patient Care and Procedural Skills: Provide care that is compassionate, appropriate, and effective treatment for health problems and to promote health.
- Systems-based Practice: Demonstrate awareness of and responsibility to the larger context and systems of health care. Be able to call on system resources to provide optimal care (e.g. coordinating care across sites or serving as the primary case manager when care involves multiple specialties, professions or sites).

- Medical Knowledge: Demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and their application in patient care.

- Interpersonal and Communication Skills: Demonstrate skills that result in effective information exchange and teaming with patients, their families and professional associates (e.g. fostering a therapeutic relationship that is ethically sound, uses effective listening skills with non-verbal and verbal communication; working as both a team member and at times as a leader). Professionalism: Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to diverse patient populations.

- To be able to practice independently, one must be able to recognize both uncommon as well as common presentations of illness and disease. Must be aware of latest recommendations. Must be able to recognize when course of illness or treatment is not as expected and have knowledgeable base to intervene appropriately

- Pharmacology, differential diagnosis, diagnostic ordering, referral protocol, dual diagnosis co-management

- Emergency management. Safety/adverse effects management, risk assessment (in our field suicide, violence, relapse, etc. prognosis/outcome and disability assessment and opinion, referral for hospice palliative care (example, terminal dementia patients), assessment of testing needs - in our field for EEG, MRI, Psychometry, etc.

- Specialty specific exam, differential diagnosis, proper imaging and lab orders, prescription management, influence of co-morbidities on active problems, proper follow-up.

- Understanding normal physiology and pathophysiology. Being able to create a broad differential diagnosis. Understanding pharmacology and which medications to prescribe. Also to know which medications to prescribe when patients have various organ failures.

- Differential diagnosis Evaluation and management of disease processes. Ability to discuss goals of care with patients and families Ability to know when one does not know - know when to ask for help (appropriate consultation).

- Differential diagnosis, surgical skills, managing immunosuppressive medications and immunosuppressive patients.

- Differential diagnosis, multiple procedures such as intubation, lumbar punctures, central lines, thoracostomy, cricothyroidoyomy, ultrasound, control of nosebleeds, etc., pharmacology, triaging, handling multiple complex patients simultaneously, knowing when to admit vs outpatient treatment, know when need emergent referral vs urgent or outpatient referral.

- Solid knowledge of medication interactions, side effects, pharmacokinetics. Ability to think outside of the box. Experience with disease process. Differential diagnosis and appropriate workup.

- Pharmacology, differential diagnosis, experience with rotations in various core fields (pulmonary, GI, cardiac, endocrine, rheum, ID etc.). In hospital experience is also a necessary requirement.

- Understanding the interplay between disease states and the various treatment options available.
- The ability to take a thorough history with the answers leading to more in depth questions, do a complete physical, and be able to assimilate the information into a diagnosis or differential. Then the ability to do a cost effective workup to confirm or narrow down the diagnosis.

- Ability to develop a robust differential diagnosis, recognizing when patients have problems/require treatment outside one's skill set, ability to critically evaluate evolving medical science and safely incorporate relevant portions into practice, managing patients with comorbidities, mastery of standards of care, stability within a single lane of practice.

- Ability to develop a robust Differential diagnosis, recognizing when patients have problems/require treatment outside one's skill set, ability to critically evaluate evolving medical science and safely incorporate relevant portions into practice, managing patients with comorbidities, mastery of standards of care, stability within a single lane of practice, perspective supervision on testing, such as stress testing.

- Risk stratification, EKG interpretation, recognizes tissue quality that is not normal. Assemble differential diagnoses. Develop treatment; plan to work through the differential. Utilize technology to manage the process of treating patients.

- Working knowledge of medication efficacy, adverse effects, and therapeutic range. Adequate differential diagnosis, for each problem. Knowledge of illnesses with significant co-morbidities.

- History taking, physical examination, differential diagnosis, appropriate ordering of diagnostic tests, pharmacology, and referral protocol.

- Profound knowledge of medication side effects and potential unknown interactions, based on pharmacodynamics of the medication. Ability to formulate a differential diagnosis in a non-linear fashion.

- Prioritizing care for sicker patients as well as the most life threatening aspects of each patient's condition and taking ownership of the care without unnecessary referrals to multiple other specialists when cases get more challenging Ability to formulate/initiate treatment plans for all the patients who are normally covered within a particular specialty, not only the top 10 diagnosis.

- Full education with complete anatomy and physiology course work, full complement of clinical pharmacology course work, full understanding and competence of managing patients with multiple co-morbidities, evidence of health outcomes that are within the national averages and not below, an established referring access to specialties, backup for caseloads that require additional clinical expertise.

- Understanding of physiology, Understanding of organ systems, tools needed for efficient evaluation of problems. 1. Obtaining a focused, thorough history 2. Understanding of risk factors for various comorbidities 3. Physical exam appropriate for complaint- with the knowledge of what is normal and what you are looking for in each step 4. Understand the underlying pathophysiology of disease so as to link various history and physical exam findings 5. Thorough knowledge of evidence based medicine 6. Ability to develop a reasonable differential diagnosis with the reasoning for and against each differential 7. Understand the risks and benefits of serious work ups, with the knowledge of how to respond to abnormal results of said workups 8. Understand the various treatment modalities, with their risks and benefits. Knowledge of disease, differential diagnosis, treatment options / algorithms, potential side effects, associations with internal disease, diagnostic testing, procedures (biopsies, injections, excisions), managing complex patients, drug interactions.

- Able to take a full history and do a thorough PE including a rectal, filament testing for diabetics, neurologic testing. Fully evaluate lab, x-ray, pathology and the tests. Read EKGs formulate disease hypotheses; know when to follow and when to refer. Discuss diseases with patients and family. Follow-up and be available.

- Understanding of pharmacology, drug interactions, physiology of body systems and pharmacodynamics. 2. Understanding of basic disease processes, complications, prevention and treatment. 3. Recognition of emergency scenarios and ability to manage emergency scenarios to basic lifesaving techniques and triage. 4. Adequacy to ensure follow up of abnormalities and test data etc. 5.Understanding of aseptic technique, sterilization, and disease control, both for procedures and for communicable diseases. 6. Ability to properly hand off and refer problems out of knowledge base or scope of ability, e.g. no dumping or putting referral into patients responsibility when it should be the practitioner's responsibility.

- Understanding of pathophysiology, pharmacology, indications for surgical referrals as well as managing psychiatric and developmental comorbidities Interpretation of medical imaging and neurophysiology results, referral pattern and facilitation of consultations.

- Strong knowledge base, ability to recognize limitations, extensive knowledge of pharmacology, ability to refer to MD quickly, managing multiple health problems with the understanding of why we do things - for ex, not just giving diuretic for swollen legs but recognizing that this maneuver might be life threatening if heart failure symptoms are due to pericardial effusion.

- Differential diagnosis Management of chronic conditions Understanding of management of complications of pregnancy/postpartum care Understanding of when to refer/transfer care

- Pharmacology Procedural skills (IUDs, biopsies, etc.). Adherence to current best clinical practice guidelines.

- A working knowledge of a broad range of medical conditions and interactions as well as the ability to recognize situations or conditions that may be rare, but if unrecognized or not addressed, can lead to significant morbidity or mortality. The ability to formulate a differential diagnosis that is appropriately focused (so as not to promote a shotgun approach to the workup) while recognizing the existence of less likely but critically important conditions/situations. The ability to demonstrate a clear understanding of the limitations of one's training and the need to refer patients to specially trained providers when it is in the patient's best interest WITHOUT needing to rely solely on specialists for conditions typically treated by others within one's field. An appropriate respect for training differences amongst different provider types and the ability to acknowledge that "we don't know what we don't know" and to discuss cases with other providers when patients are atypical or have atypical responses to treatment.

- Knowledge in basic science, pathology, physiology. The training and experience to apply this knowledge to create a differential diagnosis. Appropriate diagnostic testing. Formulating a treatment plan. Ability to carry out the treatment plan. Ability to recognize when a treatment plan is not working. Knowledge of ones limitations.

- Comprehensive background in pathology, physiology, anatomy, pharmacology, co-morbidity disease/injury management, radiology, wound management, methodical diagnostic protocol.

- Exposure to mental health issues, demonstrated communication skills are also important pharmacology, differential diagnosis, knowing when to refer, managing co-morbidities, recognizing and managing common mental health co-morbidities, vaccination schedules/side effects/counseling, developmental assessment and recognition/management of abnormalities; recognizing and addressing social determinants of health; effective care coordination skills; effective community interactions (schools, CSBs, etc.), ability to manage and support those with disabilities (including knowledge of waivers, disability benefits, etc.).

- Adequate clinical patient contact hours under the supervision of an experienced provider, demonstrated knowledge in pharmacology and pharmokenetics, documented core knowledge in illness and disease mechanisms coupled with treatment modalities of the same, established resources for consultation and collaboration with adequate peers for management of difficult/refractory patients.

- Physiology, pharmacology, physical diagnosis, referral protocol, pathology, hematology, laboratory science, management of chronic illness.

- The ability to do a proper examination, understand what testing to order (and not order), and interpretation of results. They will also need to be familiar with the wide range of disease processes and how that's relevant to each other. They will also need to be familiar with various therapeutic options as well as contraindications. They should also need to have a process to keep up to date with changing technology, information, guidelines, etc.

- Core competencies include pathophysiology, anatomy and physiology, pharmacology, the ability to have a wide differential diagnosis but know which are the most critical and relevant tests to order to determine etiology. It is vitally important for clinicians to know what they do not know and when to ask for help through consultation or referral. Knowledge of systems based practice and the barriers to care for different patient populations are also important. Autonomous practice should be limited to those who are able to shoulder the associated liability and consequences.

- Knowledge of oncology drugs and comprehensive treatment of cancer. Hematology knowledge. Pain management. End of life issues.

- Accurate history taking, physical exam, creation and refinement of differential diagnosis, pharmacology, lifesaving procedures, routine procedures, appropriate consultation, admission criteria recognition, discharge and follow up plan creation, EMTALA procedure, documentation, medicolegal concerns.

- Pharmacology, correct visual diagnosis of cancer and concerning lesions (often incredibly subtle), differential diagnosis, referral protocol, appropriate procedural technique AND appropriate decision making for performance of procedures such as biopsies and cryosurgery.

- Pharmacology principles such as pharmacokinetics and pharmacodynamics. Rapid evaluation of critically ill patients and initiation of therapy with continuous reassessment Management of multiple co-mire diseases in the acute setting pharmacology, knowledge of emergent vs. non-emergent complaints, differential diagnosis, managing complex patients, knowledge of vaccinations.

- Critical thinking skills and medical synthesis skills Strong foundation in basic and clinical sciences in order to generate a broad differential diagnosis. Clinical pharmacology skills. Ability to manage patients with multiple co-morbidities. Understanding of the interdependency of the health care system and navigating the complexities. Laboratory ordering and interpretation .Clinical pharmacology and medication prescribing.

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

Comments in Enactment of Regulations to Implement HB 793
1 message

Deborah Oswalt <doswalt@vhcf.org>
To: "elaine.yeatts@dhp.virginia.gov" <elaine.yeatts@dhp.virginia.gov>
Cc: Denise Daly Konrad <dkonrad@vhcf.org>

Fri, May 4, 2018 at 4:02 PM

Elaine Yeatts

Senior Policy Analyst

Virginia Department of Health Professions

9960 Mayland Drive

Henrico, VA 23233

Dear Ms. Yeatts:

Thank you for the opportunity to comment on the enactment of regulations to implement HB 793. We see it as a step forward that Virginia nurse practitioners (*NPs*) will be able to practice independently as a result of this bill, like colleagues in 22 other states and the District of Columbia.

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

We encourage the Department of Health Professions and the Joint Board of Medicine and Nursing to adopt a regulatory approach for transition to practice that does not exceed a total of 5 years of collaboration for an NP who is credentialed and licensed in more than one specialty area. To accomplish this, it may be that an individualized approach to each application will be needed. We ask you to develop a framework that

will enable the Joint Board to review, understand and consider the person's individual level of training, credentials and work experience related to the field in which s/he desires to practice independently, rather than a more "cookie cutter" approach that establishes a uniform norm.

Requiring an NP to collaborate with a physician for an additional 5 years for each specialty area in which s/he chooses to work independently will create significant barriers to practice at a time when the Commonwealth has an insufficient number of providers.

This is especially true in the area of behavioral health. More than 3/4 of Virginia is federally-designated as mental health professional shortage area; 40% of Virginians live in these communities. This shortage will soon become worse, because, two-thirds of practicing psychiatrists are age 50 or older with an insufficient number in training to replace them.

In addition, *The Milbank Quarterly* reports that many primary care providers are not well-equipped or comfortable diagnosing and managing behavioral health conditions or prescribing psychotropic medicines. This is a problem since it reports that as many as 70% of primary care visits stem from psychosocial issues.

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

VHCF makes a point of staying out of policy issues between various types of health professions. We are taking this unusual step to comment on regulations for HB 793, because it affects our work and our mission. For the past 10 years, we have focused much effort and money to help increase access to behavioral health services for uninsured and underserved Virginians. In the process, we have discovered the state's shortage of behavioral health professionals, the important role and scope of practice of Psych NPs, and that there are only 213 of these valuable health professionals in Virginia (*71 localities don't have any*).

As a result, for the last 4 years, VHCF has worked with Virginia's Schools of Nursing to encourage education of more Psych NPs and invested nearly $200,000 in scholarships, which pay tuition and fees for existing nurse practitioners who return to school to obtain a post-master's Psych NP certificate. These are typically family nurse practitioners or other medically-trained nurse practitioners with years of practice experience. We have found this combination of both medical and behavioral health training to be particularly valuable as more practices move to integrate behavioral health care with primary care.

While there are unlikely to be a lot of Psych NPs who wish to practice independently, we want to ensure those who do are able to do so without barriers. Following our suggestion of a more customized approach when reviewing applications from NPs with credentials in multiple specialties will help. In considering this request, it is important to remember that all NPs are credentialed to practice independently upon successful completion of their coursework, clinical experience and passage of their national certification exam.

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

Sincerely,

Deborah D. Oswalt

Executive Director

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April 30, 2018

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

Re: Nurse Practitioner Regulation

Dear Ms. Yeatts:

Thank you for the opportunity to provide comments on potential amendments related to HB 793 on behalf of the Virginia Council of Nurse Practitioners. These comments address the structure and design of the regulations. It is my understanding that the advisory committee and staff are looking at other state regulations related to attestation. In my review of other state regulations, I have noted that states generally hold nurse practitioners affirmatively responsible for affirming and proving that they have achieved the requisite hours of practice. Attestation occurs in either a form or affidavit with the nurse legally responsible for the certification of those hours.

Please note that some states require nurses to identify and report their employers when they become licensed, which provides boards of nursing with mechanisms to track the adherence to statute through employment verification documents.

We also found states which allow the nurses to calculate, self-certify and retain records of those hours, to be made available to the Boards of Nursing upon request. Please find enclosed selected documents related to attestation for your use and review. We believe they will be informative to your research.

Please let me know we can be of further assistance.

Sincerely,

Winifred Carson-Smith

Winifred Y. Carson-Smith, Esq.
Consultant to the Virginia Council of Nurse Practitioners

Encl. Selected Attestation Forms and Requirements

Virginia Council of Nurse Practitioners
Nurse Practitioners: Partners for a Healthier Tomorrow
250 West Main Street, Suite 100 • Charlottesville, VA 22902 • (434) 977-3716 • Fax (434) 979-2439 • vcnp@vcnp.net • www.vcnp.net

Selected Attestation Forms and Requirements

Colorado has attestation regulations and requirements. For the first 3 years after having been issued a license and no less than 2,000 hours of practice, NPs must perform acts of diagnosis and treatment of alterations in health status in collaboration with a physician. The collaboration must address a reasonable and appropriate level of consultation and referral, coverage for the patient in the absence of the APRN, a method to review patient outcomes and a method of disclosure of the relationship to the patient. (Online application)

Connecticut: For the first 3 years after having been issued a license and no less than 2,000 hours of practice, NPs must perform acts of diagnosis and treatment of alterations in health status in collaboration with a physician. Any APRN who elects to practice without a collaborative agreement shall maintain documentation of having engaged in the performance of advanced practice level nursing activities in collaboration with a Connecticut licensed physician for a period of not less than three (3) years and not less than two thousand (2,000) hours in accordance with provisions in CGS 20-87a.

Such APRN shall maintain such documentation for a period of not less than three (3) years after completing such requirements and shall submit such documentation to the Department of Public Health for inspection not later than forty-five (45) days **after a request made by the department for such documentation** .

APRNs shall submit written notice to the Department of his or her intention to practice without a collaborative agreement after completing the requirements described above and prior to practicing without a collaborative agreement.

http://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/practitioner_licensing_and_investigations/plis/nursing/aprn/APRNIndPracticepdf.pdf?la=en

Illinois: A notarized attestation, signed by both the APRN and collaborating physician of 1) 4000 hours of clinical experience and 2) 250 hours of continuing education or training after first attaining national certification, 3) such documentation shall be provided to IDFPR upon request. (Online application requires password).

Virginia Council of Nurse Practitioners
Nurse Practitioners: Partners for a Healthier Tomorrow
250 West Main Street, Suite 100 • Charlottesville, VA 22902 • (434) 977-3716 • Fax (434) 979-2439 • vcnp@vcnp.net • www.vcnp.net

Maine: Supervision is required for the first 24 months of practice. For licensure, NP must submit evidence of a minimum of 1500 hours of practice in an expanded specialty nursing role within 5 years preceding application, or have completed a nurse practitioner program within 5 years preceding application. If more than 5 years have elapsed since completion of an advanced practice registered nurse program and the applicant does not meet the practice requirement of 1500 hours, the applicant shall complete 500 hours of clinical practice supervised by a physician or nurse practitioner in the same specialty area of practice.

The nurse practitioner must practice for a minimum of 24 months under the supervision of a licensed physician, or a supervising nurse practitioner, or be employed by a clinic or hospital that has a medical director who is a licensed physician. The applicant shall identify a supervisory relationship with a licensed physician or nurse practitioner practicing in the same practice category who will provide oversight for the nurse practitioner. The NP registers the relationship as part of initial licensure process.

http://www.maine.gov/boardofnursing/docs/Registration-of-a-Supervisory-Relationship.pdf

Maryland: No longer has an attestation process, but has a clean certification process, which can be found at 10.27.07.03 – Certification. The attestation form is still online should you wish to review it.The link is listed below.

http://www.dsd.state.md.us/comar/comarhtml/10/10.27.07.03.htm
https://www.pdffiller.com/30418053-fillable-attestation-form-for-nurse-mbon

Minnesota: A collaborative practice agreement with a physician or APRN is required only for the first 2,080 hours of clinical practice. A NP must practice for at least 2,080 hours, within the context of a collaborative agreement, within a hospital or integrated clinical setting where APRNs and physicians work together to provide patient care. The NP shall submit written evidence to the board with the application, or upon completion of the required collaborative practice experience. A collaborative agreement is a mutually agreed upon plan for the overall working relationship between a NP and one or more physicians or APRNs that designates the scope of collaboration necessary to manage the care of patients. The NP and collaborating physician(s)/APRN(s) must have experience in providing care to patients with the same or similar medical problems. Minnesota uses a post graduate practice verification form.

https://mn.gov/boards/assets/APRN_Post_Grad_Pract_5-19-17_tcm21-295958.pdf

Nebraska: Applicants who have not practiced a minimum of 2000 hours following graduation and initial certification as a Nurse Practitioner must submit a Transition to Practice agreement (see form appended to this application). Applicants who do not have 2000 practice hours and who do not submit a Transition to Practice for any reason will be issued a temporary license (see Temporary Licensure below). Section G of the Nurse Practitioner Application includes the attestation questions.

http://dhhs.ne.gov/publichealth/licensure/Documents/APRNNPapp.pdf

New York: Has an attestation process which places the obligation and responsibilities associated with attestation on the nurse, who can be sanctioned if they do not honestly complete the application. Link is to the attestation form.

http://www.op.nysed.gov/prof/nurse/np-npcr.pdf

South Dakota: A collaborative practice agreement with a physician, nurse practitioner, or nurse midwife is required for the first two years and 1,040 hours of clinical practice. The board uses a practice verification form.

https://doh.sd.gov/boards/nursing/Licensure/CNM_CNP_PracticeVerificationForm.pdf

Vermont: Graduates with fewer than 24 months and 2,400 hours of licensed active advanced nursing practice in an initial role and population focus shall have a formal agreement with a collaborating physician or APRN) APRNs who obtain a subsequent certification in an additional role and population focus shall have a formal agreement with a collaborating physician or APRN for no fewer than 12 months and 1,600 hours.

https://cms.sec.state.vt.us:8443/share/s/M1jU1fNxRPC3961hkPeg9Q

American Association of
NURSE PRACTITIONERS™

The Voice of the Nurse Practitioner®

Virginia Board of Nursing
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

May 3, 2017

Dear Members of the Committee of the Joint Boards of Nursing and Medicine,

The American Association of Nurse Practitioners (AANP) appreciates the opportunity to respond to the request by the Boards of Medicine and Nursing for public comment on the promulgation of regulations to implement HB793 (Chapter 776 of 2018 General Assembly). In drafting regulations, AANP would encourage the boards to be as flexible as the new law allows and to avoid adding new requirements or restrictions that are in excess of those required under the previous career-long nurse-physician contracted agreements. AANP looks forward to providing added comment when a copy of proposed rule is available for public comment.

Sincerely,

Tay Kopanos

Vice President, State Government Affairs

American Association of Nurse Practitioners

Comments on HB793

Deborah Quinn <dermnp@cox.net> Apr 22

Dear Ms. Yeatts,

This email is in support of "other evidence" to obtain independent practice. I personally have practiced in the same specialty for 10 years, with the same privately owned small corporation for 8 of those years. I am completely confident and competent in my specialty area of expertise, and all my colleagues are aware of this. Physicians have financial concerns that may create hesitancy in signing attestation of practice forms. Other proof of practice must be put in place. Documentation of previous annual continued medical education, proof of prescription authorization and verification of Medicaid & Medicare billing are other options for proof of practice that could be considered.

Sincerely,
Deborah Quinn, MSN,FNP, DCNP
Doctorate candidate

Mark and Val Wrobel <mvwrobel@hotmail.com> Apr 19

Ms Yeatts,
As the President of the Virginia Council Of Nurse Practitioners, Northern Virginia Region, I represent over 300 member NPs. We are excited to now have an opportunity in Virginia to transition to practice for which we have been trained and certified. Here are some concepts to consider as you enact regulations to implement the bill.

- NPs have unique skills and expertise which are often complimentary to the physician and other team members and are not expected to be an exact overlay of the physician's area of practice
-
- NPs are prepared at the graduate level and are deemed competent clinicians upon graduation and passage of national certification. There is no evidence to support the need for additional post-licensure supervision of NPs' practice beyond current educational and certification standards.
- The five-year post-licensure "transition to practice" requirement is the result of political compromise with no evidence to support the regulatory mandate. This has created variability from state to state, making Virginia an outlier with the most arduous practice environment in the nation for NPs.
- The five-year requirement creates a costly bottleneck to building provider workforce and equitable distribution in primary care delivery for underserved and vulnerable populations. Unduly burdensome regulations on top of this requirement will result in additional bottlenecks compromising access to care.
-
- The General Assembly overwhelmingly approved the central concept of transition to practice with the five year compromise. The Joint Boards should approach the regulatory process bearing this in mind and obstacles limiting those central concepts should be kept to a bare minimum as they are against the thrust of the legislation. Any overly strict interpretations suggested by those opposing the legislation would not be consistent with the spirit of the legislation and bipartisan will of General Assembly.
- **Many NPs may have multiple team physicians during the transition period and there needs to be several signature lines for the physician. Each could specify the full time equivalent period of supervision if sequential collaborative MDs exist.**
- **Request that the attestation form be a simple check box of the requirements listed in the statute. For example:**

[ ] Patient care team physician has served with the NP pursuant on a practice agreement
[ ] Patient care team physician routinely practiced with a patient population and practice area for which the NP is certified and licensed

- Request that office administrators, human resources department, health system administrators, credentialing documents, etc., may be used as other evidence.
-
- Request that an NP in any state or working for U.S. Armed Forces, U.S. Veterans Administration or the Public Health Service submit evidence that the five-year full-time equivalent collaborative requirements have been met with signature from employer, physician, practice administrator, etc.

Respectfully submitted,
Valerie Wrobel, MSN, RN, AGNP-BC
President, Virginia Council of Nurse Practitioners, Northern Virginia Region.

Bridgette Vest <bridgevest@yahoo.com> Apr 17

Hello and thank you for allowing us to comment on this historic piece of legislation. While I am thrilled with the passage of this bill and the fact that it has been signed into law, I find the 5 year post licensure "transition to practice' requirement nothing more than a symptom of the bigger problem which is financial profit off of the work of NPs. I can honestly say that in all of my years of practice as a NP (13 now) I have had a collaborative agreement with physicians but no mentoring. I learned with the help of my fellow NPs and the physician was not much more than a signature from someone who gained financially from my skills. I believe that NPs should be able to mentor these new NPs if a transition requirement is present since the skillset is unique. I still believe that the requirement will only hinder access to care and should be reevaluated. The attestation requirement does seem rigid and I hope that it does not present a barrier for experienced NPs who have worked with different physicians within a five year period.

I realize that Virginia is extremely conservative and am grateful for the progress we have made even though it still has this 'feel of physician control' that puts a 'wet blanket' on the celebration of independence we deserve. I will be thankful for the progress nonetheless and continue to advocate for our honorable and highly skilled profession.

Most sincerely,

Bridgette Vest

Patricia Modestino <pmodesti714@aol.com> Apr 16

Good Morning, Ms Yeatts,

I would like to submit a comment; however, prefer to send it via email. I am a Virginia NP, so am not sure my comment qualifies as public comment, since my practice will be impacted by the outcome of the bill.

About the attestation: I have been a Family NP for 9 years. My work history includes 4 years working in an Urgent Care setting with several different physicians - most of whom have since moved on. One year in a free clinic - I really never met my collaborating MD at the time, it was a paperwork trail only. And, the past 4 years in skilled rehab/post acute care/long term care with one MD.

No problem having my current partnering physician attest for me (I don't think it will be a problem, but haven't asked yet); however, I will be ONE YEAR short of the 5 year requirement since we've only worked together for 4 years. I guess I can track down one of the other docs I worked with…but, to be honest, I am not sure I will do so. I might just wait out another year, or go with whatever the 'other evidence' turns out to be.

I am sure I am not alone in this kind of work scenario…and I am simply asking if there isn't a way to just make it easy for us to achieve attestation?

I am not a fan of having to ask for someone to attest that I have worked as an NP. The BON has the data they need - I have proof of certification, etc. I realize there is no way around attestation; however, having to ask makes me feel subordinate, and it just doesn't feel right. In a way, asking for public comment is similar - I'm sitting here right now feeling as if NPs - those who are affected by this bill - have the least input.

So, in a nutshell, here is what I ask:
1. Consideration for those of us who have had similar practice experiences - those who qualify for attestation but have not worked solely with one practice or MD the entire time..such as ER or UCC history
2. Regarding practice areas: Consider wherever the NP practiced to be sufficient. If he or she is/was qualified to work in their chosen area - then that should be good enough.
3. I do not agree with MD attestation; however, requirements should be simple and not complicated. Please don't make it difficult to achieve.
4. I am fine with whatever fees are determined
5. Other evidence: Consider employer being able to attest how long and in what position the NP served. (honestly, the NP can attest for him or herself. sigh.)

I am hopeful that none of my colleagues would falsify attestation. I don't think I even have a comment on that because if anyone were willing to falsity attestation, there are bigger problems in their overall practice.

Thank you for reading this. I am currently getting ready to go to work, so my note here was rather quickly done, and not perfect. I appreciate the opportunity to be "heard" , and am more than happy/willing to be part of the solution for any of the topics regarding HB 793.

Thank you again,

Patricia Modestino, FNP-C
Life Care Center of New Market
New Market, Va. 22844

Carlson, Rachel A. <rcarlson@valleyhealthlink.com> Apr 27

Good morning Elaine,

I am reaching out to provide comments as an employer of advanced practitioners (not a representative of any PA related society or board work, etc.)

I appreciate the compromise that went into effect during this process for the Nurse Practitioners. As an employer of NPs, I feel the law was very careful to allow those with experience the full autonomy that they have earned and demonstrated with a consistent relationship with a physician.

While the traditional NP in practice came from a strong nursing background, this is not the trend we are seeing and as an employer this has required more work once NP have been employed to

provide additional training, and when a profession is asking for autonomy, experience is important in this equation.

The more common NP applicant to an open position within in our system is an RN with less than 3 years experience (a growing number going straight through) and then went to an online NP program so that they could work while they were going to school. This has resulted in cohorts of NPs who are not prepared to practice autonomously upon graduation. While the current law with a patient care team physician doesn't ameliorate this issue, it has required a relationship to exist and I have found many new grad NPs (who understand their limitations) asking for this relationship upon hire. I have also found new-grad NPs who don't want the restrictions of a relationship with a physician, which is a sign they don't understand their own limitations just yet.

I think this need in VA for providers in primary care is extremely high and feel that there are many experienced NPs who are capable of providing this care without a forced relationship and the new law as written allows this.

I think that there are specialties in which this isn't realistic, nor necessary, as they should always be working in a team.

Since there are not certifications for most specialties, therefore not license for most specialties, this needs to be accounted for. E.g. certified and licensed as a Family Nurse Practitioner, but attestation to neurology or neurosurgery?

My concern, is the NP who worked for 5 years in cardiology with a physician, receives an attestation from that physician, but then wants to work in primary care-does the law and will the regulations allow this to happen without another relationship (or should there be an amended time frame for those NPs who were in a non-surgical subspecialty as they transition to primary care).

There is also concern that these "attestations" could be something that becomes a marketable item, so making sure there is an audit process or demonstration of relationship for the attestations.

I don't think a different degree should allow for "other evidence" demonstrating that the applicant met requirements.

I do think that there should be an ability to be endorsed from another state. We have NPs who work in MD and WV who don't require a collaborating physician and would love for them to come work in VA, with their demonstrable years of experience, and provide excellent care without the need to find a new collaborating physician.

Rachel A. Carlson
Director of APC Services

Paige French <pfrench@bridgewater.edu>

May 1

Hello,

I am a NP with 18 years of experience and I practice by myself with a LPN. Currently we pay a physician to collaborate out of necessity due to the current restrictions. My hope is that we will no longer need to do this and will not be bound by the concept of a physician led team. I would hate for that wording to bind me to a physician and cost the college unnecessary money.

This law will also allow for a fill-in NP without a collaborating agreement which will further improve access to care when I am out and need a substitute. Thank you for your consideration.

Paige French, MSN,FNP-BC | Student Life | *Director of Health Services*

Martha Giddings <giddingsmartha@gmail.com> May 1

Thank you for the opportunity to provide public comment. I have been a nurse practitioner (NP) for 1 year practicing in an acute care setting in Petersburg, an underserved area. Completion of graduate education and national board certification deem that I am a competent clinician. Please keep this in mind as rules are being promulgated.
Please keep in mind the following talking points that apply to all NP, both new and experienced.

- The five-year equivalent requirement creates a costly bottleneck to building provider workforce and equitable distribution in primary care delivery for underserved and vulnerable populations. Unduly burdensome regulations on top of this requirement will result in additional bottlenecks compromising access to care.

- NPs already pay fees associated with RN, NP, and prescribing licenses. Any additional fees associated with submission of attestation and issuance of autonomous designation should not create a financial barrierfor qualified NPs to practice.

- Acceptance of "other evidence"demonstrating that the applicant has met the requirements must be broadly interpreted. We ask that the Joint boards issue a guidance document listing examples of supporting evidence that they would take into consideration. Office administrators, health system administrators, and credentialing documents should all be accepted as evidence that an applicant has met the necessary requirements.

- The Boards should credit applicantsby endorsement for all of their time employed and licensed in other states towards calculating their clinical experience requirement for practicing without a practice agreement.

- NPs in any state or working for U.S. Armed Forces, U.S. Veterans Administration or the Public Health Service should be able to submit evidence that the five-year full-time equivalent collaborative requirements have been met with signature from employer, physician, practice administrator, etc.

- There is no demonstrated need for additional requirements on the attestation in order to protect the public beyond what is listed in HB 793. The attestation should be used to document clinical experience under a sworn statement that this information is accurate and meets the requirements of the law.

- Most, if not all, states requiring attestation of transitional clinical hours are not overly prescriptive in what they require in their regulations or on their attestation forms. Therefore, in Virginia it should not be necessary to further define what is meant by "the patient care team physician routinely practiced with a patient population and in a practice area included within the category for which the nurse practitioner was certified and licensed."

- Both the NP and the patient care team physician should be held to disciplinary standards for providing falsified documentation to the Boards.

Thank you for your time.
Sincerely,
Martha Giddings APRN, FNP-C

June Alsgaard <j.alsgaard@gmail.com> May 1

Dear Elaine Yeatts,

Thank you for the opportunity to provide public comment. My name is June Alsgaard. I have been a nurse practitioner (NP) for almost one year practicing in an acute care setting in Fairfax county. Completion of graduate education and national board certification deem that I am a competent clinician.
Here are some thought I have about HB 793.

- The five-year equivalent requirement creates a costly bottleneck to building provider workforce and equitable distribution in primary care delivery for undeserved and vulnerable populations. Unduly burdensome regulations on top of this requirement will result in additional bottlenecks compromising access to care.

- NPs already pay fees associated with RN, NP, and prescribing licenses. Any additional fees associated with submission of attestation and issuance of autonomous designation should not create a financial barrier for qualified NPs to practice.

- Acceptance of "other evidence" demonstrating that the applicant has met the requirements must be broadly interpreted. It will be easier for everyone in the future when things get more clear. Please issue a guidance document listing examples of supporting evidence that they would take into consideration. Office administrators, health system administrators, and credentialing documents should all be accepted as evidence that an applicant has met the necessary requirements.

- The Boards should credit applicants by endorsement for all of their time employed and licensed in other states towards calculating their clinical experience requirement for practicing without a practice agreement. All states has their rules for reasons, and nurse practitioners who provide patient care have to follow local rules. It does not matter where they practice, it is experience for patient care.

- NPs in any state or working for U.S. Armed Forces, U.S. Veterans Administration or the Public Health Service should be able to submit evidence that the five-year full-time equivalent collaborative requirements have been met with signature from employer, physician, practice administrator, etc.

- There is no demonstrated need for additional requirements on the attestation in order to protect the public beyond what is listed in HB 793. The attestation should be used to document clinical experience under a sworn statement that this information is accurate and meets the requirements of the law.

- Most, if not all, states requiring attestation of transitional clinical hours are not overly prescriptive in what they require in their regulations or on their attestation forms. Therefore, in Virginia it should not be necessary to further define what is meant by "the patient care team physician routinely practiced with a patient population and in a practice area included within the category for which the nurse practitioner was certified and licensed."

- Both the NP and the patient care team physician should be held to disciplinary standards for providing falsified documentation to the Boards.

Please feel free to contact me if you have any questions.

Best wishes!

Felicia Pricenor <felicia@vacatholic.org> May 2

Dear Ms. Yeatts,
Please see the Virginia Catholic Conference's Public Comments below:

"As the Boards of Nursing and Medicine seek to enact regulations to implement House Bill 793, the Virginia Catholic Conference urges the Boards to not lose sight of the underlying goal of the

Bill to enhance access to quality health care in underserved areas in the Commonwealth. As the regulations are finalized, the VCC urges the Boards to make that a paramount consideration."

Thank you,

Felicia A. Pricenor, Esq.
Associate Director
Virginia Catholic Conference

Hayes, Deborah C *HS
<DCH6B@hscmail.mcc.virginia.edu>

5/3

Thank you for the opportunity to provide public comment. I have been a nurse practitioner (NP) for _15__ years practicing in __out pt ambulatory ______ setting in _Charlottesville _______ county/city. Completion of graduate education and national board certification deem that I am a competent clinician. Please keep this in mind as rules are being promulgated.

The five-year equivalent requirement creates a **costly bottleneck to building provider workforce and equitable distribution** in primary care delivery for underserved and vulnerable populations. Unduly burdensome regulations on top of this requirement will result in additional bottlenecks compromising access to care.

NPs already pay fees associated with RN, NP, and prescribing licenses. Any additional fees associated with submission of attestation and issuance of autonomous designation **should not create a financial barrier** for qualified NPs to practice.

Acceptance of **"other evidence"** demonstrating that the applicant has met the requirements must be **broadly interpreted**. We ask that the Joint boards issue a **guidance document** listing examples of supporting evidence that they would take into consideration. **Office administrators, health system administrators, and credentialing documents should all be accepted as evidence** that an applicant has met the necessary requirements.

The Boards **should credit applicants** by endorsement for all of their time employed and licensed **in other states** towards calculating their clinical experience requirement for practicing without a practice agreement.

NPs in any state or working for **U.S. Armed Forces, U.S. Veterans Administration or the Public Health Service** should be able to submit evidence that the five-year full-time equivalent collaborative requirements have been met with signature from employer, physician, practice administrator, etc.

There is **no demonstrated need for additional requirements on the attestation** in order to protect the public beyond what is listed in HB 793. The attestation should be used to **document clinical experience** under a sworn statement that this information is accurate and meets the requirements of the law.

Most, if not all, states requiring attestation of transitional clinical hours are **not overly prescriptive** in what they require in their regulations or on their attestation forms. Therefore, in Virginia it should not be necessary to further define what is meant by "the patient care team physician routinely practiced with a patient population and in a practice area included within the category for which the nurse practitioner was certified and licensed."

Both the NP and the patient care team physician should be held to disciplinary standards for providing falsified documentation to the Boards.

Deborah Hayes NP-C
Employee Health

From: Rosemarie Trapnell [mailto:rjtrapnell@earthlink.net]
Sent: Thursday, May 3, 2018 9:07 AM
To: jay.douglas@dhp.virginia.gov
Subject: Supporting

I am writing as a private citizen and as a Clinical Social Work in support of Nurse Practitioners and HB 793 as passed. Thank you. Rose Trapnell

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From: Rick Goodling [mailto:goodlingoffice@gmail.com]
Sent: Wednesday, May 2, 2018 5:18 PM
To: jay.douglas@dhp.virginia.gov
Subject: Enactment of regulations to implement House Bill 793

I am writing as a private citizen and as co-President of the Virginia Society for Clinical Social Work in support of Nurse Practitioners and HB 793 as passed.

Townhall Comments on Board of Nursing website

4/16/18 10:27 am

Commenter: Raschid Ghoorahoo FNP-BC, NP-C

NP independent practice time requirement

Dear Board of Nursing and Medicine

I have over 8 years of experience as a certified nurse practitioner. I have only been in my current job for 5 months, however, in the last 5 years I have worked at two other offices. When the law is implemented will a clause be placed in the requirements that multiple collaborative physicians can attest to the years worked under them to total the 5 years requirement?

4/17/18 6:58 pm

Commenter: Carolyn Friedman

How is attestation done

How is attestation done? Is MD required to "Attest" to the 5 years of experience of the NP? If so, would rather just have the NP attest to the experience. What are the "attestation" barriers the NP could face at the 5 year mark, if any?

4/17/18 8:54 pm

Commenter: Cynthia M Fagan

HB 793 Regulations

Dear Boards of Medicine and Nursing,

I respectfully request that the Joint Boards consider that the General Assembly overwhelmingly approved the fundamental concepts of nurse practitioner (NP) transition to practice with the five-year post-licensure compromise. Any obstacles that limit these fundamental concepts should be minimized as they would not be consistent with the spirit of the legislation and bipartisan will of General Assembly.

The NP community acknowledges that the five-year post-licensure transition to practice requirement resulted from political compromise and is not based on any evidence. NPs are prepared at the graduate level and are deemed competent clinicians upon graduation and passage of national certification. Policy development without supporting evidence, results in variability as evidenced by the significant inconsistency between the transition to practice time requirements from state to state. Virginia is the outlier among all other states in the nation and as such will be in the spotlight as regulations are being promulgated.

It is requested that the Joint Boards bear in mind that NPs have unique skills and expertise that are complimentary to the physician and other team members on the patient care team. It is therefore not reasonable to expect that there would be an absolute overlay of the physician's area of practice and the NPs licensure and certification. We work in many settings with MDs, DOs and DPMs to illustrate this point. A broad interpretation of basic internal medicine education of any specialist physician must be considered sufficient to meet the requirement for practice in a patient population and practice area that the NP is licensed and certified.

The board must consider the portability of professionals and that an NPs may have had several collaborating physicians during the required 5-year transition period. Therefore, the attestation needs to accommodate the names of several physicians and/or other evidence from entities such as practice administrators, employers, or credentialing documents, etc. based on individual circumstances. It is suggested that the boards consider formatting the attestation in a check list format for physicians to check the requirements specified in the law.

For example:

- physician has served with the NP pursuant on a practice agreement
- physician routinely practiced with a patient population and practice area for which the NP is certified and licensed
- physician practiced with NP from ___________date to __________date

It is also suggested that the boards consider that NPs in any state or working for U.S. Armed Forces, U.S. Veterans Administration or the Public Health Service be able to submit evidence of the five-year equivalent post-licensure practice requirement with signature from an employer, a physician, a practice administrator, etc. when coming from another state to practice in Virginia. This will prevent bottlenecks to building the necessary provider workforce and equitable distribution in primary care delivery for underserved and vulnerable populations.

Thank you for considering my comments for promulgation of regulations for NPs in Virginia.

Respectfully,

Cynthia M. Fagan, MSN, RN, FNP-BC

4/18/18 7:10 am

Commenter: University of Vrigina

Support of HB 793

Dear Sir/Madam,

I am in full support of this legislation because I am a family nurse practitioner and I know the experiece, knowledge, and services they provide will make a huge difference in medical care. Further, for the past 23 years, my "doctors" have all been nurse practitioners. You would have to experiece the difference to know the difference.

Sincerely,

Jane Miller, MS, FNP-BC, RD, CDE

4/18/18 12:57 pm

Commenter: Stacey Lambour

No evidence for "Transition to practice"

The five-year post-licensure "transition to practice" requirement is the result of political compromise with no evidence to support the regulatory mandate. This has created variability from state to state, making Virginia an outlier with the most arduous practice environment in the nation for NPs.

4/18/18 5:47 pm

Commenter: Linda Thurby-Hay, President of VaCNS

Support for full practice authority for NPs

The Virginia Association of Clinical Nurse Specialists (VaCNS) supports full practice authority for nurse practitioners (NP) in order to fulfill the need for increased primary care services across Virginia, in both rural and metropolitan areas, so all Virginias have access to healthcare. Advanced Practice Registered Nurses, inclusive of NPs, provide excellent nursing care through demonstrated patient outcomes. VaCNS notes that the evidence neither supports: 1) the stipulation that NPs work for 10,000 hours (5 years) before competence is

demonstrated, or 2) physician supervision/oversight provides protection for the public. Professional nurses remain the most trusted profession in the US for a reason!

4/21/18 9:19 am

Commenter: Sandra Hearn Eastern Shore Rural Health System, Inc

NP independent practice attestation

As a recently retired military NP, I'm concerned how we provide "attestation of practice" since moving all over the world for the last 18 years of my practice. Therefore I request that an NP in any state or working for U.S. Armed Forces, U.S. Veterans Administration or the Public Health Service submit evidence that the five-year full-time equivalent collaborative requirements have been met with signature from employer, physician, practice administrator, etc. Thank you for your attention to this specifically.

Sandra Hearn DNP-c, CPNP

Chief Nursing Officer, ESRH

4/23/18 8:11 am

Commenter: Carolyn Friedman

Attestation by NP only

I suggest that the NP attestation NOT require any signatures except that of the NP. If an NP is untruthful about her/his hours, they would risk losing their license – incentive enough, no? The attestation should be subject to audit, just as it is when I renew my NP certification (via the American Academy of Nurse Practitioners).

4/23/18 11:40 am

Commenter: Kathleen LaSala

Transition to practice for NPs

As a nurse educator and administrator with experience working in multiple states with NP programs, I fully endorse the VA legislation to move independent practice for NPs forward. It is regretful that political motives added yet another restriction of delaying such independence. NPs move to other states in order to practice independently. There should be no roadblocks in assuring the citizens of Virginia have quick and proper access to Advance Practice Nurses in a timely, effective manner. Any barriers to prevent such access should be removed. I commend the legislative movement and fully support the direction.

Kathleen B. LaSala, PhD, RN, former PNP,

Dean and Professor, Eleanor Wade Custer School of Nursing, Shenandoah University,

4/23/18 5:47 pm

Commenter: Carolyn Rutledge, Old Dominion University

Five year tranision to practice is a barrier to care

There is no evidence to support the need for the five-year post-licensure "transition to practice" requirement. However, this has been agreed upon in order to have a political compromise that would allow at least some NPs to practice independently. This mandate is unnecessarily and sets the stage for Virginia havng the most arduous practice environment in the nation for NPs. This requirement continues to create an access barrier to care for the states underserved populations.

4/24/18 10:41 am

Commenter: Olde Towne Medical & Dental Center

Support of Bill

In a safety net clinic setting, nurse practitioners present an excellent means of delivering economically affordable quality care to the uninsured and underinsured patients we serve. We commend this bill for expanding the ability of nurse practitioners to function in this setting. We believe attestation by the nurse practitioner is appropriate, and would favor recognizing experience gained in other states.

4/24/18 1:20 pm

Commenter: Marsha Stonehill, MSN, PMHNP/CNS, BC

Attestation to Practice

I graduated from UVA in 2003 and moved to California and practiced in San Diego for the first 4 years, then moved back to Virginia and practiced 2 more years with a residential program that folded because of economic crash and lack of insurance reimbursement on this coast. Then transitioned to a Free Clinic which was first to provide psych services full-time with grant from VHCF. My concern.....locating the physicians who could attest to my competence. Please make this realistic for those of us who have been out there a long time and have moved. It would be realistic to get the companies human resources departments attestation to my employment and time with them, but much harder to get the actual physician at the time. Please take this into consideration. Also, we already pay many licensure fees. I'm not sure why a fee would be necessary for this transition to practice. Thank you and looking forward to the transition!

4/24/18 4:47 pm

Commenter: Julie Sanford, James Madison University

Nurse Practitioner Education

NPs are prepared at the graduate level and are deemed competent clinicians upon graduation and passage of national certification. There is no evidence to support the need for additional post-licensure supervision of NPs' practice beyond current educational and certification standards.

The education provided to Nurse Practitioner students in Virginia's Schools of Nursing is outstanding and we routinely graduate competent individuals willing and able to provide healthcare in communities where there are precious few healthcare providers. Restricting independent practice restricts access to care for Virginia's citizens who all deserve better.

Julie Sanford, DNS, RN, FAAN

Director, School of Nursing

James Madison University

Harrisonburg, Virginia

4/25/18 9:39 am

Commenter: Jessica Ruff, FNP-C; VCNP GR committee member

Proposed Regulations

Dear Joint Boards of Medicine and Nursing and Advisory Commitee,

We've established that APRNs provide safe quality healthcare and I'm thankful that Virginia has recognized this by passing legislation that makes us one step closer to FPA. When formulating regulations to implement HB793, I propose that we adopt a similar regulation to the proposed one below.

The board shall grant recognition as an advanced practice registered nurse without a practice agreement to a nurse who has: (1) A current, unencumbered license as a registered nurse in this State; (2) An unencumbered license as a registered nurse in all other states in which the nurse has a current and active license; (3) An unencumbered recognition as an advanced practice registered nurse with an equivalent of at least 5 years of physician lead collaboration in a similar field as the nurse practitioner is certified. Similar field is defined as graduate level generalized training/residency or clinical practice in the area of certification as the APRN. Five years of experience is defined as a total length of certification, by an acceptable certifying body, as an APRN to include practice among any state in the U.S. and it's territories. (4) Acquired clinical experience of sufficient depth and breadth to reflect the intended license as evidenced by meeting all of the criteria above and presents a letter of attestation from one collaborating physician during the 5 year reporting period. A letter of attestation is defined as a standardized form that outlines the APRNs length of practice, current certification, current unencumbered liscensure as an APRN and RN in the state of practice. (5)_Paid the appropriate fees to issue a new liscense to reflect a registered nurse practitioner or other APRN to practice without a practice agreeement. Appropriate fees is defined as a one time free initial liscense and then a 2 year renewal to match the current renewal liscensure fees.

Thank you for your time to read this and your consideration.

Jessica Ruff, FNP-C

4/25/18 1:54 pm

Commenter: Marie I. Goodwin, FNP-C

HB 793

I am disappointed in the outcome of this bill. I feel that VCNP has settled for an 'anything is better than nothing' approach and has caved to the political pressure of the organization not in support of autonomous practice for NP's. I would hope that VCNP would continue to pressure for ammendments that lift restrictions. I do agree that there should be a waiting period for new graduate NP's especially for those with limited nursing experience. Five years, I feel is excessive. I feel that Virginia continues to remain an outlier with this bill.

4/25/18 7:34 pm

Commenter: Barbara G. Schimming

HB 793

Dear Boards of Medicine and Nursing:

I respectfully ask that you would approach the regulatory process with the same bipartisan spirit that overwhelmingly approved the proposed legislature. Nurse practitioners (NPs)have unique skills and expertise that are a compliment to the health care team caring for all of the citizens of Virginia. The result of the five-year transition to practice requirement is the result of compromise in the political arena and there is no evidence to support the regulations proposed. Moreover, this distinguishes Virginia with the most arduous practice environment in the nation for NPs. I have practiced in this state for over twenty years and I am devoted to the patients that I have had the honor to serve. NPs are prepared at the graduate level and are deemed competent clinicians upon graduation and subsequent passage of the national board certification. I ask you to make the process fair, succint and timely. I would like for you all to consider a simple attestation form that may include the patient care physician (MD, DO or DPM) that has practiced with the NP for the equivalent of at least five years. Moreover, please consider allowing office adminstrators, health system administrators, credentialing documentation to also be used as evidence. Please also consider that any NP in any state working for the United States (U.S.) Armed Forces, U.S. Veterans Administration or the Public Health Services submit evidence that the five year full time equivalent collaborate requirements have been met with signature from the employer, physician, or practice administrator. Sincerely, Barbara G. Schimming FNP-BC

4/25/18 9:48 pm

Commenter: Rebecca Castellanos, DrNP, APN

Collaborative consultant team APN's, MDs, DOs

I've been employed in adult/geriatric care for over 18 years as an APN. The patient care teams I've collaborated with have been respectful of nursing philosophy and the professionlism of care experienced APN's bring to the health care industry. Medical schools have been embracing medical student collaboration and respect of APN colleagues, for over a decade. It is timely for the full scope of medical community and nursing profession grant independent practice to experienced Advance Nurse Practitioners.

It is requested that the Joint Boards recognize ANPs have unique skills and expertise, complimentary to the physician and other diverse members on the patient care team. Therefore it is reasonable to expect there will be overlap of the various consulting physician's area of practice and the ANP's. Our expertise and clinical experience is validated by our licensure and certification. The Veteran's administration as well as 23 other states recognize practice and licensure laws providing for all nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments—including prescribing medications and controlled substances—under the exclusive licensure authority of the state board of nursing.

We work in many settings with MDs, DOs and DPMs to illustrate this point. A broad interpretation of basic internal medicine education of any specialist physician is considered sufficient to meet the requirement for practice in the medical profession for a patient population. The practice area of the ANP licensed and certified by our national board meets requirements to practice within our profession. It is timely for the Commonwealth of Virginia to retire barriers to patient choices and practice restrictions. I applaud promulgation of emergency regulations to implement HB 793. This legistative is timely and well needed.

4/26/18 10:23 am

Commenter: Melissa Bond, BSN, RN, James Madison University

Proposed Independent Practice Bill

I am a family nurse practitioner student at James Madison University, and I will be graduating in May 2019, thus these regulations will impact my future practice. The FNP program at JMU is rigorous with both classroom and clinical applications. We are instructed on using the most current guidelines and evidence when treating our patients, as well as seeking answers from specialist consultants when faced with a complicated cases. This ensures safe, high quality care for our patients. For these reasons, nurse practitioners are prepared for independent practice because of this commitment to changing practice based on evidence based research and using the most current resources to guide care. I support this bill, and I do feel that my education will prepare me for independent practice.

4/26/18 12:29 pm

Commenter: Shelly Smith

HB 793

Type over this text an

Esteemed colleagues thank you for your consideration of public comment regarding the promulgation of HB 793.

Promulgating HB 793 will provide an excellent opportunity for Virginia to transition nearly 50% of licensed nurse practitioners to independent practice. This will increase access to care in our Commonwealth and is a demonstration of compromise between nursing and medicine.

The five year full time equivalence period is the longest in the nation, however, there are many examples of transitional licensing approaches in other states. Connecticut, Delaware, Maine, Maryland, Minnesota, South Dakota and Vermont all use a transition to independent practice model, however, none of these states require an attestation. Nebraska requires a transition to practice agreement for the first 2,000 hour of nurse practitioner practice, there is no mention of an attestation. New York allows transition after 3,600 hours at which time nurse practitioners attest that a collaborating physician is available to them. Virginia's attestation requirement seems arduous, it would be a travesty to create an unbearable work burden for the Joint Boards.

The current nurse practitioner workforce in Virginia operates under collaborative agreements that are regulated by the Joint Boards. These collaborative agreements should be honored when considering the five year work equivalence. The boards should not have to redefine who is an acceptable collaborator simply because new legislation was passed. This creates unnecessary work and would unduly penalize our current workforce, thereby, defeating expansion of access to care. Therefore, it seems reasonable that the Joint Boards can create a simple attestation form that acknowledges the prior collaborative agreements between nurse practitioner and physician. The physician would simply verify that the nurse practitioner collaborated under the pre-existing contract for at least five years full time work equivalence.

d enter your comments here. You are limited to approximately 3000 words.

4/26/18 2:45 pm

Commenter: Rachel Brandon Sears, RN (BS GMU Fairfax)

New Law Governing Nurse Practitioners

I agree that the need in our state for more General and Family doctors is greater under the Affordable Care Act. Nurse Practitioners already can work nearly independently, but with physician supervision. I suggest that NPs continue to have a physician association as a consultant in their new completely independent status. And, for accountability, NPs should closely affiliate with the Nursing Instructors at one of Virginia's colleges. Thank you

4/26/18 8:04 pm

Commenter: Ann McTernan

Website with information concerning a NP license that was expired way back in 2000 and not renewed

Please remove the website with my information about my military dependent license as an RN and ANP from the State of Virginia. The license was not renewed and expired back 18 years ago. I was a USMC dependent wife stationed in Northern Virginia and have not lived or been in the State of Virginia since 2000. I am an original and permanent resident of the State of Minnesota and have never been a resident of Virginia. I was only there as a military dependent on USMC military orders of my former husband and in military sponsored housing. The Adult Nurse Practitioners are not licensed anywhere in the United States as our programs were eliminated from the Schools of Nursing in 2015. Therefore this information is not accurate. If you have any doubts - contact Nicholas Liensch JD with the Minnesota State Attorney General's Office. Ann McTernan

4/26/18 10:53 pm

Commenter: Joseph G. Lynch LCSW, Virginia Society for Clinical Social Work

Promulgation of regulations to implement HB793

I appreciate the opportunity to make public comment to the Boards of Medicine and Nursing promulgation of regulations to implement HB793. I encourage the Boards to hold true to the intent of the General Assembly and the Governor in their passage of this legislation. Because of this legislation Nurse Practitioners are enabled to practice more independently and thus the citizens of the Commonwealth have increased access to health care providers. As a Licensed Clinical Social Worker with 43 years of clinical practice in a more rural area of Virginia I am familiar with the difficulty my clients experienced gaining access to Psychiatrist for their

medication needs. Nurse Practitioners are more widely distributed across the Commonwealth and have prescribing authority. This legislation is intended to extend the delivery of health care services and it is my hope that the Boards do not promulgate regulations that make any narrow interpretation of the legislation that in any manner inhibits this extension of service delivery.

5/1/18 5:07 pm

Commenter: Ameanthea Blanco-Knezovich

HB793

Thank you for the opportunity to provide public comment. I have been a nurse practitioner (NP) for 13 years practicing in family Practice setting in Virginia Beach county/city. Completion of graduate education and national board certification deem that I am a competent clinician. Please keep this in mind as rules are being promulgated.

5/1/18 5:24 pm

Commenter: Ann Ball, FNP-BC

HB793

Thank you for the opportunity to provide public comment. I have been a nurse practitioner (NP) for 3 years practicing family practice in Virginia Beach. Completion of graduate education and national board certification deem that I am a competent clinician. Please keep this in mind as rules are being promulgated.

5/1/18 10:01 pm

Commenter: Theresa G. Long DNP

HB 793 barriers in rural areas

Thank you for the opportunity to provide public comment. I have been a nurse practitioner (NP) for 13 years practicing on the Eastern Shore of Virginia. We are an underserved, low socioecomonic community. As physician retirements increase, the use of locum tenens has become the norm. This practice limits the ability for NPs in this area to identify an active physician with whom they have practiced for 5 years. An employer or health system however, could verify practice length and status. I would ask that you make this process flexible to accomodate those of us who serve in underserved communities where physician turnover is high and the use of locum tenems is the norm.

5/1/18 10:20 pm

Commenter: Patricia Porter ADAMS, ANP, LLC

HB 793

Thank you for allowing me to comment on the above Bill and its implementation period.I have been a Nurse Practitioner in the Fairfax County section of Northern Virginia for almost 25 years.I fully agree with a five-year period of experience in collaboration with a physician colleague. The mentorship which I obtained from my physician colleagues was invaluable. I agree with others who have recommended that the process of documenting and attesting to the five years of experience not be overly difficult, especially for our colleagues who have traveled from other states or who have worked with the government and with the military during that five-year timeperiod. I disagree with the use of practice administrators, corporate or hospital administrators or other non-medical people giving any type of input which could affect our attestation period. Again, thank you for considering my comments.

5/1/18 11:09 pm

Commenter: Sreeja Manoj, Anthem CareMore

HB 793

Thank you for the opportunity to provide public comment. I have been a nurse practitioner (NP) for __4_ years practicing in _Primary Care setting in Richmond . Completion of graduate education and national board certification deem that I am a competent clinical provider.

The five-year equivalent requirement creates a **costly bottleneck to building provider workforce and equitable distribution** in primary care delivery for underserved and vulnerable populations. Unduly burdensome regulations on top of this requirement will result in additional bottlenecks compromising access to care

5/2/18 12:54 am

Commenter: Rosie Taylor-Lewis, DNP, ANP-BC, GNP, PMHNP student RU, APD DNP SUO

HB793

Dear Boards of Nursing and Medicine,

Thank you for the opportunity to provide public professional advisement on the promulgation of HB 793. I have been a board certified adult nurse practitioner for 25 years, practicing in various primary care facilities, have taught at the graduate level for 23 years and have recently returned for a post-doctoral certification as a psychiatric mental health NP. I will complete my program of study in May of 2019. I am not starting over, I am adding to my current credentials. The catalyst is to provide integrative holistic care to my primary care patients and to prepare my NP/DNP students to do the same. I am blessed to have been "raised and mentored" by both nurse and physician educators and I want to pay that forward.

I respectfully request the joint boards to consider the near unanimous support of this bill by the General Assembly as decisions on regulations are made to promote the health of Virginians, some of which are our most vulnerable and underserved citizens. **The testimony of our competency is far greater than a signature by a physician colleague. Neither should it change the collegial relationship between two professional groups who are working for the same cause, best patient outcomes.** The evidence of education, certification, licensure, annual continuing education credits, employment records/agreements, involvement in local, state and national organizations and most certainly evidence of patient outcomes are but a few of the cumulative attestations of our competency, professionalism and commitment to being *providers of Primum non nocere* "do no harm". I advocate for diverse attestations that will qualify and quantify the competency of the nurse practitioner. Specific to additional certifications and endorsements, I ask the board to acknowledge and waive any additional 5 year period requirement for second certifications. We need our experienced NPs to return for additional credentialing in order to provide augmented care to population health, especially in the area of mental and behavioral health. I believe our physician colleagues who acquire additional "training" have no "wait period" in executing a new skill or procedure and their licensure and certification suffice.

I appreciate your task at hand and I look forward to the outcomes that will bring us closer to the professional parity that we deserve.

With much gratitude,

Dr. Rosie Taylor-Lewis, DNP, ANP-BC, GNP

5/2/18 6:57 am

Commenter: Rhonda Arthur

HB 793

Thank you for the opportunity to comment. Reducing barriers to practice for Nurse Practitioners to practice is one way Virginia can increase accessibility to health care for Virginians. The requirement of five years full time practice to reach the goal of practice without a practice agreement with a patient care physician is already significantly out of line with what most states require and increases barriers to practice and care I Virginia.

I would recommend that the process be a simple and straightforward as possible. I have worked seven years in primary care, then seven years in public health. During my time at public health I have had three medical directors. It would be difficult track down former physician team leaders. It would be uncomfortable to ask the person who worked the most consistently with me to sign a form, because I worked with him more than 7 years ago. While my physician team leaders will probably be willing to sign, the one I work with now, I have worked with less than two years. Should she sign and take my word? Wouldn't it be better cutting out the middle man?

Consider the individual physician team leaders. What if they personally disagree with nurse practitioners being granted the authority to practice to the full extent of their training? A Virginia Nurse practitioner should not have to stalk former physician team leaders or be at the mercy of a current physician team leader for permission to work to the full extent of her training and certification.

To prevent increased tensions and waste of time, I recommend that nurse practitioners be allowed to attest to their own work history. Nurses are consistently voted the most trusted profession and are no more likely to tell an untruth than a physician.

Thank you.

Rhonda Arthur DNP, CNM,
WHNP-BC, FNP-BC

5/2/18 10:14 am

Commenter: Kristin Andrs, NP, Andrs Wellness Consulting, LLC

HB 793

Thank you for the opportunity to provide public comment. I have been a nurse practitioner (NP) for 18 years practicing in acute, outpatient, geriatric and Integrative Medicine settings in the greater Richmond area. Completion of graduate education and national board certification deem that I am a competent clinician. Please keep this in mind as rules are being promulgated. I am board certified as an Adult Acute Care NP, but after working in an acute setting, mostly Cardiac Surgery at 2 hospitals in Ricmond for 8 years, I transitioned to outpatient in Gastroenterology, then Endocrinology. In 2010, I began an 2-year fellowship in Integrative Medicine at the University of Arizona. After completeion of that, I opened my own practice in Integrative Medicine, mostly managing chronic disease. I request that the requirement for "Routine practice in a practice area included within the category for which the NP was certified and licensed" be examined. As, I have 8 years of practice in the field in which I was board certified, that is not the area I'm practicing now. I am fully trained via a 2-year fellowship, as well as many other training programs and CME conferences, I would not want this bill to prohibit my ability to practice practice without a practice agreement with a patient care team physician. I would like consideration for NPs such as myself who have worked in other practice settings in which they are fully competent to do so. The regulations should not be written in a restrictive manner.

Additionally, NPs already pay fees associated with RN, NP, and prescribing licenses. Any additional fees associated with submission of attestation and issuance of autonomous designation should not create a financial barrier for qualified NPs to practice. There is also no need for additional requirements on the attestation beyond what is listed in HB 793. It should be used to doucment clinical experience under a sworn statement and meets the requirments of the law. Both the NP and the patient care team physician should be appropriately disciplined for falsifying docments of attestation or other docments presented to the Board.

Sincerely,

Kristin Andrs, NP

5/2/18 10:27 am

Commenter: Amanda Whitney, BSN, RN-BC

common-sense policy

Even in reviewing this small comment section, one can see the various challenges that NPs may face with the attestation process. I look forward to completing my Doctor of Advanced Nursing Practice in 2020. Currently, I am a resident of northern Virginia, but I hope to move to a more rural area in the future to bring primary care to underserved populations. I sincerely hope the attestation process is made simple, allowing the heart of the bill the shine. If we make the process of submitting for independent licensure overly complex, then we are missing the point of what this legislation is trying to achieve. I, respectively, urge the board to honor the heart of the law by developing a common-sense attestation policy.

5/2/18 12:23 pm

Commenter: Sharon Zook, James Madison University

HB793

Dear colleagues on the Boards of Nursing and Medicine,

Thank you for the opportunity to comment on Bill 793. It is gratifying to see that Virginia is finally recognizing that the evidence shows nurse practitioners are educated and highly qualified to provide healthcare to the citizens of Virginia. I would request that you make attestation for the independent practice a simple process that can be completed by the NP. As many of the comments note requiring physician attestation may be a burden for many NPs and violates the spirit of the bill for access to healthcare for many Virginians. This is our opportunity to show the collegueality between all members of the healthcare team.

Sincerely,

Sharon Zook, DNP, FNP-BC, Professor JMU

5/2/18 1:10 pm

Commenter: Karen Hill, FNP-C

HP793

5 yrs experience in practice is reasonable. We all need experience to be our best! The attestation to meet this requirement should be allowed to come from any physician in any specialty, as all are physicians, specialties should not be excluded. I don't feel we should have to pay to be noted as being "FPA", our licensure fees should cover this.

5/2/18 2:47 pm

Commenter: Jennifer Fellman DNP, FNP-C

Attestation issues/concerns

I have worked as a NP for 13 years. The last 4 of those years I owned my own house calls practice. Unfortunately, I closed that practice in December due to excessive costs of running the business in relation to Medicare reimbursements. A major cost for me was paying a monthly fee for a collaborating physician. I am very happy that we are in the process of reducing this barrier to practice, but as many know we still have a ways to go.

I ask the boards to consider the inconvenience and expense (time and/or money) in chasing down former physician employers to sign a permission slip to allow experienced NPs to practice without a collaborative agreement. And to that, what are the requirements for the physician? Is it possible a physician would chose to not sign, not because the NP is incompetent, but that they don't want the liability of "vouching" for the NP. What exactly would the board ask the physician to attest to? Is it a simple yes/no and signature? What, if any, are the implications of the signing physician in the event the NP does violate standards of the profession? One would not think this would be fair or reasonable. However, the concern of some physicians is that it would imply liability for the NP just as many fear collaborating with NPs for the same reason (even though the law states otherwise).

As another NP stated in comments earlier, the NP is the only person who should have to attest to their 5 years of experience. If the board has reason to believe (or a complaint is filed) that a NP has falsified that attestation then a formal review/investigation would be appropriate and a better use of time and money for the joint boards.

I thank you for the opportunity to comment on this issue. Please consider keeping this process as basic and paperless as possible.

Jennifer Fellman DNP, FNP-C

5/2/18 4:27 pm

Commenter: Karen Karlowicz, Old Dominion University

Five year full time equivalence period is too long

The legislation passed that allows nurse practitioners to engage in independent practice is long overdue. However, the five year full time equivalence period is too long. I understand the reasoning behind this requirement, but the proposed time frame is excessive, the longest in the nation, and negatively impacts efforts to increase access to health providers in underserved areas of the Commonwealth. Schools of Nursing that educate nurse practitioners meet strict academic and clinical standards to assure that graduates are able to practice competently and safely within this advanced practice role. Graduates of medical education programs complete residencies and fellowships over several years before launching into independent sub-specialty practice, and yet technically, in most states (but not all) medical school graduates are required to complete only a one-year internship before engaging in independent practice. Why should this be different for nurse practitioners who likely have had 2 or more years of practice in the RN role before earning certification as a NP, whereas medical graduates have had no prior experience in the provider role. The Boards must take care not to get caught implementing a double standard.

5/2/18 7:17 pm

Commenter: Kimberly Marshall, AG-ACNP

attestation

Dear Board of Nursing and Board of Medicine: The attestation process should be broad and allow for other avenues in addition to physician declaration. There are many physicians who will not do this and their reasons will be plentiful including a presumed liability and feeling as if they are "releasing" an NP therefore implying that their "certification" on the attestation may imply a possible future liability. Consider that on each bi-annual license renewal, NPs, RNs, etc., already "attest" that they are meeting the continuing education requirements and there is no process for submitting documentation unless audited. A similar process could be done for attestation. Additionally, you could consider other records such as employment records from HR, etc. There are

many NPs who have held multiple positions, changed jobs, have more than one job, etc., that will make gathering the "physician signature" a challenge that is against the current of this new law. The "equivanlent of 5 years full time practice" is HUGE, and when an NP finally meets that requirement, it is very likely that they would be able to support their own attestation by other means. The process of only having sworn statements by physicians is burdensome, and worrysome for both NPs and our colleague physicians. Thank you for the opportunity to express our concerns.

5/2/18 9:39 pm

Commenter: Nancy Nicolson, RN, MSN, ANP-BC

Nurse practitioners

Nurse practitioners are highly educated and committed nurses who work tirelessly to help those in need. Nurse practitioners constantly work to improve the health and wealthfare of their patients and those in the community. They provide excellent care and provide needed services and medical care to those who request care. Demanding >10,000 hours of supervised oversight is extravagant. Nurse Practitioners work within a framework of a medical team at all times collaborating with team members as needed. A more realistic requirement would be less than 1 year of collaborative practice. Many nurse practitioners work in practices that they are already working alone or with one MD, should the collaborative physician become ill or incapacitated the patients in that practice would be without medical care. Studies have shown that Nurse Practitioners provide equal or better care to their patients with chronic illnesses than their physician counterparts. Most nurse practitioners presently work within a medical team but those who choose to go out on their own should not face barriers to practice within their scope of practice. With the expansion of Medicaid more nurse practioner swill be needed to provide care to those in need.

5/2/18 10:45 pm

Commenter: Phyllis C Everett, NP-C, Sapient Health Services, PLLC

HB793 Regulations, Comments

May 2, 2018

To the members of the Committee of the Joint Boards of Nursing and Medicine and it's Advisory Committee,

I am a nurse practitioner with 13 years experience. I am pleased with the passage of HB793 and the potential for release from the requirement of a collaboration agreement. I own my own practice in southern, central Virginia and in order to maintain a collaborative agreement, my physician collaborator and that of my colleague, expect to be paid for this service. This takes money away from the practice and the services we can offer. I am requesting an expedited process for the promulgation of these regulations so that we can obtain attestation and these funds can be retained in the practice.

I ask that the fee for attestation be modest and the consideration of adding the letter "A" to the license number to designate those nurse practitioners who have completed attestation. The time frame to complete attestation should be limited to no more than 30 days from the date of the request to avoid delays in the process. The form should be simple, requiring only a check box and signature. The use of electronic signature such as with DocuSign should be considered in addtition to paper forms.

I would add that the skill set of a nurse practitioner has components that are common to any practice site such as taking a history, completing a physical exam and making a treatment plan that reflects current evidence-based guidelines. Therefore, a nurse practitioner with 5 years of experience could easily translate those skills to any setting and should be allowed to proceed with attestation even with a variety of practice sites or specialties during that five year period. Some states do not require that nurse practitioners have experience beyond certification to practice without a practice agreement and those that do, require much less time than Virginia has legislated.

In order to fill the need for health care providers in Virginia, we should readily accept the experience of nurse practitioners outside of the commonwealth for attestation. Some of our colleagues in Northern VA left the state to practice in nearby states and DC to be able to practice to the full scope of their education and training. We would hope to attract them back to Virginia with this new law to improve access to care.

Thank you for your consideration of these comments.

With regards,

Phyllis C Everett, NP-C

Owner, Sapient Health Services, PLLC dba Huddleston Health and Wellness

5/3/18 5:59 am

Commenter: Lydia D. Shelton

HB793

Thank you for the opportunity to provide public comment regarding HB 793. I have been a NP for 35 years and practice in Virginia. I, as well as my NP peers, have completed Post Graduate Nursing Education & have National board certification. Please keep in mind that the rules you make will impact quality health care to all Virginians.

- The five year equivalent experience requirement creates additional barriers to health care across our state. This is especially true in our rural areas.
- NPs already pay fees for RN, NP, & Prescriptive Authority licenses. Any additional fees for attestation should not create a financial barrier for qualified NPs to practice in Virginia.
- There is no demonstrated need for additional requirements on the attestation beyond what is listed in HB 793
- Thank you again, Lydia D. Shelton, WHNP/FNP

5/3/18 7:06 am

Commenter: Moniqueia Flint

HB 793

Thank you for the opportunity to provide public comment. I have been a nurse practitioner (NP) for one and a half years practicing in primary care _ setting in Virginia Beach county/city. Completion of graduate education and national board certification deem that I am a competent clinician. Please keep this in mind as rules are being promulgated."

5/3/18 10:50 am

Commenter: American Association of Nurse Practitioners

HB 793 Proposed Regulations

Dear Members of the Committee of the Joint Boards of Nursing and Medicine,

The American Association of Nurse Practitioners (AANP) appreciates the opportunity to respond to the request by the Boards of Medicine and Nursing for public comment on the promulgation of regulations to implement HB793 (Chapter 776 of 2018 General Assembly). In drafting regulations, AANP would encourage the boards to be as flexible as the new law allows and to avoid adding new requirements or restrictions that are in excess of those required under the previous career-long nurse-physician contracted agreements. AANP looks forward to providing added comment when a copy of proposed rule is available for public comment.

Sincerely,

Tay Kopanos

Vice President, State Government Affairs

American Association of Nurse Practitioners

5/3/18 12:45 pm

Commenter: Norman M Jacobowitz, PMHNP-BC

HB793 / Burden of Proof / Expense

Thank you for the opportunity to submit public comments. Please note that I have 8 years of experience providing very competent care to thousands of patients in inpatient and outpatient psychiatry. I currently pay $400 per month to my collaborating physician, $4800.00 per year. This inherently limits the degree of sliding-scale fees I can charge to my indigent clients, of whom there are many. In addition, it limits my ability to take VA DMAS (Medicaid) patients.

I respectfully request that the Board keep these factors in mind when promulgating rules for HB793 implementation:

- Keep the process as paperless and inexpensive as possible, something that could be completed in a matter of minutes on your existing website;
- Use the most liberal or open standard you can in regards to what constitutes evidence of 5 years of practice;
- Make it clear in any forms you create for physician attestation that there is NO liability ascribed to the signing/attesting physician;
- Impose no extra limitations, rules or other barriers in the regulations that would slow or impede NPs from qualifying; and
- Finally, please always remember that *there is no evidence whatsoever that NPs are any less competent in our care nor are we any more likely to cause patient harm than licensed physicians.*

Physicians in all states have always been opposed to open access to NPs, strictly out of risks to their financial monopolies over caring for patients.

Therefore, it is in the rational self-interest of the Virginia Boards of Medicine and Nursing to make rules for HB793 as open and easy as possible for qualified NPs to comply with as quickly as possible with the least amount of expense or burdensome efforts.

Thank you and feel free to contact me if you request more information.

5/3/18 1:28 pm

Commenter: Laura Brooks, NP-C

Dear Sir/Madam:

5/3/18 1:45 pm

Commenter: Laura Brooks, NP-C

HB 793 Comment

I appreciate the opportunity to comment on this bill and legislation. It may be helpful for lawmakers to realize that many NPs become NPs after having already worked in the medical field as RNs for years. It is not that we know all there is to know about medicine because obviously we can't. However, we are educated enough to know what we know and are confident/competent in diagnosing/treating and what needs to be referred on to a physician or specialist. In my case, for instance, I was a practicing full-time RN for more than 30 years before attending graduate education to become a NP. Therefore, a novice to the medical field, I was not. Neither were many of my classmates and no doubt many of my current fellow NPs today. Therefore, a lengthy time period of NP practice may not always be needed. Therefore, I ask that no unnecessarily burdensome restrictions be placed upon the future of NP practice. Finally, if we are successful in completion of a graduate level NP program (especially in VA) and pass our NP board exam, I believe our competency should not be unduly challenged. Thank you.

5/3/18 2:12 pm

Commenter: Jeff Petraco, NP Student

HB 793

Thank you for the opportunity to provide public comment. I have been a nurse practitioner (NP) student who will be graduating soon.

I am writing to ask that you minimize the regulatory burden associated with the attestation of practice in to order to avoid what could become a bottleneck compromising access to care.

NPs already pay fees associated with RN, NP, and prescribing licenses. Any additional fees associated with submission of attestation and issuance of autonomous designation have the potential to create a financial barrier for qualified NPs to practice.

Acceptance of "other evidence" demonstrating that the applicant has met the requirements must be broadly interpreted. We ask that the Joint boards issue a guidance document listing examples of supporting evidence that they would take into consideration. For example, administrative and credentialing documents should be accepted as evidence that an applicant has met the necessary requirements.

The Boards should credit applicants by endorsement for all of their time employed and licensed in other states towards calculating their clinical experience requirement for practicing without a practice agreement.

There is no demonstrated need for additional requirements on the attestation in order to protect the public beyond what is listed in HB 793. The attestation should be used to document clinical experience under a sworn statement that this information is accurate and meets the requirements of the law.

Most, if not all, states requiring attestation of transitional clinical hours are not overly prescriptive in what they require in their regulations or on their attestation forms. Therefore, in Virginia it should not be necessary to further define what is meant by "the patient care team physician routinely practiced with a patient population and in a practice area included within the category for which the nurse practitioner was certified and licensed."

Thank you for consideration of my comments and for supporting expanded access to care.

5/3/18 2:16 pm

Commenter: Paula Hill, Clinical Director at The Health Wagon

Seamless Transition

I work in extreme Southwestern Virginia. We are desperately in need of ALL health care providers. HB-793 will help in giving our Nurse Practitioner managed free clinic continued sustainability. As we treat over 10000 patients, it is essential the joint board develop a transition process which most efficiently opens the doors to nurse practitioners to work independently. As has been started, attestation of clinical hours shokld have inclusions to ensure that hours can be verified in the cases of physician death, retirement or inability to obtain signtaure. HB 793 while perfect will make an extreme impact in the Commonwealas a multi disciplinary, collaborative approach to patient care is vital to solving the dilemma of healthcare shortage and access to care.

5/3/18 2:41 pm

Commenter: Jennifer H. Matthews, PhD, RN, CNS, FAAN, Shenandoah University, Winchester

HB793

Thank you for the comment period. Please reconsider the five year requirement [at least five years of full-time clinical experience]; it should be less than five years. Many APNs/Nurse Practitioners have considerably more years as registered nurses in practice as they enter graduate school and then exit school and successfully achieve certification. As a Professor in a graduate program preparing nurse practitioners I am well aware of their dedication to being the best practitioners, utilization of their prior skills as expert registered nurses, and expansion of their clinical reasoning and judgment abilities during their journey to certification. A five-year period will limit their ability to care for increasing numbers of individuals needing medical care and may stifle their innovation in developing new models of care delivery. Please consider solutions to aiding Virginia residents in seeking qualified professional care - one means is to facilitate the practice of experienced nurse practitioners.

Thank you

Jennifer Matthews, PhD, RN, CNS, FAAN

Professor, Shenandoah University

5/3/18 9:27 pm

Commenter: Bridgette Keene NP student

HB 793

Thank you for the opportunity to provide public comments on this this extremely important issue of regulating full practice authority for NPs. Many NPs have already been nurses for quite some time. The average NP has already been a nurse for 10 years prior to their NP. It would seem counter intuitive as we strive toward better and expanded access to care to heavily regulate the process of attestation. This gap is especially evident in rural areas. This should be a cumulative 5 years counted toward the attestation with the possibility of having the oversight of multiple physicians during that time. This regulation process should be simple without unreasonable fees attached as NPs already have two licenses to maintain in addition to their DEA license. This process should not be financially burdensome on the NP as they already pay fees for theses aforementioned items. I feel very well prepared to manage complex patients in my current curriculum and have a healthy discretion of when to refer my patients to other specialists as other providers also do. There should not be a limit on the number of NPs whom can attest at the 5 year mark. If they have the experience they should be able to attest. Any NP who has completed a graduate level program should be able to practice to the the full extent of their education without unduly restrictions. As we are always nurses at heart we remain the number one advocate for our patients and supporting their access to care. Make the process of attestation a simplistic one for this reason.

5/3/18 10:34 pm

Commenter: Mary Duggan MS ACNP-BC FAANP

HB793 comment

Thank you for the opportunity to comment on regulatory process related to HB793. As a nurse practitioner with 21 years of experience, I am concerned with the overall implications of this legislation. It is well established that there is absolutely no evidence that any transition to practice period for certified nurse practitioners will improve quality of care or ensure safe practice. With passage of this compromise legislation, Virginia becomes an extreme outlier compared to other states with the longest transition period of 5 years full time practice. Additionally, the attestation process is fully dependent on the physician giving permission for the nurse practitioner to practice without an agreement, not on the nurse practitioner's competence, and is overshadowed by perceived physician liability. After "transition" the NP must still, by law, consult and collaborate with other health care providers and establish a plan for referral of complex medical cases and emergencies to physicians or other appropriate health care providers. The Joint Board should consider that nurse practitioners are prepared by education and certification to practice, and these restrictions are unnecessary and a restraint of trade.

I would ask that the Joint Board consider the following in promulgation of regulations

1. The 5 year full time practice requirement should be fluid, allowing for nurse practitioners who have worked in a variety of settings during that time to combine years of practice.
2. The attestation document should be simple and not require a physician signature. Naming a physician(s) should be satisfactory. An audit process could satisfy this requirement. It should be established that a physician attestation does not imply liability and that a physician may not require payment for the attestation.
3. Nurse practitioners from out of state should, by the fact of licensure in another state for at least 5 years, qualify for the transition period without an attestation, as this creates an undue hardship and deters nurse practitioners from working in Virginia.
4. There should be a significant effort to collect data for the November 2021 report to the legislature, that will support a decrease in and/or removal of the transition period.

5/4/18 9:10 am

Commenter: Zita Buky, MSN, FNPc Physicals Plus

HB793

Thank you for the opportunity to provide public comment. I have been a nurse practitioner (NP) for 20 years practicing in a variety of settings in Virginia and overseas. Completion of graduate education and national board certification deem that I am a competent clinician. As a small business owner in a solo NP practice, implementing the following requirements places a financial burden and hardship on the business as well as barriers to growing the practice and providing patient care.

Please keep this in mind as rules are being promulgated.

- The five-year equivalent requirement creates a **costly bottleneck to building provider workforce and equitable distribution** in primary care delivery for underserved and vulnerable populations. Unduly burdensome regulations on top of this requirement will result in additional bottlenecks compromising access to care.

- NPs already pay fees associated with RN, NP, and prescribing licenses and if they are **business owners, pay fees to collaborating physicians.** Any additional fees associated with submission of attestation and issuance of autonomous designation **should not create a financial barrier** for qualified NPs to practice.

- Acceptance of **"other evidence"** demonstrating that the applicant has met the requirements must be **broadly interpreted**. We ask that the Joint boards issue a **guidance document** listing examples of supporting evidence that they would take into consideration. **Office administrators, health system administrators, and credentialing documents should all be accepted as evidence** that an applicant has met the necessary requirements.

- The Boards **should credit applicants** by endorsement for all of their time employed and licensed **in other states** towards calculating their clinical experience requirement for practicing without a practice agreement.

- NPs in any state or working for **U.S. Armed Forces, U.S. Veterans Administration or the Public Health Service** should be able to submit evidence that the five-year full-time equivalent collaborative requirements have been met with signature from employer, physician, practice administrator, etc.

- There is **no demonstrated need for additional requirements on the attestation** in order to protect the public beyond what is listed in HB 793. The attestation should be used to **document clinical experience** under a sworn statement that this information is accurate and meets the requirements of the law.

- Most, if not all, states requiring attestation of transitional clinical hours are **not overly prescriptive** in what they require in their regulations or on their attestation forms. Therefore, in Virginia it should not be necessary to further define what is meant by "the patient care team physician routinely practiced with a patient population and in a practice area included within the category for which the nurse practitioner was certified and licensed."

- Both the NP and the patient care team physician should be held to disciplinary standards for providing falsified documentation to the Boards.

Thank you,

Nurse Practitioner Buky

5/4/18 9:44 am

Commenter: Kathleen Forst Putnam, PhD, WHNP-BC, CAPT, USNR- retired

HB 793

Thank you for the opportunity to provide public comment. I have been a nurse practitioner (NP) for 25+ years. I have worked in a variety of clinical settings over my career to include private practice, military facilities and free clinics. Additionally, I am a veteran, having served our nation as a Nurse Practitioner in the United States Navy Nurse Corps for 20 years. I am currently working in a private practice in Lynchburg.

In addition to my clinical experience, I have worked much of my career educating nurse practitioners. I was the program director of a women's health nurse practitioner program, and have taught nurse practitioner students at UVa.

Completion of graduate education and national board certification are evidence that I am a competent clinician. Nurse practitioners have demonstrated that we provide excellent patient care. I stressed to my students over the years that "we must know what we know, and know what we DON'T know" in order to provide safe care. Please keep in mind our dedication to safe patient care as rules are being promulgated.

Acceptance of "other evidence" demonstrating that the applicant has met the requirements must be broadly interpreted. We ask that the Joint boards issue a guidance document listing examples of supporting evidence that they would take into consideration. Office administrators, health system administrators, and credentialing documents should all be accepted as evidence that an applicant has met the necessary requirements.

The five-year equivalent requirement creates a costly bottleneck to building provider workforce and equitable distribution in primary care delivery for underserved and vulnerable populations. In Central Virginia where I currently practice, there are many patients who don't have access to health care for a variety of reasons. Unduly burdensome regulations on top of this requirement will result in additional bottlenecks compromising access to care.

Over my career as a nurse practitioner, I have been witness to our expanding responsibilities. We were given prescriptive authority many years ago when I began to practice. I believe that HB 793 with its 'nurse practitioner friendly' regulations will only help us to provide health care to those who need it. We celebrate the passage of HB 793.

5/4/18 10:26 am

Commenter: Jennifer Shakesby McAdoo

Adoption of regulations for HB793

Boards of Medicine and Nursing,

I concur with my colleagues in respectfully requesting that the Joint Boards consider that the General Assembly overwhelmingly approved the fundamental concepts of nurse practitioner (NP) transition to practice with

the five-year post-licensure compromise. Any interpretations that conflict with these fundamental concepts should be abstained from as they would be in opposition to the spirit of the legislation and bipartisan will of the General Assembly.

The NP community acknowledges that the five-year post-licensure transition to practice requirement resulted from political compromise and not evidence based facts. Therefore, it is requested that the Joint Boards bear in mind that NPs have unique skills and expertise that are complimentary to the physician and other team members on the patient care team. It is not reasonable to expect that the physician's area of practice and the NPs licensure and certification would be identical. NPs work in many settings with MDs, DOs and DPMs, thus a broad interpretation of basic internal medicine education of any specialist physician must be considered sufficient to meet the requirement for practice in a patient population and practice area that the NP is licensed and certified.

The board should also acknowledge the portability of professionals and that an NP may have had several collaborating physicians during the required 5-year transition period. As a result, the attestation form must accommodate the names of several physicians and/or other evidence from entities such as practice administrators, employers, or credentialing documents, etc. based on individual circumstances. It has been suggested and I fully support that the boards consider formatting the attestation as a check list for physicians to check the requirements specified in the law.

For example:

- physician has served with the NP pursuant on a practice agreement
- physician routinely practiced with a patient population and practice area for which the NP is certified and licensed
- physician practiced with NP from ____________date to ___________date

It is also suggested that the boards consider that NPs in any state or working for U.S. Armed Forces, U.S. Veterans Administration or the Public Health Service be able to submit evidence of the five-year equivalent post-licensure practice requirement with signature from an employer, a physician, a practice administrator, etc. when coming from another state to practice in Virginia. This will prevent obstacles to building the necessary provider workforce and equitable distribution in primary care delivery for underserved and vulnerable populations.

Thank you for considering my comments for the implementation of HB793.

Sincerely,

Jennifer S. McAdoo, MSN, RN

5/4/18 10:36 am

Commenter: Brittany K HInes

Recommendations for implementation of HB793

Thank you for providing the opportunity to offer suggestions for implementation of HP 793. For the requirement of attestation of practice. I would suggest the Nurse Practitioner is the only person required to sign for the attestation to practice. This would require a one time fee for the designation. After the one time fee the standard license renewal will be sufficient. A 10% review of applications are randomly chosen to verify the five years of full time clinical experience.

As for documents to verify 5 years of full time clinical practice. Written verification by a provider of employment, physician or Nurse Practitioner who has full practice authority including those practicing in an independent practice state/already met independent practice in the state of Virginia or a employers human resources department can be signed stating the amount of clinical experience specifically in hours. I would suggest a fillable form be available for standardization that can be found of the board website. This verification can cover

any amount of time. For salaried Nurse practitioners a contract with pay stubs can also be used to verify clinical experience. For Nurse practitioners that are hourly a contract with pay stubs showing number of hours practiced used. When using a contract and paystubs no signature is required by the physician, employer or practice representative. When using a contract and pay stubs a fillable form should be provided to allow Nurse Practitioners to calculate the exact hours of clinical experience and for standardization. For Nurse Practitioners moving from an independent practice state that were in solo practice the license from the Independent state must be valid for 5 years with no additional requirements. Nurse Practitioners applying by attestation should have these documents prepared to present at the request of the board.

The equivalence of five years could be simply calculated as 5years x 52 weeks x 40hours = 10,400 hours. This however does not take into account any paid time off that is used and could result in actuality a longer period of practice before a Nurse Practitioner is able to apply. If a Nurse Practitioner took only 2 weeks of vacation per year this totals a loss of 400hrs of clinical experience and an additional 10 weeks of supervised practice. 2 weeks is likely a underestiment of lost time. I request the board take into consideration Continuing education credits to also be applied to the clinical experience requirement. Continuing education credits provide ongoing learning and if often considered a part of the clinical experience. While in Nurse Practitioner school students gain valuable clinical experience. This student clinical experience and continuing education should also be valid to count as supervised hours and off set any lost clinical hours due to normal employment.

The way to determine hours should be very clear so Nurse Practitioners can accurately count hours prior to attestation to prevent accidental application. If a Nurse Practitioner is audited and found to not have sufficient hours, it should be brought to the board to determine accidental vs intentional falsification. If possible, I would suggest the option for a voluntary review prior to application with an additional charge separate from the attestation fee.

While ensuring public safety that Nurse Practitioners have fulfilled the 5 years of full time clinical experience. I ask when you are making decisions to put yourselves in the shoes of a applicants from different situations Nurse Practitioners moving to Virginia, experienced providers and new grads.

Thank you for the opportunity again.

Brittany K Hines,

5/4/18 11:11 am

Commenter: Seeba george RN,MSN FNP-C

H793 regulations

Nurse practitioners are graduated with masters in nursing with a specialization and are certified by the state boards to be able to practice as providers. Instead of having the nurse practitioners have proper residency training like the medical doctors do; it is not fair for NPs to depend on 5 year experience attestation by a physician. Rather the new graduate nurse practitioners could be required to finish a year of residency if needed to make them feel at ease to practice. Although NPs have collaborating and supervising physicians, they work under their own license. If an NP finds any limitations with patient medical management, he or she has an option to refer the patient to another provider. I see any professional NP or a doctor would naturally collaborate with their counterparts if a question arises.

I believe NPs are committed, dedicated and reliable professionals who understand quality care and best of all are cheaper compared to the doctors. Patient satisfaction rates have been much higher because of the caring and teaching model included in practice by the nurse practitioners beyond the business and medical management. I believe that the competent NPs have become a threat to the medical doctors who have a

narrow prospective. On the other hand, NPs bring easy and quality healthcare to the table with a teaching and caring model added to the medical practice. It is totally unfair for NPs to wait a period of five years to get to an independent practice model. I believe one year is sufficient for a Nurse practitioner to feel competent in her practice.

Therefore, I hope and pray that the board of directors make an informed decision and allow the NPs to work under the full capacity of their license.

Thanks,

Seeba George

5/4/18 12:46 pm

Commenter: Angela M. Allen

HB 793

Thank you for the opportunity to provide public comment. I have been a nurse practitioner (NP) for 3 years practicing in family care and mental health care settings in the cities of Norfolk and Virginia Beach, state of Virginia. Completion of graduate education and national board certification deem that I am a competent clinician. Please keep this in mind as rules are being promulgated.

Respectfully,

Angela M. Allen, FNP-BC

5/4/18 3:08 pm

Commenter: Valerie Wrobel, MSN, RN, AGNP-BC President, VCNP Northern Region

Keep the intent of HB 793 transition to practice as streamline as possible

As the President of the Virginia Council Of Nurse Practitioners, Northern Virginia Region, I represent over 300 member NPs. We are excited to now have an opportunity in Virginia to transition to practice for which we have been trained and certified. Here are some concepts to consider as you enact regulations to implement the bill.

- NPs have unique skills and expertise which are often complimentary to the physician and other team members and are not expected to be an exact overlay of the physician's area of practice.
-
- NPs are prepared at the graduate level and are deemed competent clinicians upon graduation and passage of national certification. There is no evidence to support the need for additional post-licensure supervision of NPs' practice beyond current educational and certification standards.
- The five-year post-licensure "transition to practice" requirement is the result of political compromise with no evidence to support the regulatory mandate. This has created variability from state to state, making Virginia an outlier with the most arduous practice environment in the nation for NPs.
- The five-year requirement creates a costly bottleneck to building provider workforce and equitable distribution in primary care delivery for underserved and vulnerable populations. Unduly burdensome regulations on top of this requirement will result in additional bottlenecks compromising access to care.
-

- The General Assembly overwhelmingly approved the central concept of transition to practice with the five year compromise. The Joint Boards should approach the regulatory process bearing this in mind and obstacles limiting those central concepts should be kept to a bare minimum as they are against the thrust of the legislation. Any overly strict interpretations suggested by those opposing the legislation would not be consistent with the spirit of the legislation and bipartisan will of General Assembly.

- Many NPs may have multiple team physicians during the transition period and there needs to be several signature lines for the physician. Each could specify the full time equivalent period of supervision if sequential collaborative MDs exist.

- Request that the attestation form be a simple as simple as possible, perhaps with check boxes re the requirements listed in the statute. For example:

[ ] Patient care team physician has served with the NP pursuant on a practice agreement

[ ] Patient care team physician routinely practiced with a patient population and practice area for which the NP is certified and licensed

- Request that office administrators, human resources department, health system administrators, credentialing documents, etc., may be used as other evidence.
-
- Request that an NP in any state or working for U.S. Armed Forces, U.S. Veterans Administration or the Public Health Service submit evidence that the five-year full-time equivalent collaborative requirements have been met with signature from employer, physician, practice administrator, etc.

Respectfully submitted,

Valerie Wrobel, MSN, RN, AGNP-BC

President, Virginia Council of Nurse Practitioners, Northern Virginia Region.

5/4/18 3:13 pm

Commenter: Carole Everhart, DNP

Promulgation of Regulations for HB793

Thank you for the opportunity to provide public comment. I have been a nurse practitioner (NP) for 30 years practicing in a primary health care setting in Carroll County. Completion of graduate education and national board certification deem that I am a competent clinician. Please keep this in mind as rules are being promulgated.

- The five-year equivalent requirement creates a **costly bottleneck to building provider workforce and equitable distribution** in primary care delivery for underserved and vulnerable populations. Unduly burdensome regulations on top of this requirement will result in additional bottlenecks compromising

access to care by not allowing NP practices to grow and serve citizens of the Commonwealth in areas where physician services are scarce.

- NPs already pay fees associated with RN, NP, and prescribing licenses. Any additional fees associated with submission of attestation and issuance of autonomous designation **should not create a financial barrier** for qualified NPs to practice.
- Acceptance of **"other evidence"** demonstrating that the applicant has met the requirements must be **broadly interpreted**. The Joint boards should issue a **guidance document** listing examples of supporting evidence that they would take into consideration. **Office administrators, health system administrators, and credentialing documents should all be accepted as evidence** that an applicant has met the necessary requirements.
- The Boards **should credit applicants** by endorsement for all of their time employed and licensed **in other states** towards calculating their clinical experience requirement for practicing without a practice agreement.
- NPs in any state or working for **U.S. Armed Forces, U.S. Veterans Administration or the Public Health Service** should be able to submit evidence that the five-year full-time equivalent collaborative requirements have been met with signature from employer, physician, practice administrator, etc.
- There is **no demonstrated need for additional requirements on the attestation** in order to protect the public beyond what is listed in HB 793. The attestation should be used to **document clinical experience** under a sworn statement that this information is accurate and meets the requirements of the law.
- Most, if not all, states requiring attestation of transitional clinical hours are **not overly prescriptive** in what they require in their regulations or on their attestation forms. Therefore, in Virginia it should not be necessary to further define what is meant by "the patient care team physician routinely practiced with a patient population and in a practice area included within the category for which the nurse practitioner was certified and licensed."
- Both the NP and the patient care team physician should be held to disciplinary standards for providing falsified documentation to the Boards.

5/4/18 8:42 pm

Commenter: Kathleen Tauer

HB793

Thank you for the opportunity to provide public comment. I have been a nurse practitioner for 43 years in Connecticut, New York and Virginia. I have completed graduate and national board certification which deemed me competent to practice. Please keep this in mind as you promulgate rules.

5/4/18 9:38 pm

Commenter: William Sachau, NP-C, Dept. of Veterans Affairs Medical Center

Responses to Proposed Regulations for HB 793

Thank you for the opportunity to provide public comment. I have been a nurse practitioner (NP) for 5 years practicing in hospital settings, most recently in the City of Richmond. Completion of graduate level education and national board certification deems that I am a competent clinician. In addition, most nurse practitioners have several years of clinical experience at the RN level before entry into practice

as a nurse practitioner. I currently hold licenses in other nearby jurisdictions that recognize independent practice authority. Please keep these points in mind as rules are being promulgated.

- The five-year equivalent requirement creates a **costly bottleneck to building provider workforce and equitable distribution** in primary care delivery for underserved and vulnerable populations. Unduly burdensome regulations on top of this requirement will result in additional bottlenecks compromising access to care.

- NPs already pay fees associated with RN, NP, and prescribing licenses. Any additional fees associated with submission of attestation and issuance of autonomous designation **should not create a financial barrier** for qualified NPs to practice.

- Acceptance of **"other evidence"** demonstrating that the applicant has met the requirements must be **broadly interpreted**. We ask that the Joint boards issue a **guidance document** listing examples of supporting evidence that they would take into consideration. **Office administrators, health system administrators, and credentialing documents should all be accepted as evidence** that an applicant has met the necessary requirements.

- The Boards **should credit applicants** by endorsement for all of their time employed and licensed **in other states** towards calculating their clinical experience requirement for practicing without a practice agreement.

- NPs in any state or working for **U.S. Armed Forces, U.S. Veterans Administration or the Public Health Service** should be able to submit evidence that the five-year full-time equivalent collaborative requirements have been met with signature from employer, physician, practice administrator, etc.

- There is **no demonstrated need for additional requirements on the attestation** in order to protect the public beyond what is listed in HB 793. The attestation should be used to **document clinical experience** under a sworn statement that this information is accurate and meets the requirements of the law.

- Most, if not all, states requiring attestation of transitional clinical hours are **not overly prescriptive** in what they require in their regulations or on their attestation forms. Therefore, in Virginia, it should not be

necessary to further define what is meant by "the patient care team physician routinely practiced with a patient population and in a practice area included within the category for which the nurse practitioner was certified and licensed."

- Both the NP and the patient care team physician should be held to disciplinary standards for providing falsified documentation to the Boards.

Thank you again for the opportunity to provide comments on these important regulations which affect access to health care for many Virginians.

Townhall Comments on Board of Medicine Website

Commenter: Valerie Wrobel, President VCNP, Northern Virginia Region

Keep the intent of HB 793 transition to practice as streamline as possible.

- NPs are prepared at the graduate level and are deemed competent clinicians upon graduation and passage of national certification. There is no evidence to support the need for additional post-licensure supervision of NPs' practice beyond current educational and certification standards.

- The five-year post-licensure "transition to practice" requirement is the result of political compromise with no evidence to support the regulatory mandate. This has created variability from state to state, making Virginia an outlier with the most arduous practice environment in the nation for NPs.

- The five-year requirement creates a costly bottleneck to building provider workforce and equitable distribution in primary care delivery for underserved and vulnerable populations. Unduly burdensome regulations on top of this requirement will result in additional bottlenecks compromising access to care.

- Many NPs may have multiple team physicians during the transition period and there needs to be several signature lines for the physician. Each could specify the full time equivant period of supervision if sequential collaborative MDs exist.

- Request that the attestation form be a simple check box of the requirements listed in the statute. For example:

[ ] Patient care team physician has served with the NP pursuant on a practice

agreement

[ ] Patient care team physician routinely practiced with a patient population and

practice area for which the NP is certified and licensed

- Request that office administrators, human resources department, health system administrators, credentialing documents, etc., may be used as other evidence.
- Request that an NP in any state or working for U.S. Armed Forces, U.S. Veterans Administration or the Public Health Service submit evidence that the five-year full-time equivalent collaborative requirements have been met with signature from employer, physician, practice administrator, etc.

5/2/18 4:31 pm

Commenter: Carol Craig, University of Virginia Health System

Promulgation of Regulations to Implement HB793

(While I am the named commenter, I am submitting this comment on behalf of the University of Virginia Health System.)

Townhall Comments on Board of Medicine Website

The University of Virginia Health System thanks you for the opportunity to comment on the promulgation of regulations to implement HB 793. The University of Virginia Health System employs and teaches many people who hold divergent opinions concerning the implementation of HB 793. Taking into account these different perspectives, we have identified the following issues of importance that we ask be considered when developing regulations for HB 793.

Equivalent of at least five years of full-time clinical experience:

- Consider implementing a system for the initial licensing of independent Nurse Practitioners (NPs) that is similar to the ACGME competencies review, including an evaluation of the NP's skills each year.This will help ensure there is an accounting for all five years of clinical experience, and it will enable timely remediation of any weak areas It is recognized that this could work for new NPs, but existing NPs with greater than five years' experience should be allowed to provide other evidence of meeting the five year clinical experience requirement

- On the other hand, consider whether such a system would create more barriers in the regulations than already exist in the statutory requirements and would thwart the intent of HB 793 to allow NPs to practice to their full scope and to meet the needs of patients.

Routine practice in a practice area included within the category for which the NP was certified and licensed:

- The approved legislation requires five years of collaborative practice in a specific practice area and patient population.Consider clarifying how practice area and patient population will be defined and clarify how a NP could move between populations and practice types, and what additional supervision/documentation would be required. For example, how would an NP transition from outpatient cardiology to inpatient CCU or floorcare? Or from outpatient cardiology to dermatology or vice versa?

- Consider adopting the APRN Consensus Model which is the regulatory model that guides these types of situations. This was developed in 2008 and endorsed by over 40 nursing organizations. This Model and later statements make it clear that an APRN's practice is not setting-specific but population-specific.For example, an Acute Care NP can manage heart failure patients with acute needs in any setting—from ICU to clinic to community.

- It will be important for hiring entities and credentials committees to know the specific patient population and practice area for which the NP qualified for independent practice.To this end, consider making this information readily available to hiring entities and credentials committees.The most straightforward way to accomplish this would be to specify the patient population and practice area on the BOM/BON issued license.As an alternative, the BOM/BON could develop a system to share this information with hiring entities and credentials committees by secure electronic means.

Requirements of an attestation of practice:

- The attestation could be a check-box type document that the collaborating physician could complete and sign.

- Indicate the FTE of the experience (1 FTE for fulltime, 0.8 FTE for 32 hours per week/part time, etc.)

- Consider including on the attestation form check-boxes specific to the patient populations and practice area that the NP has practiced in, and also check-boxes that cover the specific competencies the person has mastered in the practice area.

Townhall Comments on Board of Medicine Website

- Consider whether checking off a long list of NP competencies on the attestation form is too burdensome and creates unnecessary barriers for the NP.

Acceptance of "other evidence" demonstrating that the applicant met the requirements:

- There will be cases where the collaborating physician or physicians who worked with the NP during the required five years are unable or unwilling to sign off on approval of independent practice for that NP.In these cases, the NP may submit other evidence demonstrating that he or she has met the requirements.Consider developing a formal panel and procedures for evaluating such evidence that includes representatives from both the BON and BOM.The procedures should include actively seeking input from the NP's collaborating physicians during the time period in question.

- Consider taking proactive action to prevent the above situation from occurring by adding a requirement to NP practice agreements requiring annual reviews as part of the five year clinical experience process. The collaborating physician should be required to discuss the review with the NP, and provide a copy. This could help with documentation and remediation issues, and could allow the NP to leave the practice if the collaborating physician failed to complete the review.On the other hand, consider whether such a requirement would set up the NP for failure if the collaborating physician failed to perform the annual evaluations; leaving the practice may not be a solution if the NP cannot locate a new collaborating physician.

Endorsement of experience in other states:

- We suggest that the BON/BOM follow a similar process as is required now for NPs, i.e., the NP provides primary validation from the school where the individual obtained the NP degree, evidence of NP licensure that is in good standing from another state, evidence of professional certification issued by an agency accepted by the BON/BOM, and fingerprinting.

- To meet Virginia's five year clinical practice requirement, consider requiring the NP to meet the same attestation requirement that in-state applicants must provide, including allowing the out-of-state applicant the same opportunity to provide other evidence, if necessary, to demonstrate meeting the five year clinical practice requirement.

- Consider allowing the out-of-state applicant who has less than five years clinical experience to receive credit for their prior years of experience rather than requiring them to practice a full five years in Virginia before becoming eligible to practice independently.

- Consider the case of a NP that has practiced in a state that has a supervisory NP law rather than a collaborative NP law—how would that impact endorsement?

Fee associated with submission of attestation and issuance of autonomous designation:

- We suggest that the BON/BOM impose a reasonable fee, perhaps similar to the renewal fee and the frequency of renewal fees imposed on physicians by the BOM.

Unprofessional conduct – falsification of attestation:

- We suggest that the BON/BOM apply the same rules that already exist for physicians and nurses concerning unprofessional conduct.

Thank you for your consideration of these issues.

Townhall Comments on Board of Medicine Website

5/2/18 4:51 pm

Commenter: Linda Thurby-Hay DNP, RN, ANCS-BC

Clear Lines Accountability

As an advanced practice nurse (APN), I am highly concerned about the message this legislation sends to the public about the legitimacy and competency of all APN roles, not just nurse practitioners (NP). The medical community, with whom I have respectfully worked alongside for forty years, continues to demand all oversight of healthcare delivery. This mindset reflects the ongoing belief of our physician colleagues that medical practice encompasses the whole of healthcare, and pharmacists, physical therapists, dieticians and professional nurses (and other healthcare providers) require direction by physicians in order that patients receive appropriate care. The evidence does not substantiate this.

Healthcare is increasingly complex with no one discipline capable of "knowing" what each discipline has taken years of education and clinical experience to learn and henceforth, apply in the care of patients. There is mounting appreciation that interprofessional teamwork and patient-centered care are the most important components of our future healthcare system particularly for patients with multiple chronic conditions. The current effort to develop regulations needs to be undertaken in the spirit called for by multiple national bodies, i.e. the IOM's "*The Future of Nursing*" Report, the Institute of Healthcare Improvement, the Joint Commission and numerous others. Let healthcare professionals provide the care they were educationally prepared to deliver. The time is now for true leadership in the commonwealth of Virginia in guiding the redesign of our healthcare system so patients receive the care they deserve.

I would challenge the Joint Boards to participate in these discussions in a manner that eliminates barriers to all advanced nursing practice, and in this case, permits NPs the autonomy to deliver primary care as they were educationally prepared. NPs, like all APNs, are deemed competent to provide nursing care through educational preparation, national licensing examinations and certifications. I would specifically request that clear lines of accountability be established in these regulations for our physician colleagues. There is significant risk for license censure when APN practice is tied to physician practice. APNs have been wrongly held accountable for unprofessional physician conduct (i.e. dereliction of duty, etc.) while the involved physician(s) were not concomitantly reprimanded by the Board of Medicine. This constitutes regulatory bullying, wherein the professional competence and reputation of APNs is damaged while the physician remains unscathed. Finally, the regulations should distinguish this type of workplace violence so that the instigators and facilitators of regulatory bullying may be held accountable. Let the regulations reflect a just practice environment.

5/4/18 3:11 pm

Commenter: Medical Society of Virginia

Medical Society of Virginia Comments on HB793 - 1/2

The Medical Society of Virginia (MSV) serves as the voice for more than 30,000 physicians, residents, medical students, physician assistants and physician assistant students, representing all medical specialties in all regions of the Commonwealth. These clinicians deliver health care each day to the millions of residents of the Commonwealth. The MSV appreciates the opportunity to provide comment on House Bill 793.

House Bill 793 will allow nurse practitioners the ability to transition to practice without maintaining a practice agreement with a patient care team physician. Our members work with their nurse practitioner colleagues each day and believe they are valuable members of the patient care team. The MSV believes the regulations must ensure all practitioners are prepared to deliver care that meets Virginia's standard of care requirements. Patients deserve to be assured that every health care provider that practices autonomously has the requisite experience to provide safe and high quality care. With the wide variation in nurse practitioner programs, the regulations must require that a nurse practitioner who seeks to practice autonomously is appropriately prepared and can meet the necessary core competencies. Thus, MSV surveyed physicians and physician assistants across practice settings, practice size, and specialties for feedback.

Townhall Comments on Board of Medicine Website

Physicians and other clinicians provided feedback on the following issues:

- Strongly support matching identical or similar physician specialty to a nurse practitioner specialty;
- Identifying the core competencies, educational requirements, and clinical experience needed for nurse practitioners through the attestation process;
- Statutory requirement on physician relationship for emergencies or referrals; and
- Physician liability for attestation.

Similar specialties and patient care population

First, it is important to note lines 341-344 of the law provide that a nurse practitioner seeking to practice without an agreement must have worked with "*a patient care team physician who routinely practiced with a patient population and in a practice area included within the category for which the nurse practitioner was certified and licensed.*" The medical community believes it is of the utmost importance that the regulatory standards ensure that the physician-nurse practitioner training must require alignment either between similar patient population and/or the national certification category for each practitioner. The MSV has developed a crosswalk for consideration as a basic framework. For those nurse practitioners without a nationally certified specialty, the Joint Boards must create a strong process to consider their educational and practical experience.

Physician	**Nurse Practitioner**
Family Physician	Family Nurse Practitioner
Pediatrician or Family Physician (treating children)	Pediatric Nurse Practitioner
Internal Medicine	Adult Nurse Practitioner or Geriatric Nurse Practitioner
Psychiatrist or Internal Medicine (providing mental health services)	Psychiatric Nurse Practitioner

We also have concerns that any one physician will be able to provide the requisite training. In the current process of practice agreements, the nurse practitioner practices in a given clinical location where many resources are available and new situations can be immediately addressed by a practicing physician.

Core Competencies

Physicians are prepared to practice autonomously after four years of medical school, five to seven years of a specialized residency program, and standardized national testing that ensures their ability to safely care for patients. Only after rigorous training, testing, and supervision by expert clinical faculty, are physicians permitted to practice independently. Medical school was revolutionized after the Flexner Report[i] in 1910 which found that medical schools as a for-profit enterprise did not yield positive results. Under this model, physicians' level of practice was variable at best, and incompetent and harmful at its worst. This is relevant as we consider the impact of various education models on patient care. The medical community is very concerned about achieving and maintaining a sufficient standard for core competencies for all practitioners who practice autonomously.

Understanding these core competencies such as differential diagnosis, clinical pharmacology, identifying and managing multiple co-morbidities and referral protocol are vital in practicing independently. Further suggestions are attached in Appendix A for your consideration. The medical community requests that you develop a robust standard that defines competencies that should be met and are equivalent of at least five years of full-time clinical experience. It is important that such a knowledge base be determined by the Joint Boards of Medicine and Nursing in order to provide full confidence in public safety. Annual review of hours and monitoring of a nurse practitioner as they move through the attestation process would ensure that their training has met these high standards. This knowledge base and a plan for transition to practice should be specified at the onset of the transition to practice period of training.

To ensure the required clinical experience meets the aforementioned standards, a nurse practitioner at the start of the five year period, should submit to the Joint Boards of Nursing and Medicine a plan that outlines how they will meet the education and training requirements as established in the final regulations.

Emergency Referrals and Liability

Under the current system of care, the patient care team physician and nurse practitioner have an established partnership to address complex cases or emergencies. As individual nurse practitioners transition on their own, they will be required to "establish a plan for referral of complex medical cases and emergencies to physicians or other appropriate health care providers." The MSV strongly supports patients having access to the most appropriate health care provider, especially for complex or emergency issues; there is concern about how this will be accomplished. Physicians are concerned about the management of this relationship. Will they unknowingly be designated as part of a nurse practitioner's plan? Who would be accountable for the care of the patient? Do these physicians have to be readily available at all times? Is the physician able to review the patient panel and records regularly? These questions all lead to concerns of patients' well-being.

Physicians are also concerned about the potential for liability. As illustrated in the questions above, what legal responsibility are they incurring as a result of being unofficially associated with a nurse practitioner? Further, there are concerns about their potential liability regarding attestation. The attestation must be carefully constructed so that physicians are attesting only to the completion of the required time while being of the same specialty and/or treating the same population; it is the responsibility of the Joint Boards to ensure competency for nurse practitioners. Currently, Virginia statute provides that a physician is not liable solely for being a patient care team physician; the regulations need to extend this same liability protection to physicians for signing off on attestation.

The Medical Society of Virginia appreciates the opportunity to provide comments on this important issue. Should you have questions or need additional information, please do not hesitate to reach out to Ralston King (rking@msv.org).

Sincerely,

Kurtis S. Elward, M.D., M.P.H., FAAFP

President

Medical Society of Virginia

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[i] Cooke, M., Irby, D., Sullivan, W., Ludmerer, K. (2006) American Medical Education 100 Years After the Flexner Report. *New England Journal of Medicine, 355:1339-1344.* Retrieved from https://www.nejm.org/doi/full/10.1056/NEJMra055445

5/4/18 3:12 pm

Commenter: Medical Society of Virginia

Medical Society of Virginia Comments on HB793 Appendix A - 2/2

Medical Society of Virginia Public Comments

Appendix A – Suggested Core Competencies

These are comments from a wide array of physicians who have worked with nurse practitioners and who wished to convey their experience in what skill set affords the ability to provide appropriate patient care.

- Good fund of knowledge, sufficient clinical experience via residency and fellowships, excellent physical exam skills, pharmacology knowledge, managing patients with co-morbidities.

Townhall Comments on Board of Medicine Website

- Differential diagnosis and to be steeped particularly in Internal Medicine which would be helpful as a basic start in any subspecialty.

- In addition to anatomy, pathology, pharmacology, history/physical examination, differential diagnosis, and management of the complex patient, a clinical experience pathway that provides opportunity to distinguish conditions that may rapidly become critical from those conditions that are unlikely to become critical.

- Core knowledge in specialty, knowledge of pharmacotherapy in said specialty, ability to generate a reasonable differential diagnosis and plan of action, the ability to manage several different issues simultaneously, and the ability to know when to refer and who to refer to.

- Experience with diverse patient populations. Background in internal medicine, so a practitioner can make an adequate evaluation and judgment of a condition of a patient.

- Having a broad scope of medicine to handle pharmacology, differential diagnosis, co-morbidities, and how multiple fields of medicine overlap, proper work up, referrals and what their limits are.

- Ability to take comprehensive history and generate differential diagnosis. Understand medication and medication interactions. Also in children understand weight based dosing. Understand community resources and refer appropriately.

- Differential diagnosis referral protocol medical knowledge, including current evidence based medicine. This also will include managing complex patients and their co-morbidities with multiple medications

- The ability to critically think in the areas of history taking, physical examination, diagnostic study and imaging interpretation, pharmacology, differential dx, and having understanding of the patient population and health system/setting that you work in.

- Diagnostic acumen, clinical exam specialty skills, differential diagnosis, managing medications, interpreting lab and radiographic testing, referral sources.

- Diagnostic capabilities with both visual and pathological correlation, ability to prescribe and manage medications in an aging population, appropriate work up and treatment algorithm for both common and rare dermatological conditions.

- Understanding of normal physiology. Understanding pathophysiology of disease states. An ability to compile a comprehensive differential diagnosis list and narrow down this list in an efficient manner. The ability to balance the care of complex patients with a number of comorbid conditions.

- Competent history taking and physical exam. Differential diagnosis, know when to refer and/or ask for consultation.

- Practice-based Learning and Improvement: Show an ability to investigate and evaluate patient care practices, appraise and assimilate scientific evidence, and improve the practice of medicine.

Townhall Comments on Board of Medicine Website

- Patient Care and Procedural Skills: Provide care that is compassionate, appropriate, and effective treatment for health problems and to promote health.

- Systems-based Practice Demonstrate awareness of and responsibility to the larger context and systems of health care. Be able to call on system resources to provide optimal care (e.g. coordinating care across sites or serving as the primary case manager when care involves multiple specialties, professions or sites).

- Medical Knowledge: Demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and their application in patient care.

- Interpersonal and Communication Skills Demonstrate skills that result in effective information exchange and teaming with patients, their families and professional associates (e.g. fostering a therapeutic relationship that is ethically sound, uses effective listening skills with non-verbal and verbal communication; working as both a team member and at times as a leader) Professionalism: Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to diverse patient populations.

- To be able to practice independently, one must be able to recognize both uncommon as well as common presentations of illness and disease. Must be aware of latest recommendations. Must be able to recognize when course of illness or treatment is not as expected and have knowledgeable base to intervene appropriately

- Pharmacology, differential diagnosis, diagnostic ordering, referral protocol, dual diagnosis co-management

- Emergency management. Safety/adverse effects management, risk assessment (in our field suicide, violence, relapse, etc. prognosis/outcome and disability assessment and opinion, referral for hospice palliative care (example, terminal dementia patients), assessment of testing needs - in our field for EEG, MRI, Psychometry, etc.

- Specialty specific exam, differential diagnosis, proper imaging and lab orders, prescription management, influence of co-morbidities on active problems, proper follow-up.

- Understanding normal physiology and pathophysiology. Being able to create a broad differential diagnosis. Understanding pharmacology and which medications to prescribe. Also to know which medications to prescribe when patients have various organ failures.

- Differential diagnosis Evaluation and management of disease processes. Ability to discuss goals of care with patients and families Ability to know when one does not know - know when to ask for help (appropriate consultation).

- Differential diagnosis, surgical skills, managing immunosuppressive medications and immunosuppressive patients.

Townhall Comments on Board of Medicine Website

- Differential diagnosis, multiple procedures such as intubation, lumbar punctures, central lines, thoracostomy, cricothyroidoyomy, ultrasound, control of nosebleeds, etc., pharmacology, triaging, handling multiple complex patients simultaneously, knowing when to admit vs outpatient treatment, know when need emergent referral vs urgent or outpatient referral.

- Solid knowledge of medication interactions, side effects, pharmacokinetics. Ability to think outside of the box. Experience with disease process. Differential diagnosis and appropriate workup.

- Pharmacology, differential diagnosis, experience with rotations in various core fields (pulmonary, GI, cardiac, endocrine, rheum, ID etc.). In hospital experience is also a necessary requirement.

- Understanding the interplay between disease states and the various treatment options available.
- The ability to take a thorough history with the answers leading to more in depth questions, do a complete physical, and be able to assimilate the information into a diagnosis or differential. Then the ability to do a cost effective workup to confirm or narrow down the diagnosis.

- Ability to develop a robust differential diagnosis, recognizing when patients have problems/require treatment outside one's skill set, ability to critically evaluate evolving medical science and safely incorporate relevant portions into practice, managing patients with comorbidities, mastery of standards of care, stability within a single lane of practice.

- Ability to develop a robust Differential diagnosis, recognizing when patients have problems/require treatment outside one's skill set, ability to critically evaluate evolving medical science and safely incorporate relevant portions into practice, managing patients with comorbidities, mastery of standards of care, stability within a single lane of practice, perspective supervision on testing, such as stress testing.

- Risk stratification, EKG interpretation, recognizes tissue quality that is not normal. Assemble differential diagnoses. Develop treatment; plan to work through the differential. Utilize technology to manage the process of treating patients.

- Working knowledge of medication efficacy, adverse effects, and therapeutic range. Adequate differential diagnosis, for each problem. Knowledge of illnesses with significant co-morbidities.

- History taking, physical examination, differential diagnosis, appropriate ordering of diagnostic tests, pharmacology, and referral protocol.

- Profound knowledge of medication side effects and potential unknown interactions, based on pharmacodynamics of the medication. Ability to formulate a differential diagnosis in a non-linear fashion.

- Prioritizing care for sicker patients as well as the most life threatening aspects of each patient's condition and taking ownership of the care without unnecessary referrals to multiple other specialists when cases get more challenging Ability to formulate/initiate treatment plans for all the patients who are normally covered within a particular specialty, not only the top 10 diagnosis.

Townhall Comments on Board of Medicine Website

- Full education with complete anatomy and physiology course work, full complement of clinical pharmacology course work, full understanding and competence of managing patients with multiple co-morbidities, evidence of health outcomes that are within the national averages and not below, an established referring access to specialties, backup for caseloads that require additional clinical expertise.

- Understanding of physiology, Understanding of organ systems, tools needed for efficient evaluation of problems. 1. Obtaining a focused, thorough history 2. Understanding of risk factors for various comorbidities 3. Physical exam appropriate for complaint- with the knowledge of what is normal and what you are looking for in each step 4. Understand the underlying pathophysiology of disease so as to link various history and physical exam findings 5. Thorough knowledge of evidence based medicine 6. Ability to develop a reasonable differential diagnosis with the reasoning for and against each differential 7. Understand the risks and benefits of serious work ups, with the knowledge of how to respond to abnormal results of said workups 8. Understand the various treatment modalities, with their risks and benefits. Knowledge of disease, differential diagnosis, treatment options / algorithms, potential side effects, associations with internal disease, diagnostic testing, procedures (biopsies, injections, excisions), managing complex patients, drug interactions.

- Able to take a full history and do a thorough PE including a rectal, filament testing for diabetics, neurologic testing. Fully evaluate lab, x-ray, pathology and the tests. Read EKGs formulate disease hypotheses, know when to follow and when to refer. Discuss diseases with patients and family. Follow-up and be available.

- Understanding of pharmacology, drug interactions, physiology of body systems and pharmacodynamics. 2. Understanding of basic disease processes, complications, prevention and treatment. 3. Recognition of emergency scenarios and ability to manage emergency scenarios to basic lifesaving techniques and triage. 4. Adequacy to ensure follow up of abnormalities and test data etc. 5 Understanding of aseptic technique, sterilization, and disease control, both for procedures and for communicable diseases. 6. Ability to properly hand off and refer problems out of knowledge base or scope of ability, e.g. no dumping or putting referral into patients responsibility when it should be the practitioner's responsibility.

- Understanding of pathophysiology, pharmacology, indications for surgical referrals as well as managing psychiatric and developmental comorbidities Interpretation of medical imaging and neurophysiology results, referral pattern and facilitation of consultations.

- Strong knowledge base, ability to recognize limitations, extensive knowledge of pharmacology, ability to refer to MD quickly, managing multiple health problems with the understanding of why we do things - for ex, not just giving diuretic for swollen legs but recognizing that this maneuver might be life threatening if heart failure symptoms are due to pericardial effusion.

- Differential diagnosis Management of chronic conditions Understanding of management of complications of pregnancy/postpartum care Understanding of when to refer/transfer care

- Pharmacology Procedural skills (IUDs, biopsies, etc.). Adherence to current best clinical practice guidelines.

Townhall Comments on Board of Medicine Website

- A working knowledge of a broad range of medical conditions and interactions as well as the ability to recognize situations or conditions that may be rare, but if unrecognized or not addressed, can lead to significant morbidity or mortality. The ability to formulate a differential diagnosis that is appropriately focused (so as not to promote a shotgun approach to the workup) while recognizing the existence of less likely but critically important conditions/situations. The ability to demonstrate a clear understanding of the limitations of one's training and the need to refer patients to specially trained providers when it is in the patient's best interest WITHOUT needing to rely solely on specialists for conditions typically treated by others within one's field. An appropriate respect for training differences amongst different provider types and the ability to acknowledge that "we don't know what we don't know" and to discuss cases with other providers when patients are atypical or have atypical responses to treatment.

- Knowledge in basic science, pathology, physiology. The training and experience to apply this knowledge to create a differential diagnosis. Appropriate diagnostic testing. Formulating a treatment plan. Ability to carry out the treatment plan. Ability to recognize when a treatment plan is not working. Knowledge of ones limitations.

- Comprehensive background in pathology, physiology, anatomy, pharmacology, co-morbidity disease/injury management, radiology, wound management, methodical diagnostic protocol.

- Exposure to mental health issues, demonstrated communication skills are also important pharmacology, differential diagnosis, knowing when to refer, managing co-morbidities, recognizing and managing common mental health co-morbidities, vaccination schedules/side effects/counseling, developmental assessment and recognition/management of abnormalities; recognizing and addressing social determinants of health, effective care coordination skills, effective community interactions (schools, CSBs, etc.), ability to manage and support those with disabilities (including knowledge of waivers, disability benefits, etc.).

- Adequate clinical patient contact hours under the supervision of an experienced provider, demonstrated knowledge in pharmacology and pharmokenetics, documented core knowledge in illness and disease mechanisms coupled with treatment modalities of the same, established resources for consultation and collaboration with adequate peers for management of difficult/refractory patients.

- Physiology, pharmacology, physical diagnosis, referral protocol, pathology, hematology, laboratory science, management of chronic illness.

- The ability to do a proper examination, understand what testing to order (and not order), and interpretation of results. They will also need to be familiar with the wide range of disease processes and how that's relevant to each other. They will also need to be familiar with various therapeutic options as well as contraindications. They should also need to have a process to keep up to date with changing technology, information, guidelines, etc.

- Core competencies include pathophysiology, anatomy and physiology, pharmacology, the ability to have a wide differential diagnosis but know which are the most critical and relevant tests to order to determine etiology. It is vitally important for clinicians to know what they do not know and when to ask for help through consultation or referral. Knowledge of systems based practice and the barriers to care for

different patient populations are also important. Autonomous practice should be limited to those who are able to shoulder the associated liability and consequences.

- Knowledge of oncology drugs and comprehensive treatment of cancer. Hematology knowledge. Pain management. End of life issues.

- Accurate history taking, physical exam, creation and refinement of differential diagnosis, pharmacology, lifesaving procedures, routine procedures, appropriate consultation, admission criteria recognition, discharge and follow up plan creation, EMTALA procedure, documentation, medicolegal concerns.

- Pharmacology, correct visual diagnosis of cancer and concerning lesions (often incredibly subtle), differential diagnosis, referral protocol, appropriate procedural technique AND appropriate decision making for performance of procedures such as biopsies and cryosurgery.

- Pharmacology principles such as pharmacokinetics and pharmacodynamics. Rapid evaluation of critically ill patients and initiation of therapy with continuous reassessment Management of multiple co-mire diseases in the acute setting pharmacology, knowledge of emergent vs. non-emergent complaints, differential diagnosis, managing complex patients, knowledge of vaccinations.

- Critical thinking skills and medical synthesis skills Strong foundation in basic and clinical sciences in order to generate a broad differential diagnosis. Clinical pharmacology skills. Ability to manage patients with multiple co-morbidities. Understanding of the interdependency of the health care system and navigating the complexities. Laboratory ordering and interpretation. Clinical pharmacology and medication prescribing.

5/4/18 11:15 pm

Commenter: Virginia Academy of Family Physicians

Virginia Academy of Family Physicians - Comments on HB 793 Implementing Regulations

On behalf of the Virginia Academy of Family Physicians ("VAFP"), we are writing to provide comment as the Joint Boards of Medicine and Nursing consider regulations to carry out House Bill 793. The VAFP represents nearly 3,000 family physicians and family medicine residents across Virginia.

In commenting regarding the topics specifically under consideration at the Joint Boards upcoming meeting, VAFP respectfully requests that you consider the following:

<u>Equivalent of at least five years of full-time clinical experience</u>
• VAFP's position is that the quality of the five year's of full-time clinical experience is equally important to the quantity of the experience. After medical school, physicians achieve post-graduate, formal, structured training in medical residency programs. Some physicians go on to complete additional formal, structured training in fellowship programs. The Joint Boards regulations in this area should seek to ensure the quality of the nurse practitioner's five years of full-time clinical experience mirrors the quality of a medical residency program as closely as possible.

<u>Routine practice in a practice area included within the category for which the NP was certified and licensed</u>
• VAFP's position is that it is fundamentally important for there to be alignment between the attesting physician's board certification and the category for which the NP was certified and licensed. For instance, a Board certified family physician should attest to a family practice nurse practitioner's qualifications for independent practice. It would be inappropriate for a family physician to attest to a nurse practitioner practicing in an acute care setting, such as cardiology. Likewise, it would be inappropriate for a cardiologist to attest to a

nurse practitioner practicing in a family practice setting. Additionally, "routine," as set forth in line 342 of House Bill 793, should be defined to ensure that the physician and the nurse practitioner have robust overlap in their physical presence during their interactions with their common patient population in order to promote the collaboration and training necessary to empower the nurse practitioner to practice independently.

Requirements of an attestation of practice

• VAFP's position is that the physician attestation should include, in addition to the stated requirements of Lines 339 – 345 of House Bill 793, significant detail regarding the patient population served by the attesting physician and the nurse practitioner, a description of the amount and nature of collaboration between the physician and the nurse practitioner while serving the common patient population, and any recommendations by the attesting physician for limitations on the nurse practitioner's independent practice.

Fee associated with submission of attestation and issuance of autonomous designation

• VAFP has no position on the appropriate fee associated with an attestation and application for independent practice.

Acceptance of "other evidence" demonstrating that the applicant met the requirements

• VAFP's position is that the Board should maintain a very conservative standard for other evidence, in lieu of a physician attestation, satisfactory to justify independent practice. Absence of a physician attestation may be indicative that the non-attesting physician has reservations regarding the nurse practitioner's readiness for independent practice. VAFP strongly recommends that the Joint Boards require that a statement be sought from a non-attesting physician so that the Joint Boards may fully evaluate the circumstances of the nurse practitioner's application for independent practice.

Endorsement of experience in other states

• VAFP's position is that the standard for endorsement in other states should mirror the standards for the composition of the five years of full-time clinical experience established for Virginia-based nurse practitioners. The attestation should require a similar accounting of both these clinical hours and their composition.

Unprofessional conduct – falsification of attestation

• VAFP's position is that falsification of an attestation constitutes unprofessional conduct and should subject the offending nurse practitioner to disciplinary action by the Joint Boards.

The VAFP appreciates the opportunity to provide input into the Joint Board's regulatory development process. Thank you for your efforts to ensure that the regulatory framework established to implement House Bill 793 best protects the health and safety of all Virginians.

Respectfully,

Rupen Amin, M.D   Jesus Lizarzaburu, M.D

Commonwealth of Virginia

Nurse Practitioner Licensing Categories

18VAC90-30-70. Categories of licensed nurse practitioners.

A. The boards shall license nurse practitioners consistent with their specialty education and certification in the following categories (a two-digit suffix appears on licenses to designate category):

1. Adult/geriatric acute care nurse practitioner (01);
2. Family nurse practitioner (02);
3. Pediatric/primary care nurse practitioner (03);
4. Adult/geriatric primary care nurse practitioner (07);
5. ~~Certified registered nurse anesthetist (08);~~
6. ~~Certified nurse midwife (09);~~
7. Neonatal nurse practitioner (13);
8. Women's health nurse practitioner (14);
9. Psychiatric nurse/mental health practitioner (17); and
10. Pediatric/acute care nurse practitioner (18).

18VAC90-30-90. Certifying agencies.

A. The boards shall accept the professional certification by examination of the following:

1. ~~American Midwifery Certification Board~~;
2. American Nurses Credentialing Center;
3. ~~National Board of Certification and Recertification for Nurse Anesthetists~~;
4. Pediatric Nursing Certification Board;
5. National Certification Corporation;
6. American Academy of Nurse Practitioners; and
7. American Association of Critical-Care Nurses Certification Corporation.

<u>Adult/Geriatric Acute Care Nurse Practitioner</u> - The Adult-Gerontology Acute Care Nurse Practitioner (AG ACNP) provides care to adults and older adults with acute, critical and complex chronic physical and mental illnesses across the entire adult age spectrum from young adults (including late adolescents), to adults and older adults (including frail older adults). AG ACNPs are prepared to provide services ranging from disease prevention to critical care to stabilize the patient's condition, prevent complications, restore maximum health and/or provide palliative care. The AG ACNP practice focuses on patients who are characterized as "physiologically unstable, technologically dependent, and/or are highly vulnerable to complications" (AACN, 2012). These patients require ongoing monitoring and intervention. The patients with acute, critical and complex chronic physical and mental illnesses may be encountered across the continuum of care settings. The scope of practice of the AG ACNP is not setting specific but rather is based on patient care needs. The AG ACNP also coordinates comprehensive care in and across care settings to ensure that the acute and chronic illness needs of patients are met during care transitions.

<u>Family Nurse Practitioner</u> - The Family Nurse Practitioner (FNP) is prepared to care for individuals and families across the lifespan. The FNP role includes preventative healthcare, as well as the assessment, diagnosis and treatment of acute and chronic illness and preventative health care for individuals and families. Family nurse practitioners demonstrate a commitment to family –centered care and understand the relevance of the family's identified community in the delivery of family-centered care.

<u>Pediatric/Primary Care Nurse Practitioner</u> - The role of the Primary Care Pediatric Nurse Practitioner (PCPNP) is to provide care to children from birth through young adult with an in-depth knowledge and experience in pediatric primary health care including well child care and prevention/management of common pediatric acute illnesses and chronic conditions. This care is provided to support optimal health of children within the context of their family, community, and environmental setting. Although primary

Adult/Geriatric Primary Care Nurse Practitioner - The scope of the Adult-Gerontology Primary Care Nurse Practitioner (AG PCNP) is specific to the adult-gerontology population, which includes adolescents and young adults at one end of the spectrum and frail, older adults at the other. The student is prepared to provide primary care services to the entire adult-gerontology age spectrum across the continuum of care from wellness to illness, including preventive, chronic, and acute care. The main emphasis of primary care NP educational preparation is on comprehensive, chronic, continuous care characterized by a long-term relationship between the patient and the AG PCNP. The AG PCNP provides care for most health needs and coordinates additional health care services that would be beyond the AG PCNP's area of expertise. The scope of practice of the AG PCNP is not setting specific but rather is based on patient care needs.

Neonatal Nurse Practitioner – The Neonatal Nurse Practitioner (NNP) provides health care to neonates, infants, and children up to 2 years of age. Practice as a NNP requires specialized knowledge and skills if safe, high-quality care is to be delivered to patients. Competencies are identified by the professional organization, along with an established set of standards that protect the public, ensuring patients' access to safe, high-quality care. The National Association of Neonatal Nurse Practitioners (NANNP, 2010) had established competencies for the neonatal population focus that built upon the Domains and Core Competencies of Nurse Practitioner Practice developed by the National Organization of Nurse Practitioner Faculties (NONPF, 2006).

Women's Health Nurse Practitioner - The Women's Health Nurse Practitioner (WHNP) provides primary care to women across the life cycle with emphasis on conditions unique to women from menarche through the remainder of their life cycle within the context of sociocultural environments – interpersonal, family, and community. In providing care, the women's health nurse practitioner considers the inter-relationship of gender, social class, culture, ethnicity, sexual orientation, economic status, and socio-political power differentials.

Psychiatric Nurse/Mental Health Practitioner - The Psychiatric-Mental Health Nurse Practitioner (PMHNP) focuses on individuals across the lifespan (infancy through old age), families, and populations across the lifespan at risk for developing and/or having a diagnosis of psychiatric disorders or mental health problems. The PMHNP provides primary mental health care to patients seeking mental health services in a wide range of settings. Primary mental health care provided by the PMHNP involves relationship-based, continuous and comprehensive services, necessary for the promotion of optimal mental health, prevention, and treatment of psychiatric disorders and health maintenance. This includes assessment, diagnosis, and management of mental health and psychiatric disorders across the lifespan.

Pediatric/Acute Care Nurse Practitioner - The Acute Care Pediatric Nurse Practitioner (ACPNP) is prepared to care for children with complex acute, critical and chronic illness across the entire pediatric age spectrum, from birth to young adulthood. Circumstances may exist in which a patient, by virtue of age, could fall outside the traditionally defined ACPNP population but by virtue of special need, the patient is best served by the ACPNP. The ACPNP implements the full scope of the role through assessment, diagnosis and management with interventions for patients and their families. The ACPNP provides care to patients who are characterized as "physiologically unstable, technologically dependent, and/or are highly vulnerable to complications" (AACN Scope and Standards, 2006, p 9), and a continuum of care ranging from disease prevention to critical care in order to "stabilize the patient's condition, prevent complications, restore maximum health and/or provide palliative care" (AACN p. 10). Patients may be encountered across the continuum of care settings and require ongoing monitoring and intervention.

Source: National Organization for Nurse Practitioner Faculties - http://www.nonpf.org/?page=14

Nurse Practitioner Core Competencies Content

A delineation of suggested content specific to the NP core competencies

2017

NP Core Competencies Content Work Group

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* The 2017 Nurse Practitioner Core Competencies Content publication aligns the competencies with the 2016 Adult-Gerontology Acute Care And Primary Care NP Competencies.

Nurse Practitioner Core Competencies with Suggested Curriculum Content 2017

In the development of the nurse practitioner (NP) population-focused competencies, a task force had extensive discussions of competencies vs. content. The task force concluded that it would be beneficial to programs if some content could be included as exemplars of how to support curriculum development for addressing a competency. Within the 2013 edition of the NP population-focused competencies, the final column in each population's competency table presents the respective competency work group's ideas of relevant content.

NONPF convened a work group to identify the suggested curriculum content for the NP Core Competencies. This work group consisted of members of the task force that prepared the 2014 edition of the NP Core Competencies, as well as additional representation from the NONPF Board and Curricular Leadership Committee. A sub-group of the NONPF Curricular Leadership Committee completed a review of the draft content, and the work group incorporated the review feedback into the final document presented herein. Please see the cover page for a list of work group members and an acknowledgment of the reviewers.

The table that follows includes the NP Core Competencies and a list of suggested curriculum content. NONPF does not intend for the requirement of all of this content, nor is the content list comprehensive for all that a program would cover with population-focused competencies. The content column reflects only suggestions for content relative to the core competencies. This document should be used in combination with the population-focused competencies.

Competency Area	NP Core Competencies	Curriculum Content to Support Competencies *Neither required nor comprehensive, this list reflects only suggested content specific to the core competencies*
Scientific Foundation Competencies	1. Critically analyzes data and evidence for improving advanced nursing practice.	Comparison of patient data sets with evidence-based standards to improve care
	2. Integrates knowledge from the humanities and sciences within the context of nursing science.	Scientific foundations to practice, including, but not limited to, knowledge of advanced pathophysiology, pharmacology, physiology, genetics, and communication skills
	3. Translates research and other forms of knowledge to improve practice processes and outcomes.	
	4. Develops new practice approaches based on the integration of research, theory, and practice knowledge.	Science from other disciplines relevant to health care

Competency Area	NP Core Competencies	Curriculum Content to Support Competencies *Neither required nor comprehensive, this list reflects only suggested content specific to the core competencies*
		Theories/conceptual frameworks/principles for practice: • Translational research that guides practice • Critical evaluation of research findings • Mid-range nursing theories and concepts to guide nursing practice • Evidence-based care • Physiologic • Communication • Developmental • Genetic • Behavior change • Population health Critical thinking development: • Evidence appraisal • Formulating a practice problem • Use of science-based theories and concepts to assess, enhance, and ameliorate health care delivery phenomena • Use of PICO questions to initiate research and quality improvement projects Qualitative and quantitative research and quality improvement methods Ethical and legal protection of human subjects Inquiry processes and practices related to health literacy, vulnerable populations, and culture Monitoring of health outcomes
Leadership Competencies	1. Assumes complex and advanced leadership roles to initiate and guide change. 2. Provides leadership to foster collaboration with multiple	Content related to: • Crisis management and leadership • Stress management (for staff and patient/family) • Teams and teamwork, including team leadership, building

Competency Area	NP Core Competencies	Curriculum Content to Support Competencies *Neither required nor comprehensive, this list reflects only suggested content specific to the core competencies*
	stakeholders (e.g. patients, community, integrated health care teams, and policy makers) to improve health care. 3. Demonstrates leadership that uses critical and reflective thinking. 4. Advocates for improved access, quality and cost effective health care. 5. Advances practice through the development and implementation of innovations incorporating principles of change. 6. Communicates practice knowledge effectively, both orally and in writing. 7. Participates in professional organizations and activities that influence advanced practice nursing and/or health outcomes of a population focus.	effective teams, and nurturing team Leadership, change, and management theories with application to practice Political processes, political decision making processes, and health care advocacy Problem solving: • Influencing and negotiation • Conflict management • Strategic thinking • Managing change Business development: • High reliability organization principles • Building and maintaining effective teams • Project management concepts • Principles of effective decision making • Principles of change management • Civility • Principles of innovation Communications: • Scholarly writing, manuscript, and abstract preparation • Structuring and presenting persuasive arguments Peer review: • Publications • Presentations • Research • Practice. Leadership development:

Competency Area	NP Core Competencies	Curriculum Content to Support Competencies *Neither required nor comprehensive, this list reflects only suggested content specific to the core competencies*
		• Skills to influence decision-making bodies at the system, state, or national level • Interprofessional leadership • Assuming leadership positions in professional, political, or regulatory organizations • Structure and functions of editorial/board roles • Ethical and critical decision making, effective working relationships, and a systems-perspective Concepts of strategic planning process Leadership styles How to lead change in practice, manage practice changes • Monitoring implementation and fidelity • Adaptation of change to patients, providers and organizational needs and resources • Interim feedback on achievements and efficiencies • Interpretation of data and articulating evidence Self-reflection of leadership style e.g., personal leadership strengths and weaknesses; working with diverse skills sets and diverse teams
Quality Competencies	1. Uses best available evidence to continuously improve quality of clinical practice. 2. Evaluates the relationships among access, cost, quality, and safety and their influence on health care. 3. Evaluates how organizational structure, care processes, financing, marketing, and policy decisions impact the quality of health care. 4. Applies skills in peer review to promote a culture of	Quality Safety Education in Nursing (QSEN) principles and content Evaluation of outcomes of care such as quality improvement projects with an evaluation component Reflective practice Culture of safety Quality improvement processes and practices Knowledge of quality improvement methods such as: • Plan-Do-Study Act • Six Sigma

Competency Area	NP Core Competencies	**Curriculum Content to Support Competencies** *Neither required nor comprehensive, this list reflects only suggested content specific to the core competencies*
	excellence. 5. Anticipates variations in practice and is proactive in implementing interventions to ensure quality	Cost benefit analysis Peer review process • Reviewer • Reviewee Collaborative team processes and practices Leadership skills for leading change for quality clinical practice Methods and measures of quality assurance during transitions of care Laws and rules to enhance quality such as • Meaningful use • Federal, state, and local quality data sources and indicators
Practice Inquiry Competencies	1. Provides leadership in the translation of new knowledge into practice. 2. Generates knowledge from clinical practice to improve practice and patient outcomes. 3. Applies clinical investigative skills to improve health outcomes. 4. Leads practice inquiry, individually or in partnership with others. 5. Disseminates evidence from inquiry to diverse audiences using multiple modalities. 6. Analyzes clinical guidelines for individualized application into practice	Leadership for role in practice improvement Clinical investigation strategies: • Identifying clinical practice problems • Appraising evidence for application to practice (e.g., design, methods, tools, analysis) • Literature search methods, including, but not limited to, the PICO Model to define a clinical questions and search for the best clinical evidence Use of electronic databases, such as electronic health records: • Assessing clinical practice • Reviewing patient technology • Exploring behaviors and risk factors • Using data to support evidence based changes in clinical management • Template development

Competency Area	NP Core Competencies	**Curriculum Content to Support Competencies** *Neither required nor comprehensive, this list reflects only suggested content specific to the core competencies*
		Patient management, including, but not limited to, discerning gaps in care and barriers to care needing resolution during patient encounters Project development and management: • Synthesis and translation/extrapolation of research to selected populations • Frameworks to guide projects • Quality improvement methods • Assessment of resources needed and available for projects • Competing priorities of patients, payers, providers, and suppliers • Data-based, needs assessment for project • Processes used in conducting projects based on current and best evidence, including evaluation of the application of evidence or inquiry to the population of concern • Evaluation of outcomes (for health status of patient and population as well as system outcomes) • Evaluation of why expected results were or were not attained and lessons learned • Making recommendations for further work • Addressing issues of sustainability of project findings Dissemination of work and findings: • Abstract and manuscript writing to support the dissemination of project/research outcomes • Discussion of clinically meaningful results that may or may not be statistically significant • Presentation skill development with modification for different audiences

Competency Area	NP Core Competencies	Curriculum Content to Support Competencies *Neither required nor comprehensive, this list reflects only suggested content specific to the core competencies*
		Integration of findings: • Results, methods, and tools, as appropriate, into care delivery • Identification of best practices • Opportunities for multidisciplinary team/inter-professional collaboration for patient care • Development and use of clinical guidelines • Use of clinical judgment to improve practice • Application of evidence to validate or change policy Evaluation of alternative care delivery models and treatments, including costs, cost benefits, and return on investment Institutional review board policies and processes Interprofessional research and scholarship exemplars and opportunities
Technology and Information Literacy Competencies	1. Integrates appropriate technologies for knowledge management to improve health care. 2. Translates technical and scientific health information appropriate for various users' needs. 2.a Assesses the patient's and caregiver's educational needs to provide effective, personalized health care. 2.b Coaches the patient and caregiver for positive behavioral change. 3. Demonstrates information literacy skills in complex decision making. 4. Contributes to the design of clinical information systems	Technology available in clinical practice: • Electronic resources that identify current evidenced-based care • Electronic resources that enhance patient safety • Technological care delivery systems • Telehealth • Information databases used by health care systems • Electronic communication with other professionals and patients • Encrypted and unencrypted technology • Electronic resources to support differential diagnosis, algorithmic thinking, and medical record review • Templates for documentation in nursing care • Use of electronic datasets to evaluate practice and improve quality, cost, and efficiency of care Technology available to support education: • Standardized patient encounters • Electronic/computer based learning modules based on characteristics such as cultural literacy, educational level,

Competency Area	NP Core Competencies	Curriculum Content to Support Competencies *Neither required nor comprehensive, this list reflects only suggested content specific to the core competencies*
	that promote safe, quality and cost effective care. 5. Uses technology systems that capture data on variables for the evaluation of nursing care.	and home assessment • Coaching/teaching resources adapted to population, health literacy, and age of patient learning styles, • Age-appropriate concepts and development of educational tools • Use of applications for references at point of care Using telehealth to provide care for the adult population, considering benefits, methods, differences, and regulatory issues. IT resources such as: • Informatics competencies from Technology Informatics Guiding Education Reform (TIGER) initiative • American Medical Informatics Association (AMIA) Use of electronic communication methods, including social media, with healthcare professionals, patients, families, and caregivers Compliance issues related to patient privacy with use of technology Population-appropriate clinical indicators for incorporation into information systems, such as electronic health records Use of technologies to monitor and evaluate clinical problems, e.g. • Blood pressure • Vital signs • Glucose • Weight
Policy Competencies	1. Demonstrates an understanding of the interdependence of policy and practice. 2. Advocates for ethical policies that promote access, equity, quality, and cost. 3. Analyzes ethical, legal, and social factors influencing policy	Policy analysis process: • Political environment • Political feasibility • Economic feasibility • Implementation strategy and planning • Outcomes evaluation at local, state, national, and international levels

Competency Area	NP Core Competencies	Curriculum Content to Support Competencies *Neither required nor comprehensive, this list reflects only suggested content specific to the core competencies*
	development. 4. Contributes in the development of health policy. 5. Analyzes the implications of health policy across disciplines. 6. Evaluates the impact of globalization on health care policy development. 7. Advocates for policies for safe and healthy practice environments.	• Specific NP role for influencing health care agenda and patient advocacy Health policy and health care reform: • Federal budget • National health priorities • Methods for appropriation of funding • Vulnerable populations and needs • The relationship between the USPSTF guidelines and Affordable Care Act implementation Legislative and regulatory processes: • Origin of laws • Regulatory process • How to influence/impact passage of laws and their translation into regulation • Health care financing and third party reimbursement Population health model and its impact on policy planning Introduction of global issues: • Infections • Travel • Immigration • Disasters/terrorism • Access to health care Ethical issues in health care planning: • Fairness • Equity and health disparities • Access and resource allocation • Health behavior • Social determinants of health

Competency Area	NP Core Competencies	Curriculum Content to Support Competencies *Neither required nor comprehensive, this list reflects only suggested content specific to the core competencies*
		Comparative health systems Proactive and responsive use of media Barriers to NP practice Legislative process and resources, e.g., Congress.gov Policy theories Examples of policy making at multiple levels and individual and collective contributions to shape policy
Health Delivery System Competencies	1. Applies knowledge of organizational practices and complex systems to improve health care delivery. 2. Effects health care change using broad based skills including negotiating, consensus-building, and partnering. 3. Minimizes risk to patients and providers at the individual and systems level. 4. Facilitates the development of health care systems that address the needs of culturally diverse populations, providers, and other stakeholders. 5. Evaluates the impact of health care delivery on patients, providers, other stakeholders, and the environment. 6. Analyzes organizational structure, functions and resources to improve the delivery of care. 7. Collaborates in planning for transitions across the continuum of care.	Organizational practices: • Organizational structure, tables of organization • Organizational decision making • Organizational theory • Principles of management Interprofessional collaborative partnerships Informatics/information systems: • Interpreting variations in outcomes • Use of data to improve practice • Use of collateral information • Organizational delivery subsystems, (e.g. electronic prescription writing-pharmacy software) Needs assessment of populations served: • Socioeconomic and cultural factors • Unique population needs • System resources to meet population needs (e.g. use interpreters to facilitate communication) • Community resources/system outreach to community • Diversity among providers

Competency Area	NP Core Competencies	Curriculum Content to Support Competencies *Neither required nor comprehensive, this list reflects only suggested content specific to the core competencies*
		Financial issues: • Financial business principles • Health care system financing • Reimbursement systems • Resource management • Billing and coding principles Interprofessional/team competencies: • Communication (theory) • Collaboration • Conflict resolution • Consultations/referrals • Team building • Values and ethics • Roles and responsibilities Safety and quality: • Cost-effective care • Legal/ethical issues • Research and quality improvement • Continuous quality improvement • Quality and Safety Education in Nursing Transitional care: • Navigating transitions across health care settings • Coordination of services Planning, delivering and/or evaluating models of care: • Models of planned change • Process and evaluation design implementation • Evaluation models • Process of proposing changes in practice

Competency Area	NP Core Competencies	Curriculum Content to Support Competencies *Neither required nor comprehensive, this list reflects only suggested content specific to the core competencies*
		Legislative and regulatory issues: • Relevant and current issues (e.g., Accountable Care Act implementation) • Process of health care legislation • Scope and standards of practice • Cultural competence • Theories of vulnerability • Social determinants of health Policy and advocacy: • Reducing environmental health risks • Implications of health policy • Variations in policy
Ethics Competencies	1. Integrates ethical principles in decision making. 2. Evaluates the ethical consequences of decisions. 3. Applies ethically sound solutions to complex issues related to individuals, populations and systems of care.	Ethics in decision making: • Ethical considerations in decision making in clinical practice • Applications of ethical principles in policy making and in care delivery • Sources of information to facilitate ethical decision making - theories of ethical decision making - ethics committee - genetic counseling - clinical research - legal statutes - cultural sensitivity - scope of practice Evaluation of ethical decisions: • Methods of evaluating outcomes (long-term and short-term) • Debriefing and assessment of outcomes • Ethical frameworks. Population-specific complex ethical issues occurring in clinical practice

Competency Area	NP Core Competencies	Curriculum Content to Support Competencies *Neither required nor comprehensive, this list reflects only suggested content specific to the core competencies*
		System-specific resources to implement ethical decisions (e.g. hospice care, palliative care) Spiritual resources for patients and families (e.g., on site and media based)
Independent Practice Competencies	1. Functions as a licensed independent practitioner. 2. Demonstrates the highest level of accountability for professional practice. 3. Practices independently managing previously diagnosed and undiagnosed patients. 3.a Provides the full spectrum of health care services to include health promotion, disease prevention, health protection, anticipatory guidance, counseling, disease management, palliative, and end-of-life care. 3.b Uses advanced health assessment skills to differentiate between normal, variations of normal and abnormal findings. 3.c Employs screening and diagnostic strategies in the development of diagnoses. 3.d Prescribes medications within scope of practice. 3.e Manages the health/illness status of patients and families over time. 4. Provides patient-centered care recognizing cultural diversity and the patient or designee as a full partner in decision-making. 4.a Works to establish a relationship with the patient characterized by mutual respect, empathy, and collaboration. 4.b Creates a climate of patient- centered care to include	Clinical decision making based on evidence and patient/provider partnership Current and emerging professional standards Novice to expert continuum of clinical practice Political, policy and regulatory issues regarding licensure, national certification, and scope of practice. Leadership approaches for employment contract negotiation, networking, and advancing professional standards and roles Application of select sciences to practice: • Pharmacology • Physiology • Pathophysiology Specific areas of assessment, including but not limited to: • Physical • Psychosocial • Developmental • Family • Psychiatric mental health • Oral health Screenings Diagnostics (tests, labs) Specific procedures

Competency Area	NP Core Competencies	Curriculum Content to Support Competencies *Neither required nor comprehensive, this list reflects only suggested content specific to the core competencies*
	confidentiality, privacy, comfort, emotional support, mutual trust, and respect. 4.c Incorporates the patient's cultural and spiritual preferences, values, and beliefs into health care. duplicate. 4.d Preserves the patient's control over decision making by negotiating a mutually acceptable plan of care. 4e. Develops strategies to prevent one's own personal biases from interfering with delivery of quality care. 4f. Addresses cultural, spiritual, and ethnic influences that potentially create conflict among individuals, families, staff and caregivers. 5. Educates professional and lay caregivers to provide culturally and spiritually sensitive, appropriate care 6. Collaborates with both professional and other caregivers to achieve optimal care outcomes. 7. Coordinates transitional care services in and across care settings. 8. Participates in the development, use, and evaluation of professional standards and evidence-based care.	Health promotion, prevention, and disease management Pharmacology and complementary alternative therapies Provider-patient relationship: • Role of culture in patient-centered care • Contracting a management plan with patient and/or family • Culture of trust in interpersonal relationship w/patient and/or families Business of practice: • Legal, business, and ethical issues • How to set up, finance and evaluate a practice , • Writing a business plan Cultural issues Concepts of life-long learning