Committee of the Joint Boards of Nursing and Medicine

Instructions for Accessing June 16, 2021 at 9:00 A.M.

Virtual Business Meeting & Providing Public Comment

- **Access:** Perimeter Center building access remains restricted to the public due to the COVID-19 pandemic. To observe this virtual meeting, use one of the options below. Participation capacity is limited and is on a first come, first serve basis due to the capacity of CISCO WebEx technology.
- **Public comment**: Comments will be received during the public hearings and during the Committee meeting form those persons who have submitted an email to huong.vu@dhp.virginia.gov no later than 8 am on June 16, 2021 indicating that they wish to offer comment. Be sure to specify if the comment is associated with the public hearing or the Committee meeting. Comment may be offered by these individuals when their names are announced by the chairman.
- Public participation connections will be muted following the public comment periods.
- Should the Committee enter into a closed session, public participants will be blocked from seeing or hearing the discussion. When the Board re-enters into open session, public participation connections to see and hear the discussions will be restored.
- Please call from a location without background noise.
- Dial (804) 367-4515 to report an interruption during the broadcast.
- FOIA Council *Electronic Meetings Public Comment* form for submitting feedback on this electronic meeting may be accessed at http://foiacouncil.dls.virginia.gov/sample%20letters/welcome.htm.

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https://covaconf.webex.com/covaconf/j.php?MTID=m3641ae3be12bd391d2deec80024ed55b

Meeting number (access code): 161 359 3396

Meeting password: hJnXqyMG355

Please note → *Type your real name upon entering the meeting.* ***Do not enter the meeting using the default username****. It is imperative that the meeting organizer be able to determine who is attending.*

COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
AND ADVISORY COMMITTEE OF THE JOINT BOARDS
Department of Health Professions
Henrico, Virginia 23233

VIRTUAL **BUSINESS MEETING Amended** *FINAL* **AGENDA**
June 16, 2021 at 9:00 A.M.

JOIN BY AUDIO ONLY

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JOIN THE INTERACTIVE MEETING

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Call To Order – Marie Gerardo, MS, RN, ANP-BC; Chair

Establishment of Quorum

Announcement

- Appreciation for Louise Hershkowitz' service on the Committee of the Joint Boards of Nursing and Medicine

A. Review of Minutes

A1 April 21, 2021 Business Meeting*
A2 April 21, 2021 Informal Conference*

Dialogue with Agency Director – Dr. Brown and or Dr. Allison-Bryan

Public Comment

B. Legislation/Regulations – Ms. Yeatts

B1 Chart of Regulatory Actions as of June 1, 2021**
B2 Chart of Post-General Assembly Actions/Studies**

B3 Regulatory Actions – Adoption of Exempt Regulations Pursuant to **2021 Legislation** Draft Regulations for Licensure of Nurse Practitioners (**Chapter 30**), and Prescriptive Authority for Nurse Practitioners (**Chapter 40**)**
B4 Fast-Track Changes for the Licensure of Nurse Practitioners(**Chapter 30**) and the Prescriptive Authority for Nurse Practitioners (**Chapter 40**)

C. **New Business**
- **C1** - 2022 Committee of the Joint Boards of Nursing and Medicine Meeting Dates – **Ms. Gerardo/Ms. Douglas****
- Revision of Guidance Document (GD) 90-56 – *Practice Agreement Requirements for Licensed Nurse Practitioners* – **Dr. Hills**
  - **C2a –** Current Version of GD 90-56**
  - **C2b –** Proposed Draft Version of GD 90-56**
  - **C2c –** Nurse Practitioner Side-by-Side Comparison Table (**FYI**)**
- **C3** – Communication sent to all CNSs on May 27, 2021(**FYI**)**
- **C4 –** Sentara Letter (**FYI**)

HB 793 – Preliminary Report on Nurse Practitioners with Autonomous Practice Designation - Dr. Carter, Healthcare Workforce Data Center (HWDC) Executive Director, and Rajana Siva, HWDC Data Analyst

- Bate Stamped Materials from 001 to 017**

- Results in Tableau online interactive map and table with dropdown menus link: https://public.tableau.com/profile/rajana.siva#!/vizhome/npspecialtycounts/Story1

Discussion regarding "*any recommended modifications to the requirements of this act including any modifications to the clinical experience requirements for practicing without a practice agreement*" (HB 793, 2018) – **Committee Members and Advisory Committee Members**

Environmental Scan – Advisory Committee Members (**verbal report**)

12:30 P.M. - Consideration of Consent Order - Joint Boards Member ONLY

- Charmayne L. Lanier-Eason, LNP**

12:30 P.M - Agency Subordinate Recommendation Consideration – Joint Boards Member ONLY

#1 – Darlene Whitfield Olive, LNP

Next Meeting – Wednesday, October 13, 2021, at 9:00 A.M in Board Room 2

Adjourn

Our mission is to ensure safe and competent practice of nursing to protect the health, safety of the citizens of the Commonwealth

(* mailed 5/26) (** mailed 6/3)

VIRGINIA BOARD OF NURSING
COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
***VIRTUAL* BUSINESS MEETING**
MINUTES
April 21, 2021

TIME AND PLACE: The virtual meeting of the Committee of the Joint Boards of Nursing and Medicine via Webex was called to order at 9:00 A.M., April 21, 2021.

Due to COVID-19 declared state of emergency and consistent with Amendment 28 to HB29 (Budget Bill for 2018-2020) and the applicable provision of §2.2-3708.2 in the Freedom of Information Act, the Committee convened a virtual meeting to consider such regulatory and business matters as was presented on the agenda for the Committee to discharge its lawful purposes, duties, and responsibilities.

COMMITTEE MEMBERS PARTICIPATED VIRTUALLY:
Marie Gerardo, MS, RN, ANP-BC; Chair
Ann Tucker Gleason, PhD
Louise Hershkowitz, CRNA, MSHA
David Archer, MD
Lori Conklin, MD
Karen Ransone, MD

MEMBERS ABSENT: None

ADVISORY COMMITTEE MEMBERS PARTICIPATEDG VIRTUALLY:
Kevin E. Brigle, RN, NP
Mark Coles, RN, BA, MSN, NP-C
David Alan Ellington, MD
Sarah Hobbgood, MD
Stuart Mackler, MD
Janet L. Setnor, CRNA

STAFF PARTICIPATED VIRTUALLY:
Jay P. Douglas, MSM, RN, CSAC, FRE; Executive Director; Board of Nursing
Robin L. Hills, DNP, RN, WHNP; Deputy Executive Director for Advanced Practice; Board of Nursing
Huong Vu, Executive Assistant; Board of Nursing
Sally Ragsdale, Discipline Specialist

OTHERS PARTICIPATED VIRTUALLY:
Erin Barrett, Assistant Attorney General; Board Counsel
David Brown, DO, Director; Department of Health Professions
Barbara Allison-Bryan, MD; Chief Deputy, Department of Health Professions

Elaine Yeatts, Policy Analyst; Department of Health Professions
William L. Harp, MD, Executive Director; Board of Medicine
Ann Tiller, Board of Nursing Compliance Manager
Patricia Dewey, RN, BSN; Board of Nursing Case Manager
Christine Smith, RN, MSM; Nurse Aide/RMA Education Program Manager
Randall Mangrum, DNP, RN; Nursing Education Program Manager

PUBLIC PARICIPATED VIRTUALLY:

W. Scott Johnson, Esquire/Hancock, Daniel & Johnson, PC
Clark Barrineau, Assistant Vice President of Government Affair, Medical Society of Virginia (MSV)
Gerald C. (Jerry) Canaan, II, Esq. Byrne Legal Group
Julianne Condrey, Lobbyist, Virginia Public Access Project (VPAP)
Kassie Schroth, Virginia Association of Nurse Anesthetists (VANA)
Richard Grossman, Virginia Council of Nurse Practitioners (VCNP)
Becky Bower-Lanier,
Cynthia Ward
Sarah W. Taylor
Lisa Jamerson
Erin M. Smith
Cindy Difranco
Komkwuan Paruchabutr
14349****16
17032****20
18048****27
18048****30
18043****59
14436****66
18048****77

ESTABLISHMENT OF A QUORUM:

Ms. Gerardo called the meeting to order and established that a quorum consisting of six members was present.

ANNOUNCEMENT:

Ms. Gerardo noted the announcement as stated in the Agenda that was provided electronically:

- Resignation of CNM Advisory Committee Member, Kathleen Bailey, RN, CNM, MA, MS due to relocation

There were no additional announcements.

REVIEW OF MINUTES:

Ms. Gerardo stated that staff provided the following document electronically:

- **A1** December 9, 2020 Business Meeting
- **A2** February 8, 2021 Formal Hearing
- **A3** February 17, 2021 Formal Hearing

Ms. Gerardo asked of the Committee have any questions regarding the minutes. None was noted.

Dr. Ransone moved to accept the minutes as presented. The motion was properly seconded by Dr. Conklin. A roll call was taken and the motion carried unanimously.

PUBLIC COMMENT:

Ms. Gerardo said that as indicated in the meeting notice on Regulatory Townhall and in the agenda package, comments will be received during this public comment period from those persons who submitted an email to Huong Vu no later than 8 am on April 21, 2021 indicating that they wish to offer comment.

Ms. Gerardo noted that written comment from Medical Society of Virginia was received via email and the Committee will take into consideration. Ms. Gerardo asked if any additional email requests had been received. Ms. Vu reported that no additional email requests for public comment were received as of 8 am today and no one is present on the call to make comment.

DIALOGUE WITH AGENCY DIRECTOR:

Dr. Brown reported the following:
Marijuana – effective July 1, 2021, possession of marijuana in Virginia will be legal. The 2021 General Assembly (GA) also passed the bill allowing marijuana flowers to be distributed in Virginia.

The 2022 Session of the General Assembly (GA) will consider the new cannabis authority to regulate recreational and medical marijuana with the anticipation that Board of Pharmacy will turn the authority over to the new administration in 2023.

Dr. Allison-Bryan reported on the COVID-19 vaccines as follows:

- Virginia is now in Phase 2
- 25% plus of adult Virginians have received vaccination
- 5.5 millions dosages were administered
- Vaccine hesitancy was noted from political and not racial discrepancy

Dr. Archer asked who will take the lead in educating practitioners about marijuana's dosage and how it can be used.

Dr. Brown said that he is not certain but anticipating that pharmacists will take the lead.

LEGISLATION/
REGULATIONS:

Ms. Gerardo stated that staff have provided the following documents electronically:

- **B1** Regulatory Update
- **B2** Report of the 2021 General Assembly
- **B3** Unprofessional Conduct/Conversion Therapy (18VAC-90-30)

Ms. Gerardo invited Ms. Yeatts to proceed.

Ms. Yeatts noted that **B1** and **B3** are provided for information only, no action needed.

Ms. Hershkowitz inquired if the Conversion Therapy regulations are consistent with other boards. Ms. Yeatts replied yes.

Ms. Yeatts reviewed the report of 2021 General Assembly (**B2**) that was provided in the agenda noting the following bills:

HB 1737 (Nurse practitioners; practice without a practice agreement) - reduces from five to two the number of years of full-time clinical experience a nurse practitioner must have to be eligible to practice without a written practice agreement. The bill has an expiration date of July 1, 2022.

HB 1747 Clinical nurse specialist; licensure of nurse practitioners as specialists – effective July 1, 2021. Changes from the requirement of registration as clinical nurse specialists to the licensure as nurse practitioners in the category of clinical nurse specialists by the Boards of Medicine and Nursing and authorize prescriptive authority. Practice Agreement is required.

HB 1817 Certified nurse midwives; practice – eliminated the requirement that certified nurse midwives practice pursuant to a practice agreement who has practiced 1,000 hours or more.

HB 1953 Licensed certified midwives; clarifies definition, licensure – directs the Boards of Medicine and Nursing to establish criteria for the licensure and renewal of a license as a certified midwife, and requires licensed certified midwives to practice in consultant with a license physician in accordance with a practice agreement. The bill also directs DHP to convene a work group to study the licensure and regulation of certified nurse midwives, certified midwives, and certified professional midwives, and to submit its findings and conclusions to the Governor and the General Assembly by November 1, 2021.

SB 1189 Occupational therapists; licensure – Authorizes Virginia to become a signatory to the Occupational Therapy Interjurisdictional

Licensure Compact. The bill will be effective on January 1, 2022 and Virginia is one of the first states to have Occupational Therapy Compact.

Dr. Archer inquired as if Virginia plans to issue identification card for COVID-19 vaccination. Dr. Allison-Bryan replied that she has not heard of such plan.

Ms. Gerardo inquired if CNS has to have practice agreement even without prescriptive authority. Ms. Yeatts replied yes.

Dr. Archer asked if there is a table available that lists all the categories of nurse practitioners that can be shared. Ms. Douglas said that it will be shared once it is updated by the new legislation. Ms. Douglas added that the Board plans to communicate to all CNSs regarding the change on July 1, 2021

Ms. Hershkowitz inquired about the DHP study will be conducted regarding regulation of Midwifery in Virginia. Dr. Brown responded that the workplan is still being developed.

Dr. Ransone asked why CNMs are only required to have 1000 hours in order to practice without the practice agreement while other categories of NPs are required 2 years. Dr. Brown responded this was the negotiated postion.

NEW BUSINESS:

Board of Nursing Executive Director Report:

- Board staff receive increased inquiries regarding advanced practice registered nurses (APRNs).
- Tthe Compact for APRN was voted on at the NCSBN in August 2020. North Dakoda has passed legislation to join. Delaware is in the process.
- Guam becomes First US Territory to enact Nurse Licensure Compact (NLC).
- Grants for compact development are available by the Department of Defense for selected professions such as teaching, social work and massage therapy

Virtual NCSBN APRN Roundtable April 6, 2021 Report:

Ms. Douglas reported that the Roundtable focused heavily on the educational preparation of APRN's.

Dr. Hills reported that the new edition of the National Task Force NP program criteria were presented as well as the AACN Essentials

Ms. Hershkowitz reported that the Roundtable also discussed about the effects of COVID pandemic on APRN education.

Future Regulatory & Administrative Process related to 2021 Legislation – table provided in **B2**

C1 – Licensure Statistics related to Advanced Practice Registered Nurses:
Ms. Douglas noted that this is provided for information only. Ms. Douglas added that about 260 waivers related to electronic prescribing were approved.

Appointment of CNM Advisory Committee Member to replace Kathleen J. Bailey, RN, CNM, MA, MS – Recommendation of Komkwuan P. Paruchabutr, DNP, FNP-BC, WHNP-BC, CNM from Virginia Affiliate of ACNM:

Ms. Gerardo noted that Ms. Bailey has informed staff of her resignation effective on April 1, 202, a recommendation of Dr. Paruchabutr from the Virginia Affiliate of ACNM to replace Ms. Bailey for the unexpired term ends 2024, and the CV was provided to Committee Members in advance.

Ms. Gerardo noted that pursuant to 18VAC90-30-30.B, appointment to the Advisory Committee shall be for four years; members may be appointed for one additional four-year period.

Ms. Gerardo asked Ms. Barrett about Dr. Paruchabutr's eligibility to the Advisory Committee since Dr. Paruchabutr only holds a VA registered nurse license, not a VA nurse practitioner license.

Ms. Barrett replied that the Committee can view Dr. Paruchabutr eligible since she does not vote or participate in disciplinary matters.

Ms. Hershkowitz moved to appoint Dr. Paruchabutr as CNM Member to the Advisory Committee. The motion was properly seconded by Dr. Archer. A roll call was taken and the motion carried unanimously.

ENVIRONMENTAL SCAN: Ms. Gerardo asked for the updates from the Advisory Committee Members.

None was shared.

Mr. Coles asked in regard to HB 1737 for nurse practitioners who are coming up with two years of clinical, can they apply now for autonomous practice? Ms. Douglas replied that there will be an opportunity to apply prior to July 1, 2021, however, the Board cannot issue licenses prior to that date. Information will be communicated to licensees.

Mr. Coles noted that regarding the report due on November 1, 2021 as required by HB 793, the VCNP would share data as needed. Ms. Douglas

stated that the Board has to report specific data referenced in the enactment clause. However, recommendations will be discussed at the June meeting.

Ms. Gerardo thanked Advisory Committee Members for their participation in the meeting and reminded everyone that the next meeting is scheduled for Wednesday, June 16, 2021.

The Advisory Committee Members, Dr. Brown, Dr. Allision-Bryan, Dr. Harp and Ms. Yeatts, left the meeting at 10:23 A.M.

RECESS: The Committee recessed at 10:23 A.M.

RECONVENTION: The Committee reconvened at 10:32 A.M.

AGENCY SUBORDINATE RECOMMENDATION CONSIDERATION

CLOSED MEETING: Dr. Gleason moved that the Committee of the Joint Boards of Nursing and Medicine convene a closed meeting pursuant to §2.2-3711(A)(28) of the *Code of Virginia* at 10:33 A.M., for the purpose to reach a decision in the matter of Agency Subordinate Recommendations. Additionally, Dr. Gleason moved that Ms. Douglas, Dr. Hills, Ms. Vu, and Ms. Barrett attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was properly seconded by Dr. Ransone. A roll call was taken and the motion carried unanimously.

RECONVENTION: The Board reconvened in open session at 11:01 A.M.

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

#1 – Linda Q. Morrill, LNP 0024-053267

Ms. Morrill did not participate.

Dr. Ransone moved that the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate to

reprimand Linda Q. Morrill. The motion was properly seconded by Ms. Hershkowitz. A roll call was taken and the motion carried unanimously.

#2 – April Jae Stein Brittain, LNP 0024-134372

Ms. Brittain did not participate.

Dr. Gleason moved that the Committee of the Joint Boards of Nursing and Medicine modify the recommended decision of the agency subordinate to reprimand April Jae Stein Brittain and to require Ms. Brittain to complete 10 hours of Board approved continuing education (CE) regarding documentation and proper prescribing within 90 days from entry of the Order. These CEs are above the requirement of licensure renewal. The motion was properly seconded by Dr. Conklin. A roll call was taken and the motion carried unanimously.

#3 – Georgienne Castle Neale, LNP 0024-166304

Ms. Neale did not participate.

Dr. Ransone moved that the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate to indefinitely suspend the license of Georgienne Castle Neale to practice as a nurse practitioner in the Commonwealth of Virginia. The motion was properly seconded by Ms. Hershkowitz. A roll call was taken and the motion carried unanimously.

#4 – Stacy Lee Smith Riedt, LNP 0024-168687

Ms. Riedt did not participate.

Dr. Ransone moved that the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate to reprimand Stacy Lee Smith Riedt. The motion was properly seconded by Ms. Hershkowitz. A roll call was taken and the motion carried unanimously.

#5 – Kimberly Dawn Washbourne, LNP 0024-166086

Ms. Washbourne did not participate.

Dr. Ransone moved that the Committee of the Joint Boards of Nursing and Medicine reject the recommended decision of the agency subordinate and refer the matter of Kimberly Dawn Washbourne to a formal hearing. The motion was properly seconded by Dr. Conklin. A roll call was taken and the motion carried unanimously.

ADJOURNMENT: As there was no additional business, the meeting was adjourned at 11:06 A.M.

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

VIRGINIA BOARD OF NURSING
COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
VIRTUAL **INFORMAL CONFERENCE**
MINUTES
April 21, 2021

TIME AND PLACE: The virtual Webex informal conference of the Committee of the Joint Boards of Nursing and Medicine was called to order at 11:27 A.M., on April 21, 2021.

Due to COVID-19 declared state of emergency and consistent with Amendment 28 to HB29 (Budget Bill for 2018-2020) and the applicable provision of §2.2-3708.2 in the Freedom of Information Act, the Committee convened a virtual meeting to consider such regulatory and business matters as was presented on the agenda for the Committee to discharge its lawful purposes, duties, and responsibilities.

COMMITTEE MEMBERS PARTICIPATED VIRTUALLY:
Marie Gerardo, MS, RN, ANP-BC, Chairperson
Louise Hershkowitz, CRNA, MSHA;
Lori Conklin, MD

STAFF PARTICIPATED VIRTUALLY:
Jay P. Douglas, MSM, RN, CSAC, FRE; Executive Director
Robin Hills, RN, DNP, WHNP; Deputy Executive Director for Advanced Practice
Huong Vu, Executive Assistant
Sally Ragsdale, Discipline Specialist

OTHERS PARTICIPATED VIRTUALLY:
Anne Joseph, Adjudication Consultant, Administrative Proceedings Division (APD)
Michael Scott Addair, LNP Reinstatement Applicant
Sylvia Tamayo-Suijk, Senior Discipline Specialist
Henry Fisher, DHP Video Conference Specialist
18046****27

CONFERENCE SCHEDULED:
Michael Scott Addair, LNP Reinstatement Applicant
0024- 167226

Mr. Addair participated.

CLOSED MEETING: Ms. Hershkowitz moved that the Informal Conference Committee of the Joint Boards of Nursing and Medicine convene a closed meeting pursuant to Section 2.2-3711(A)(28) of the *Code of Virginia* at 12:38 P.M. for the purpose of deliberation to reach a decision in the matter of **Michael Scott Addair**. Additionally, Ms. Hershkowitz moved that Ms. Douglas, Dr. Hills, Ms. Vu and Ms. Joseph, attend the closed meeting because their

presence in the closed meeting is deemed necessary, and their presence will aid the Committee in its deliberations. The motion was properly seconded by Dr. Conklin. A roll call was taken and the motion carried unanimously.

RECONVENTION: The Committee reconvened in open session at 1:02 P.M.

Ms. Hershkowitz moved that the Informal Conference Committee of the Joint Boards of Nursing and Medicine certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was properly seconded by Dr. Conklin. A roll call was taken and the motion carried unanimously.

ACTION: Ms. Hershkowitz moved to deny the application of Michael Scott Addair for reinstatement of his license to practice as a nurse practitioner in the Commonwealth of Virginia. The motion was properly seconded by Dr. Conklin. A roll call was taken and the motion carried unanimously.

An Order will be entered. As provided by law, this decision shall become a Final Order thirty days after service of such Order on Mr. Addair, unless a written request to the Board for a formal hearing on the allegations made against him is received from Mr. Addair within such time. If service of the Order is made by mail, three additional days shall be added to that period. Upon such timely request for a formal hearing, the Order shall be vacated.

ADJOURNMENT: The meeting was adjourned at 1:05 P.M.

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

B 1

Agenda Item: Regulatory Actions - Chart of Regulatory Actions
As of June 1, 2021

Boards of Nursing and Medicine

Chapter		Action / Stage Information
[18 VAC 90 - 30]	Regulations Governing the Licensure of Nurse Practitioners	Unprofessional conduct/conversion therapy [Action 5441] Proposed - *Register Date: 2/15/21* *Board of Nursing adopted final: 5/18/21* *Board of Medicine to adopt final: 6/24/21*
[18 VAC 90 - 40]	Regulations for Prescriptive Authority for Nurse Practitioners	Waiver for electronic prescribing [Action 5413] Proposed - *Register Date: 5/10/21* *Board of Medicine to adopt final: 6/24/21* *Board of Nursing to adopt final: 7/20/21*

B2

Department of Health Professions – Joint Boards
Regulatory/Policy Actions – 2021 General Assembly

EXEMPT REGULATORY ACTIONS

Legislative source	Mandate	Promulgating agency	Adoption date	Effective date
HB1737	Revise autonomous practice reg consistent with 2 years	Nursing & Medicine	N – 7/20/21 M – 8/6/21	
HB1747	Licensure of CNS as nurse practitioners – Amend Chapters 30 and 40 Delete sections of Chapter 20 with reference to registration of CNS	Nursing & Medicine	N – 7/20/21 M – 8/6/21	
HB1817	Autonomous practice for CNMs with 1,000 hours	Nursing & Medicine	N – 7/20/21 M – 8/6/21	

APA REGULATORY ACTIONS

Legislative source	Mandate	Promulgating agency	Adoption date	Effective date
HB1953	Licensure of certified midwives	Nursing & Medicine	NOIRA Nursing – 7/20/21 Medicine – 8/6/21	Unknown

NON-REGULATORY ACTIONS

Legislative source	Affected agency	Action needed	Due date
HB1747	Nursing	Notification to registered certified nurse specialists that they must have a practice agreement with a physician before licensure as a nurse practitioner as of July 1, 2021	After March 31, 2021
HB793 (2018)	Medicine & Nursing	To report data on the number of nurse practitioners who have been authorized to practice without a practice agreement, the geographic and specialty areas in which nurse practitioners are practicing without a practice agreement, and any complaints or disciplinary actions taken against such nurse practitioners, along with any recommended modifications to the requirements of this act including any modifications to the clinical experience requirements for practicing without a practice agreement	November 1, 2021
SB431	Behavioral health/medicine/legal	Continuance of study of mental health services to minors and access to records *Requested an extension of 2020 study*	November 1, 2021
Budget bill	Department	To study and make recommendations regarding the oversight and regulation of advanced practice registered nurses (APRNs). The department shall review recommendations of the National Council of State Boards of Nursing, analyze the oversight and regulations governing the practice of APRNs in other states, and	November 1, 2021

		review research on the impact of statutes and regulations on practice and patient outcomes.	
HB1953	Department	To convene a work group to study and report on the licensure and regulation of certified nurse midwives, certified midwives, and certified professional midwives to determine the appropriate licensing entity for such professionals.	November 1, 2021
HB1987	Boards with prescriptive authority	Revise guidance documents with references to 54.1-3303	As boards meet after July 1
HB2079	Pharmacy (with Medicine & VDH)	To establish protocols for the initiation of treatment with and dispensing and administering of drugs, devices, controlled paraphernalia, and supplies and equipment available over-the-counter by pharmacists in accordance with § **54.1-3303.1**. Such protocols shall address training and continuing education for pharmacists regarding the initiation of treatment with and dispensing and administering of drugs, devices, controlled paraphernalia, and supplies and equipment.	Concurrent with emergency regulations
HB2079	Pharmacy (with Medicine & VDH)	To convene a work group to provide recommendations regarding the development of protocols for the initiation of treatment with and dispensing and administering of drugs, devices, controlled paraphernalia, and supplies and equipment by pharmacists to persons 18 years of age or older, including (i) controlled substances, devices, controlled paraphernalia, and supplies and equipment for the treatment of diseases or conditions for which clinical decision-making can be guided by a clinical test that is classified as waived under the federal Clinical Laboratory Improvement Amendments of 1988, including influenza virus, urinary tract infection, and group A Streptococcus bacteria, and (ii) drugs approved by the U.S. Food and Drug Administration for tobacco cessation therapy, including nicotine replacement therapy. The work group shall focus its work on developing protocols that can improve access to these treatments while maintaining patient safety.	November 1, 2021

Future Policy Actions:

HB2559 (2019) - requires the Secretary of Health and Human Resources to convene a work group to identify successes and challenges of the electronic prescription requirement and offer possible recommendations for increasing the electronic prescribing of controlled substances that contain an opioid and to report to the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health by November 1, 2022.

B3

Agenda Item:

Regulatory Actions – Adoption of Exempt Regulations pursuant to 2021 legislation

Included in agenda package:

Copy of HB1737 – Practice of NPs without practice agreement
Copy of HB1817 – Practice of CNMs without practice agreement
Copy of HB1747 – Practice of CNSs as nurse practitioners

Draft regulations for Licensure of Nurse Practitioners (Chapter 30) and Prescriptive Authority for Nurse Practitioners (Chapter 40)

Action by Committee of Joint Boards: To recommend adoption of changes to Chapters 30 and 40 to conform to changes in the Code of Virginia

VIRGINIA ACTS OF ASSEMBLY -- 2021 SPECIAL SESSION I

CHAPTER 1

An Act to amend and reenact § 54.1-2957 of the Code of Virginia, relating to nurse practitioners; practice without a practice agreement.

[H 1737]

Approved February 25, 2021

Be it enacted by the General Assembly of Virginia:

1. That § 54.1-2957 of the Code of Virginia is amended and reenacted as follows:

§ 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.

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

C. Every nurse practitioner 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. 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 is a certified registered nurse ~~anesthetists~~ *anesthetist* shall practice under the supervision of a licensed doctor of medicine, osteopathy, podiatry, or dentistry. A nurse practitioner who is appointed as a medical 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.

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 Boards of Medicine and 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 provisions for (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, 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~~ *two* 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 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~~ *two* 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.

2. That the provisions of this act shall expire on July 1, 2022.

CHAPTER 396

An Act to amend and reenact §§ 54.1-2957, 54.1-2957.01, and 54.1-2957.03 of the Code of Virginia, relating to practice of certified nurse midwives.

[H 1817]

Approved March 25, 2021

Be it enacted by the General Assembly of Virginia:

1. That §§ 54.1-2957, 54.1-2957.01, and 54.1-2957.03 of the Code of Virginia are amended and reenacted as follows:

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

A. As used in this section~~:~~,

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

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

C. Every nurse practitioner 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. 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 is a~~ certified registered nurse ~~anesthetists~~ *anesthetist* shall practice under the supervision of a licensed doctor of medicine, osteopathy, podiatry, or dentistry. A nurse practitioner who is appointed as a medical 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.

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 Boards of Medicine and 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 provisions for (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, 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 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~~ *Every* 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~~ *accordance with* regulations~~,~~ *adopted by the Boards and* consistent with the Standards for the Practice of Midwifery set by the American College of Nurse-Midwives~~,~~ governing such practice. *A certified nurse midwife who has practiced fewer than 1,000 hours shall practice in consultation with a certified nurse midwife who has practiced for at least two years prior to entering into the practice agreement or a licensed physician, in accordance with a practice agreement. Such practice agreement shall address the availability of the certified nurse midwife who has practiced for at least two years prior to entering into the practice agreement or the licensed physician for routine and urgent consultation on patient care. Evidence of the practice agreement shall be maintained by the certified nurse midwife and provided to the Boards upon request. A certified nurse midwife who has completed 1,000 hours of practice as a certified nurse midwife may practice without a practice agreement upon receipt by the certified nurse midwife of an attestation from the certified nurse midwife who has practiced for at least two years prior to entering into the practice agreement or the licensed physician with whom the certified nurse midwife has entered into a practice agreement stating (i) that such certified nurse midwife or licensed physician has provided consultation to the certified nurse midwife pursuant to a practice agreement meeting the requirements of this section and (ii) the period of time for which such certified nurse midwife or licensed physician practiced in collaboration and consultation with the certified nurse midwife pursuant to the practice agreement. A certified nurse midwife authorized to practice without a practice agreement shall consult and collaborate with and refer patients to such other health care providers as may be appropriate for the care of the patient.*

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 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.).

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 Boards of Medicine and Nursing such evidence as 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 be signed by the patient care team physician or shall clearly state the name of the patient care team physician who has entered into the practice agreement with the nurse practitioner.

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 Boards of Medicine and Nursing shall promulgate regulations governing the prescriptive authority of nurse practitioners as are deemed reasonable and necessary to ensure an appropriate standard of care for patients. Such regulations shall include 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 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 Medicine and Nursing in the category of certified nurse midwife and holding a license for prescriptive authority may prescribe ~~(i)~~ Schedules II through ~~V~~ *VI* controlled substances. *However, if the nurse practitioner licensed by the Boards of Medicine and Nursing in the category of certified nurse midwife is required, pursuant to subsection H of § 54.1-2957, to practice pursuant to a practice agreement, such prescribing shall also be* in accordance with any prescriptive authority included in ~~a~~ *such* 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~~.

H. Notwithstanding any provision of law or regulation to the contrary, a nurse practitioner licensed by the Boards of Medicine and Nursing as a certified registered nurse anesthetist shall have the authority to prescribe Schedule II through Schedule VI controlled substances and devices in accordance with the requirements for practice set forth in subsection C of § 54.1-2957 to a patient requiring anesthesia, as part of the periprocedural care of such patient. As used in this subsection, "periprocedural" means the period beginning prior to a procedure and ending at the time the patient is discharged.

§ 54.1-2957.03. Certified nurse midwives; required disclosures; liability.

A. As used in this section, "birthing center" means a facility outside a hospital that provides maternity services.

B. A certified nurse midwife who provides health care services to a patient outside of a hospital or birthing center shall disclose to that patient, when appropriate, information on health risks associated with births outside of a hospital or birthing center, including but not limited to risks associated with

vaginal births after a prior cesarean section, breech births, births by women experiencing high-risk pregnancies, and births involving multiple gestation.

C. ~~The~~ *A* certified nurse midwife who ~~provided~~ *provides* health care to a patient shall be liable for the midwife's negligent, grossly negligent, or willful and wanton acts or omissions. Except as otherwise provided by law, any (i) doctor of medicine or osteopathy who did not collaborate or consult with the midwife regarding the patient and who has not previously treated the patient for this pregnancy, (ii) *physician assistant, (iii)* nurse *practitioner*, ~~(iii)~~ *(iv)* prehospital emergency medical personnel, or ~~(iv)~~ *(v)* hospital as defined in § 32.1-123, or ~~agents thereof, who~~ *any employee of, person providing services pursuant to a contract with, or agent of such hospital, that* provides screening and stabilization health care services to a patient as a result of a certified nurse midwife's negligent, grossly negligent, or willful and wanton acts or omissions, shall be immune from liability for acts or omissions constituting ordinary negligence.

2. That any certified nurse midwife who has practiced as a certified nurse midwife in the Commonwealth for at least 1,000 hours, as determined by the Boards of Medicine and Nursing, prior to the effective date of this act shall be deemed to have met the requirements of subsection H of § 54.1-2957 of the Code of Virginia, as amended by this act, related to requirements for practice as a certified nurse midwife without a practice agreement and shall be eligible to practice as a certified nurse midwife in the Commonwealth without a practice agreement.

CHAPTER 157

An Act to amend and reenact §§ 54.1-2900, 54.1-2901, 54.1-2957, 54.1-2957.01, and 54.1-3000 of the Code of Virginia and to repeal § 54.1-3018.1 of the Code of Virginia, relating to clinical nurse specialist; licensure by the Boards of Medicine and Nursing.

[H 1747]

Approved March 18, 2021

Be it enacted by the General Assembly of Virginia:

1. That §§ 54.1-2900, 54.1-2901, 54.1-2957, 54.1-2957.01, and 54.1-3000 of the Code of Virginia are amended and reenacted as follows:

§ 54.1-2900. Definitions.

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

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

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

"Birth control" means contraceptive methods that are approved by the U.S. Food and Drug Administration. "Birth control" shall not be considered abortion for the purposes of Title 18.2.

"Board" means the Board of Medicine.

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

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

"Clinical nurse specialist" means an advance practice registered nurse who is certified in the specialty of clinical nurse specialist and who is jointly licensed by the Boards of Medicine and Nursing as a nurse practitioner pursuant to § 54.1-2957.

"Collaboration" means the communication and decision-making process among health care providers who are members of a patient care team related to the treatment of a patient that includes the degree of cooperation necessary to provide treatment and care of the patient and includes (i) communication of data and information about the treatment and care of a patient, including the 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 communicating data and information, exchanging clinical observations and assessments, accessing and assessing additional resources and expertise, problem-solving, and arranging for referrals, testing, or studies.

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

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

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

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

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

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

practice of occupational therapy.

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

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

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

"Physician assistant" means a health care professional who has met the requirements of the Board for licensure as a physician assistant.

"Practice of acupuncture" means the stimulation of certain points on or near the surface of the body by the insertion of needles to prevent or modify the perception of pain or to normalize physiological functions, including pain control, for the treatment of certain ailments or conditions of the body and includes the techniques of electroacupuncture, cupping and moxibustion. The practice of acupuncture does not include the use of physical therapy, chiropractic, or osteopathic manipulative techniques; the use or prescribing of any drugs, medications, serums or vaccines; or the procedure of auricular acupuncture as exempted in § 54.1-2901 when used in the context of a chemical dependency treatment program for patients eligible for federal, state or local public funds by an employee of the program who is trained and approved by the National Acupuncture Detoxification Association or an equivalent certifying body.

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

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

"Practice of chiropractic" means the adjustment of the 24 movable vertebrae of the spinal column, and assisting nature for the purpose of normalizing the transmission of nerve energy, but does not include the use of surgery, obstetrics, osteopathy, or the administration or prescribing of any drugs, medicines, serums, or vaccines. "Practice of chiropractic" shall include (i) requesting, receiving, and reviewing a patient's medical and physical history, including information related to past surgical and nonsurgical treatment of the patient and controlled substances prescribed to the patient, and (ii) documenting in a patient's record information related to the condition and symptoms of the patient, the examination and evaluation of the patient made by the doctor of chiropractic, and treatment provided to the patient by the doctor of chiropractic. "Practice of chiropractic" shall also include performing the physical examination of an applicant for a commercial driver's license or commercial learner's permit pursuant to § 46.2-341.12 if the practitioner has (i) applied for and received certification as a medical examiner pursuant to 49 C.F.R. Part 390, Subpart D and (ii) registered with the National Registry of Certified Medical Examiners.

"Practice of genetic counseling" means (i) obtaining and evaluating individual and family medical histories to assess the risk of genetic medical conditions and diseases in a patient, his offspring, and other family members; (ii) discussing the features, history, diagnosis, environmental factors, and risk management of genetic medical conditions and diseases; (iii) ordering genetic laboratory tests and other diagnostic studies necessary for genetic assessment; (iv) integrating the results with personal and family medical history to assess and communicate risk factors for genetic medical conditions and diseases; (v) evaluating the patient's and family's responses to the medical condition or risk of recurrence and providing client-centered counseling and anticipatory guidance; (vi) identifying and utilizing community resources that provide medical, educational, financial, and psychosocial support and advocacy; and (vii) providing written documentation of medical, genetic, and counseling information for families and health care professionals.

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

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

functional performance; vocational evaluation and training; and consultation concerning the adaptation of physical, sensory, and social environments.

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

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

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

"Practice of surgical assisting" means the performance of significant surgical tasks, including manipulation of organs, suturing of tissue, placement of hemostatic agents, injection of local anesthetic, harvesting of veins, implementation of devices, and other duties as directed by a licensed doctor of medicine, osteopathy, or podiatry under the direct supervision of a licensed doctor of medicine, osteopathy, or podiatry.

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

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

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

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

"Respiratory care" means the practice of the allied health profession responsible for the direct and

indirect services, including inhalation therapy and respiratory therapy, in the treatment, management, diagnostic testing, control, and care of patients with deficiencies and abnormalities associated with the cardiopulmonary system under qualified medical direction.

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

§ 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 accordance with the provisions of §§ 54.1-2957 and 54.1-2957.01 ~~or~~, any nurse practitioner licensed by the Boards of Medicine and Nursing in the category of certified nurse midwife practicing pursuant to subsection H of § 54.1-2957, *or any nurse practitioner licensed by the Boards of Medicine and Nursing in the category of clinical nurse specialist practicing pursuant to subsection J of § 54.1-2957* when such services are authorized by regulations promulgated jointly by the Boards of Medicine and Nursing;

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

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

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

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

8. The domestic administration of family remedies;

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

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

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

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

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

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

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

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

17. The performance of the duties of any active duty health care provider in active service in the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

competing;

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

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

B. Notwithstanding any provision of law or regulation to the contrary, military medical personnel, as defined in § 2.2-2001.4, while participating in a 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 or the chief medical officer of an organization participating in such program, or his designee who is a licensee of the Board and supervising within his scope of practice.

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

A. As used in this section:

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

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

C. Every nurse practitioner 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 clinical nurse specialist* 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. 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 is licensed by the Boards of Medicine and Nursing as a clinical nurse specialist shall practice pursuant to subsection J.* A nurse practitioner who is a certified registered nurse ~~anesthetists~~ *anesthetist* shall practice under the supervision of a licensed doctor of medicine, osteopathy, podiatry, or dentistry. A nurse practitioner who is appointed as a medical 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.

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 Boards of Medicine and 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 provisions for (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, 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 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, *or clinical nurse specialist*, 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.

J. Nurse practitioners licensed by the Boards of Medicine and Nursing in the category of clinical nurse specialist 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 practice of clinical nurse specialists shall be consistent with the standards of care for the profession and with applicable laws and regulations.

§ 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 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.).

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 Boards of Medicine and Nursing such evidence as 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 be signed by the patient care team physician or shall clearly state the name of the patient care team physician who has entered into the practice agreement with the nurse practitioner.

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 Boards of Medicine and Nursing shall promulgate regulations governing the prescriptive authority of nurse practitioners as are deemed reasonable and necessary to ensure an appropriate standard of care for patients. Such regulations shall include 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 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 Medicine and Nursing in the category of certified nurse midwife *or clinical nurse specialist* 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 *or J* of § 54.1-2957 and (ii) Schedule VI controlled substances without the requirement for inclusion of such prescriptive authority in a practice agreement.

H. Notwithstanding any provision of law or regulation to the contrary, a nurse practitioner licensed by the Boards of Medicine and Nursing as a certified registered nurse anesthetist shall have the authority to prescribe Schedule II through Schedule VI controlled substances and devices in accordance with the requirements for practice set forth in subsection C of § 54.1-2957 to a patient requiring anesthesia, as part of the periprocedural care of such patient. As used in this subsection, "periprocedural" means the period beginning prior to a procedure and ending at the time the patient is discharged.

§ 54.1-3000. Definitions.

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

"Advanced practice registered nurse" means a registered nurse who has completed an advanced graduate-level education program in a specialty category of nursing and has passed a national certifying examination for that specialty.

"Board" means the Board of Nursing.

"Certified nurse aide" means a person who meets the qualifications specified in this article and who is currently certified by the Board.

~~"Clinical nurse specialist" means an advanced practice registered nurse who meets the requirements set forth in § 54.1-3018.1 and who is currently registered by the Board. Such a person shall be recognized as being able to provide advanced services according to the specialized training received from a program satisfactory to the Board, but shall not be entitled to perform any act that is not within the scope of practice of professional nursing.~~

"Massage therapist" means a person who meets the qualifications specified in this chapter and who is currently licensed by the Board.

"Massage therapy" means the treatment of soft tissues for therapeutic purposes by the application of massage and bodywork techniques based on the manipulation or application of pressure to the muscular structure or soft tissues of the human body. The term "massage therapy" does not include the diagnosis

or treatment of illness or disease or any service or procedure for which a license to practice medicine, nursing, midwifery, chiropractic, physical therapy, occupational therapy, acupuncture, athletic training, or podiatry is required by law or any service described in subdivision A 18 of § 54.1-3001.

"Massage therapy" shall not include manipulation of the spine or joints.

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

"Practical nurse" or "licensed practical nurse" means a person who is licensed or holds a multistate licensure privilege under the provisions of this chapter to practice practical nursing as defined in this section. Such a licensee shall be empowered to provide nursing services without compensation. The abbreviation "L.P.N." shall stand for such terms.

"Practical nursing" or "licensed practical nursing" means the performance for compensation of selected nursing acts in the care of individuals or groups who are ill, injured, or experiencing changes in normal health processes; in the maintenance of health; in the prevention of illness or disease; or, subject to such regulations as the Board may promulgate, in the teaching of those who are or will be nurse aides. Practical nursing or licensed practical nursing requires knowledge, judgment and skill in nursing procedures gained through prescribed education. Practical nursing or licensed practical nursing is performed under the direction or supervision of a licensed medical practitioner, a professional nurse, registered nurse or registered professional nurse or other licensed health professional authorized by regulations of the Board.

"Practice of a nurse aide" or "nurse aide practice" means the performance of services requiring the education, training, and skills specified in this chapter for certification as a nurse aide. Such services are performed under the supervision of a dentist, physician, podiatrist, professional nurse, licensed practical nurse, or other licensed health care professional acting within the scope of the requirements of his profession.

"Professional nurse," "registered nurse" or "registered professional nurse" means a person who is licensed or holds a multistate licensure privilege under the provisions of this chapter to practice professional nursing as defined in this section. Such a licensee shall be empowered to provide professional services without compensation, to promote health and to teach health to individuals and groups. The abbreviation "R.N." shall stand for such terms.

"Professional nursing," "registered nursing" or "registered professional nursing" means the performance for compensation of any nursing acts in the observation, care and counsel of individuals or groups who are ill, injured or experiencing changes in normal health processes or the maintenance of health; in the prevention of illness or disease; in the supervision and teaching of those who are or will be involved in nursing care; in the delegation of selected nursing tasks and procedures to appropriately trained unlicensed persons as determined by the Board; or in the administration of medications and treatments as prescribed by any person authorized by law to prescribe such medications and treatment. Professional nursing, registered nursing and registered professional nursing require specialized education, judgment, and skill based upon knowledge and application of principles from the biological, physical, social, behavioral and nursing sciences.

2. That § 54.1-3018.1 of the Code of Virginia is repealed.

3. That the Boards of Medicine and Nursing shall jointly issue a license to practice as a nurse practitioner without prescriptive authority in the category of clinical nurse specialist to an applicant who is an advance practice registered nurse who has completed an advanced graduate-level education program in the specialty category of clinical nurse specialist and who is registered by the Board of Nursing as a clinical nurse specialist on July 1, 2021. A clinical nurse specialist may be granted prescriptive authority upon submission of satisfactory evidence of qualification as set forth in regulations of the Boards of Medicine and Nursing.

Commonwealth of Virginia

REGULATIONS

GOVERNING THE LICENSURE OF NURSE PRACTITIONERS

VIRGINIA BOARD OF NURSING
VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18 VAC 90-30-10 et seq.

Statutory Authority: §§ 54.1-2400 and 54.1-2957 of the *Code of Virginia*

Revised Date:

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PART I. GENERAL PROVISIONS.

18VAC90-30-10. Definitions.

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

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

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

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

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

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

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

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

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

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

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

"National certifying body" means a national organization that is accredited by an accrediting agency recognized by the U.S. Department of Education or deemed acceptable by the National Council of State Boards of Nursing and has as one of its purposes the certification of nurse

anesthetists, nurse midwives, clinical nurse specialists, or nurse practitioners, referred to in this chapter as professional certification, and whose certification of such persons by examination is accepted by the committee.

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

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

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); and
11. Clinical nurse specialist (19).

B. Other categories of licensed nurse practitioners shall be licensed if the Committee of the Joint Boards of Nursing and Medicine determines that the category meets the requirements of this chapter.

C. Nurse practitioners licensed prior to January 15, 2016, may:

1. Retain the specialty category in which they were initially licensed; or

2. If the specialty category has been subsequently deleted and if qualified by certification, be issued a license in a specialty category listed in subsection A of this section that is consistent with such certification.

18VAC90-30-86. Autonomous practice for nurse practitioners other than certified nurse midwives, ~~or~~ certified registered nurse anesthetists, or clinical nurse specialists.

A. A nurse practitioner with a current, unrestricted license, other than someone licensed in the category of certified nurse midwife, ~~or~~ certified registered nurse anesthetist, or clinical nurse specialist, may qualify for autonomous practice by completion of the equivalent of ~~five~~ two years of full-time clinical experience as a nurse practitioner until July 1, 2022. Thereafter, the requirement shall be the equivalent of five years of full-time clinical experience to qualify for autonomous practice.

1. ~~Five years of full-time~~ Full-time clinical experience shall be defined as 1,800 hours per year ~~for a total of 9,000 hours~~.

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

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

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

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

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

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

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

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

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

G. A nurse practitioner authorized to practice autonomously shall:

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

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

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

18VAC90-30-87. Autonomous practice for nurse practitioners licensed as certified nurse midwives.

A. A certified nurse midwife who has completed 1,000 hours of practice as a certified nurse midwife may practice without a practice agreement upon receipt by the certified nurse midwife of an attestation from a certified nurse midwife who has practiced for at least two years prior to entering into the practice agreement or the licensed physician with whom the certified nurse midwife has entered into a practice agreement stating (i) that such certified nurse midwife or licensed physician has provided consultation to the certified nurse midwife pursuant to a practice agreement meeting the requirements of § 54.1-2957 H of the Code of Virginia, and (ii) the period of time for which such certified nurse midwife or licensed physician practiced in collaboration and consultation with the certified nurse midwife pursuant to the practice agreement.

B. A certified nurse midwife authorized to practice without a practice agreement shall consult and collaborate with and refer patients to such other health care providers as may be appropriate for the care of the patient.

PART III. PRACTICE OF LICENSED NURSE PRACTITIONERS.

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

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

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

C. All nurse practitioners licensed in any category other than certified registered nurse anesthetist, ~~or~~ certified nurse midwife, or clinical nurse specialist shall practice in accordance with a written or

electronic practice agreement as defined in 18VAC90-30-10 or in accordance with 18VAC90-30-86.

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

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

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

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

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

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

c. Not in conflict with federal law or regulation.

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

18VAC90-30-123. Practice of nurse practitioners licensed as certified nurse midwives.

A. A nurse practitioner licensed in the category of certified nurse midwife who has practiced fewer than 1,000 hours shall practice in consultation with a licensed physician in accordance with a practice agreement between the nurse practitioner and the physician or with a certified nurse midwife who has practiced for at least two years prior to entering into the practice agreement. Such practice agreement shall address the availability of the physician or the certified nurse midwife for routine and urgent consultation on patient care.

B. The practice agreement shall be maintained by the nurse midwife and provided to the boards upon request. For nurse midwives providing care to patients within a hospital or health care system, the practice agreement may be included as part of documents delineating the nurse midwife's clinical privileges or the electronic or written delineation of duties and responsibilities; however, the nurse midwife shall be responsible for providing a copy to the boards upon request.

C. A nurse practitioner licensed in the category of a certified nurse midwife shall practice in accordance with the Standards for the Practice of Midwifery (Revised 2011) defined by the American College of Nurse-Midwives.

18VAC90-30-123.1. Practice of nurse practitioners licensed as clinical nurse specialists.

A. Nurse practitioners licensed in the category of clinical nurse specialist shall practice in consultation with a licensed physician in accordance with a practice agreement between the nurse practitioner and the licensed physician.

B. 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.

C. The practice of clinical nurse specialists shall be consistent with the standards of care for the profession and with applicable laws and regulations.

Commonwealth of Virginia

REGULATIONS
FOR
PRESCRIPTIVE AUTHORITY FOR NURSE PRACTITIONERS

VIRGINIA BOARD OF NURSING
VIRGINIA BOARD OF MEDICINE

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

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

Revised Date:

9960 Mayland Drive, Suite 300
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Part I. General Provisions.

18VAC90-40-10. Definitions.

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

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

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

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

"Chronic pain" means nonmalignant pain that goes beyond the normal course of a disease or condition for which controlled substances containing an opioid may be prescribed for a period greater than three months.

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

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

"FDA" means the U.S. Food and Drug Administration.

"MME" means morphine milligram equivalent.

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

"Nurse practitioner" means an advanced practice registered nurse who has met the requirements for licensure as a nurse practitioner as stated in 18VAC90-30.

"Practice agreement" means a written or electronic agreement jointly developed by the patient care team physician and the nurse practitioner for the practice of the nurse practitioner that also describes the prescriptive authority of the nurse practitioner, if applicable. For a nurse practitioner licensed in the category of certified nurse midwife, the practice agreement is a statement jointly developed with the consulting physician or a certified nurse midwife with at least two years of clinical experience. For a nurse practitioner licensed in the category of clinical nurse specialist, the practice agreement shall be between the nurse practitioner and a consulting physician.

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

"SAMHSA" means the federal Substance Abuse and Mental Health Services Administration.

18VAC90-40-90. Practice agreement.

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

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

C. The practice agreement shall contain the following:

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

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

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

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

E. Exceptions.

1. A nurse practitioner licensed in the category of certified nurse midwife and holding a license for prescriptive authority may prescribe in accordance with a written or electronic practice agreement with a consulting physician ~~or may prescribe Schedule VI controlled substances without the requirement for inclusion of such prescriptive authority in a practice agreement~~ or with a certified nurse midwife who has practiced for at least two years prior to entering into a practice agreement. A nurse practitioner in the category of certified nurse midwife who has qualified for autonomous practice as set forth in 18VAC90-30-87 may prescribe without a practice agreement.

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

~~2.~~ 3. A nurse practitioner who is licensed in a category other than certified nurse midwife, ~~or~~ certified registered nurse anesthetist, or clinical nurse specialist, and who has met the qualifications for autonomous practice as set forth in 18VAC90-30-86 may prescribe without a practice agreement with a patient care team physician.

COMMONWEALTH of VIRGINIA

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Virginia Board of Nursing
Jay P. Douglas, MSM, RN, CSAC, FRE
Executive Director

Board of Nursing (804) 367-4515
www.dhp.virginia.gov/Boards/nursing

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

From: Jay P. Douglas, Executive Director, Board of Nursing

Date: June 16, 2021

Subject: 2022 Meeting Dates

Wednesday, February 16, 2022	9:00 AM	Board room 2
Wednesday, April 20, 2022	9:00 AM	Board room 2
Wednesday, June 15, 2022	9:00 AM	Board room 4
Wednesday, October 12, 2022	9:00 AM	Board room 2
Wednesday, December 7 or 14, 2022	9:00 AM	**No room avail as of 5/21/22**

Please note business meetings will be scheduled from 9:00 AM to 12:00 P.M. Disciplinary proceedings will be scheduled following the meeting if there are cases to schedule.

cc: Charis Mitchell
Erin Barrett
William Harp
Elaine Yeatts
Jim Banning
Julia Bennett
Anne Joseph

Guidance document: 90-56

Practice Agreement Requirements for Licensed Nurse Practitioners

Adopted by the Board of Nursing – March 21, 2017
Adopted by the Board of Medicine – February 16, 2017

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

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

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

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

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

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

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

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

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

- Categories of drugs and devices that may be prescribed, if prescribing Schedule II through V drugs;
- Guidelines for availability and ongoing communications that provide for and define consultation and the availability of the physician for routine and urgent consultation on patient care;
- Provisions for periodic review and revision of the practice agreement; and
- Written or electronic signature of the CNM(s) and the physician(s) who has entered into the agreement.

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

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

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

The LNP is required to:

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

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

Guidance document: 90-56

Practice Agreement Requirements for Licensed Nurse Practitioners

Adopted by the Board of Nursing – ~~March 21, 2017~~
Adopted by the Board of Medicine – ~~February 16, 2017~~

KEY POINTS:

- Certified Registered Nurse Anesthetist ("CRNA") – A practice agreement is **not** required for nurse practitioners licensed in the category of CRNA. The CRNA practices under the supervision of a licensed doctor of medicine, osteopathy, podiatry, or dentistry.
- Certified Nurse Midwife ("CNM") - A practice agreement is required with either a CNM who has practiced for at least two years or a licensed physician for nurse practitioners licensed in the category of CNM prior to completion of 1,000 practice hours.
- Clinical Nurse Specialist ("CNS") – A practice agreement with a licensed physician is required for nurse practitioners licensed in the category of CNS.
- Nurse Practitioner ("NP") – A practice agreement with a patient care team physician is required for nurse practitioners other than a CNM, CRNA, or CNS with less than 2 years of clinical experience.
- Nurse practitioners who are required to have a practice agreement are responsible for maintaining the practice agreement and making it available for review by the Board of Nursing upon request.
- Practice agreements do **not** need to be submitted to the Board of Nursing to obtain or renew the professional license.

FURTHER STATUTORY DETAILS :

CNM - §§ 54.1-2957(H) and 54.1-2957.01(G)

A CNM who has practiced fewer than 1,000 hours shall practice in consultation through a practice agreement with a CNM who has practiced for at least two years prior to entering into the practice agreement or a licensed physician.

- The practice agreement shall address the availability of the consulting CNM or the licensed physician for routine and urgent consultation on patient care.
- If the CNM will prescribe, the practice agreement shall include the parameters of such prescribing of Schedules II through VI controlled substances.

Requirements for CNM autonomous practice can be found in **§ 54.1-2957(H)**

CNS - §§ 54.1-2957(J) and 54.1-2957.01(G)

A CNS shall practice in consultation with a licensed physician in accordance with a practice agreement

- The practice agreement shall address the availability of the physician for routine and urgent consultation on patient care.
- If the CNS will prescribe, the practice agreement shall include the parameters of such prescribing of Schedules II through V controlled substances.
- Inclusion of the prescribing of Schedule VI controlled substances is not required in the practice agreement.

NOTE: There are no conditions in Virginia Code under which a CNS may practice without a practice agreement

NP - §§ 54.1-2957(C) & (D) and 54.1-2957.01(B)

An NP not qualified for autonomous practice shall maintain appropriate collaboration and consultation with at least one patient care team physician, as evidenced in a written or electronic practice agreement which is periodically reviewed and revised. The practice agreement shall include:

- Provisions for the periodic review of health records by the patient care team physician and may include provisions for visits to the site where health care is delivered in the manner and at the frequency determined by the patient care team;
- Provisions for appropriate input from health care providers in complex clinical cases and patient emergencies and for referrals;
- Categories of drugs and devices that may be prescribed;
- Guidelines for availability and ongoing communications that provide for and define consultation among the collaborating parties and the patient;
- Provisions for periodic joint evaluation of services provided;
- Provisions for periodic review and revision of the practice agreement; and
- The signature of the patient care team physician or the name of the patient care team physician clearly stated.

Requirements for NP autonomous practice can be found in **§ 54.1-2957(I)**

Virginia Nurse Practitioner Side-by-Side Comparison

	NP	CRNA	CNM	CNS
Joint licensure by BON & BOM *§ 54.1-2900*	Yes	Yes	Yes	Yes
Collaboration/ Consultation/ Supervision requirement *§ 54.1-2957(C), (H), (J)*	Collaboration and consultation with at least one licensed patient care team physician unless the practitioner has been granted an autonomous practice designation.	Under supervision of a licensed doctor of medicine, osteopathy, podiatry, or dentistry.	Consultation with a certified nurse midwife who has practiced for at least two years **or** a licensed physician until CNM has practiced for 1,000 hours.	Consultation with licensed physician
Practice Agreement § 54.1-2957(C), (H), (J)	Yes, if no autonomous practice designation	No	Yes, prior to completion of 1,000 hours and receipt of attestation of completion from CNM or physician	Yes
Practice Agreement Criteria *§ 54.1-2957(D), (H), (J)* *§ 54.1-2957.01(G)*	-Shall include provisions for periodic review of health records -input from appropriate health care providers in complex clinical cases and patient emergencies and for referrals. See Virginia Code § 54.1-2957 for specifics. See also Guidance Document 90-56.	N/A	--Shall address the availability of the consulting CNM or the licensed physician for routine and urgent consultation on patient care --prescribing shall also be in accordance with any prescriptive authority included in a such practice agreement	--Shall address the availability of the physician for routine and urgent consultation on patient care. --Medications if prescribing Schedule II-V
Autonomous Practice *§ 54.1-2957(C), (H)*	Yes, if granted autonomous practice designation	No	Yes, if CNM receives attestation from CNM or physician at completion of 1,000 hours	No
Rx authority *§ 54.1-295701(A)*	Schedule II – VI	Schedule II – VI*	Schedule II – VI	Schedule II – VI**

* May prescribe to a patient requiring anesthesia, as part of the periprocedural care of such patient. "Periprocedural" means the period beginning prior to a procedure and ending at the time the patient is discharged (§ 54.1-2957.01(H))

** CNSs may be granted prescriptive authority upon submission of evidence of qualification (HB1747 Enactment Clause #3)

EMAIL TO: [All CNSs on May 27, 2021]

Subject: IMPORTANT MESSAGE from Jay Douglas, Executive Director of the Virginia Board of Nursing, on behalf of the Joint Boards of Nursing and Medicine, Virginia Department of Health Professions

HB1747 Clinical Nurse Specialists (CNSs) Jointly licensed by Boards of Nursing and Medicine as Nurse Practitioners (LNPs)

On March 18, 2021, Governor Northam signed into law HB 1747 which repeals § 54.1-3018.1 and amends §§ 54.1-2900, 54.1-2901, 54.1-2957, 54.1-2957.01 of the Virginia Code affecting the licensure and practice of CNSs as follows:

1) CNSs as Licensed Nurse Practitioners (LNPs):
    a. On July 1, 2021, CNSs currently registered by the Board of Nursing and who have completed an advanced graduate-level education CNS program will be jointly licensed by the Boards of Nursing and Medicine to practice as a nurse practitioner without prescriptive authority (RX Authority).
    b. All eligible current active Clinical Nurse Specialists registered by the Board of Nursing will be issued a new Nurse Practitioner license in the category of clinical nurse specialist (#0024) which may be verified through License Lookup.

2) Practice Agreement Requirement
    a. On July 1, 2021, all CNSs (whether they have prescriptive authority or not – see #3 below) will be required to practice in consultation with a licensed physician in accordance with a practice agreement between the CNS and the licensed physician.
    b. The practice agreement must address the availability of the physician for routine and urgent consultation on patient care as well as Schedule II-V drugs, if applicable.
    c. The practice agreement will be maintained by the CNS and only provided to the Boards upon request.

3) CNS Prescriptive Authority
    a. A CNS may be granted RX Authority upon submission of satisfactory evidence of qualification as set forth in regulations of the Boards of Medicine and Nursing.
    b. CNSs may prescribe
        i. Schedules II through V controlled substances in accordance with any prescriptive authority included in a practice agreement

ii. Schedule VI controlled substances without the requirement for inclusion of such prescriptive authority in a practice agreement.

c. Submissions of evidence qualifying a CNS for RX Authority will be accepted on or after July 1st and thereafter using the following procedure:
   i. To add RX Authority to your new Nurse Practitioner license, submit a completed paper application along with the $35 application fee to the Board of Nursing after July 1, 2021. Click here for the Nurse Practitioner Application Instruction Checklist (see page 2) for the requirements to add RX Authority to your new Nurse Practitioner license, which is also posted on the Board of Nursing webpage.
   ii. The qualifications for initial approval of prescriptive authority are found in 18VAC90-40-40 of the Regulations for Prescriptive Authority for Nurse Practitioners
   iii. Once an RX Authority application is approved, RX Authority will be clearly designated as a 'specialization' on your LNP record and in License Lookup.

C4

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June 7, 2021

Jay P. Douglas
Executive Director, Virginia Board of Nursing
9960 Mayland Drive Suite 300
Henrico, Virginia 23233

Re: Request Waiver to CNS Practice Agreement Requirement

Dear Ms. Douglas,

We are writing to request a waiver for Sentara Clinical Nurse Specialists (CNSs) to the practice agreement requirement that takes effect July 1, 2021. We understand the upcoming change in the Virginia Code affecting licensure and practice of CNSs. Following the change in licensure, we understand CNSs will be jointly licensed by the Boards of Nursing and Medicine and may apply for prescriptive authority. We also understand from the Virginia Association of Clinical Nurse Specialists that the practice agreement was not anticipated for CNSs who do not plan to seek prescriptive authority and a plan to submit an amendment to the bill is underway.

Sentara Healthcare has not changed the CNS job profile. Sentara CNSs do not function as providers at this time. We respectfully request a waiver to the practice agreement requirement at least until the amendment is filed and a final determination is made regarding the practice agreement requirement for all CNSs.

We are both available to discuss with you in more detail at your convenience.

Genemarie McGee

Genemarie McGee, MS, BSN, RN, NEA-BC
Corporate Vice President & Chief Nursing Officer - Sentara Healthcare

Joel Bundy, MD, FACP, FASN, FAAPL, CPE, CHOP
Vice President & Chief Quality & Safety Officer – Sentara Healthcare

c: Dr. William Harp, Executive Director, Virginia Board of Medicine

DISCIPLINARY ACTIONS PERTAINING TO

AUTONOMOUS LICENSED NURSE PRACTITIONERS (ALNP)

AS OF APRIL 30, 2021

In preparation for presentation to the Joint Boards on June 16, 2021, Board of Health Professions/HWDC staff requested a listing of all Licensed Nurse Practitioners who were issued the autonomous practice designations as of April 30, 2021. The first designation was issued on February 6, 2019. A search of License Lookup for the period January 1, 2019 to April 30, 2021 revealed public disciplinary records on five (5) individuals hereinafter referred to a Respondent A, B, C, D and E. The following is a brief summary. [1]

Respondent A - Family Practice and Authorization to Prescribe. An Order issued December 3, 2020 required participation in the Health Practitioners Monitoring Program.

Respondent B – Adult Acute Geriatric and Authorization to Prescribe. An order issued December 11, 2020 required participation in the Health Practitioners Monitoring Program.

Respondent C – Family Practice and Authorization to Prescribe. An order issued September 13, 2019 rendered a Reprimand for prescribing outside of a bona-fide practitioner-patient relationship and outside of an emergency and failing to document the rationale in the patient's record.

Respondent D – Family Practice and Authorization to Prescribe. An order issued November 20, 2020 rendered a Reprimand and approved course in opiate prescribing regarding a case of continued opiate prescribing for a patient with a history of opioid addiction and noncompliance with pain management. On February 22, 20201, the Board notified the Respondent of compliance with the order.

Respondent E[2] – Family Practice (out of state). Mandatory suspension issued July 21, 2020 for felony criminal conviction for conspiracy to commit Medicaid fraud.

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[1] NOTE: The data for the analyses in this report only cover the period February 6, 2019 to April 30, 2021 to coincide with the first designation issued and to allow sufficient time for analysis and reporting prior to the June 16, 2021 meeting of the Joint Boards. Results may differ with other timeframes.

[2] Respondent E's license was mandatorily suspended under the authority of the Department of Health Professions Director. For further information on mandatory suspension, reference *Code of Virginia* §54.1-2409 (accessible at https://law.lis.virginia.gov/vacode/title54.1/chapter24/section54.1-2409/.

Complaints, Violations, and Case Categories

To provide information on complaints received, the staff also analyzed the agency's disciplinary case tracking data[3] referencing "Cases Received" in the system during the February 6, 2019 to April 30, 2021 period. The complaints received per 1,000 licensees' rates for the agency, board, and profession levels follow.

Additionally, because complaints do not necessarily equate to substantiated misconduct, staff also determined the rate of case closed with a final disposition of violation per 1,000 licensees. This measure provides additional insight into boards' assessments of actual harm to the public. Here, too, the results are at the agency, board, and profession level.

Finally, staff also analyzed the categories of cases with a violation final disposition to provide additional information on the types of cases involved. The Appendix provides a listing and description of the case categories.

AGENCY

As indicated in the table below, the agency received 15,510 complaints within the jurisdiction of a licensing board. As of April 30, 2021, the majority (73.5%) had been resolved.

Received (within Jurisdiction, only)	Closed	Violation	Complaint [4] Rate/1k Lic	Violation Rate/ 1k Lic	Licensees .[5]
15,510	11,400 (73.5% of received)	1,571 (14% of closed)	35.27	3.57	439,644

The rate of **all** complaints received per 1,000 licensees within boards' jurisdiction was 35.27, and the overall violation rate was 3.57.

The following page provides a breakout by Board of the respective rates per 1,000 licensee.

[3] Data are from the agency's standard monthly download of internal disciplinary case processing data from the MLO system.

[4] The Rate of Complaints Received per 1,000 Licensees and Rate of Violations per 1,000 Licensees are similar to the standard measures tracked in the DHP Biennial Report under Appendix B – Complaints Against Licensees and C – Violations. They are calculated, respectively, as follows: (#Cases Received/#Licensees) x 1,000 and (#Cases with Violation final disposition/#Licensee)s x 1,000. Note: Here, the #Licensees refers to the count of licensees as of March 31, 2021 rather than June 30, 2021 due to the timing of the review.

[5] The number of licensees is from March 31, 2021, the latest full quarter for which there are data.

BOARD

Complaints Received Rate per 1,000 Licensees by Board

Board	Rate/1k	Board	Rate/1k
ASLP	5.46	**Optometry**	42.55
Counseling	22.78	**Pharmacy**	38.57
Dentistry	70.06	**Physical Therapy**	8.40
FD&E	58.30	**Psychology**	54.47
LTCA	83.11	**Social Work**	20.67
Medicine	60.79	**Veterinary Medicine**	97.9
Nursing	25.10		

The complaint rate ranged from a low of 5.46 for the Board of Audiology and Speech-Language Pathology to a high of 97.9 for the Board of Veterinary Medicine. For the Board of Nursing, the rate was 25.10. The average (mean) was 45.24.

As noted earlier, board findings of violation constitute substantiated evidence of harm to the public due to professional misconduct. A board renders its final disposition when the investigation is complete, evidence reviewed, and adjudication processes completed. A violation final disposition confirms that the licensee has engaged in professional misconduct.

The table below shows rate of violation per 1,000 licensees by board for those cases received and closed during the period.

Violation Rate per 1000 Licensees by Board

Board	Rate/1k	Board	Rate/1k
ASLP	0.88	**Optometry**	1.93
Counseling	0.87	**Pharmacy**	16.7
Dentistry	2.62	**Physical Therapy**	0.96
FD&E	5.64	**Psychology**	1.02
LTCA	3.96	**Social Work**	0.25
Medicine	2.83	**Veterinary Medicine**	0.12
Nursing	2.42		

The violation rates were much lower than the complaint rates, and range from a low for Veterinary Medicine of 0.12 to a high for Pharmacy (includes facility violations). The Board of Nursing's rate is a 2.42. The average (mean) across all boards is 3.02.

PROFESSIONS

Within the agency, there are over 60 regulated professions in addition to a number of facility types. The following tables provide a rank ordering of the rate of complaints and of violations per 1,000 licensees for 51 professions.[6] [7]

Profession	Complaint Rate/1KLic	Profession	Violation Rate/1KLic
Ltd Radiologic Technologist	1.84	Ltd Radiologic Technologist	0
Clinical Nurse Specialist	2.45	Lic. Clinical Social Worker	0.37
Speech-Language Pathologist	4.27	Dental Hygienist	0.49
Dental Hygienist	4.76	Sub Abuse Tx Practitioner	0.51
Occupational Therapist	5.36	Occupational Therapy Asst	0.59
Physician Selling CS	5.38	Intern & Resident	0.59
Occupational Therapy Asst	5.87	Behavioral Analyst	0.6
Sub Abuse Tx Practitioner	7.11	Physician Assistant	0.6
Radiologic Technologist	8.32	Speech-Language Pathologist	0.85
Physical Therapist	8.95	Physical Therapist	0.95
Physical Therapist Asst	10.16	Lic Clinical Psychologist	0.96
Athletic Trainer	10.27	QMHP-Child	0.99
QMHP-Child	11.22	Lic Professional Counselor	0.99
Respiratory Therapist	12.46	Lic Marriage & Family Therapist	1.05
Behavioral Analyst	13.24	Occupational Therapist	1.07
Intern & Resident	13.82	QMHP-Adult	1.32
School Speech-Language Pathologist	14.74	Physical Therapist Asst	1.37
Restricted Volunteer	15.15	Respiratory Therapist	1.44
Registered Nurse	15.35	Veterinary Technician	1.69
QMHP-Adult	18.58	Athletic Trainer	1.71
Polysomnographic Technologist	20.28	Lic. Nurse Practitioner	1.71
Veterinary Technician	20.3	Registered Nurse	1.72
Lic Massage Therapist	20.49	Physician Selling CS	1.79
Pharmacy Technician	20.78	Certified Nurse Aide	2.29
Pharmacist	21.7	TPA Optometrist	2.33
Lic Acupuncturist	24.39	Clinical Nurse Specialist	2.45
Lic. Clinical Social Worker	26.48	School Speech-Language Pathologist	2.46
Certified Nurse Aide	30.6	Doctor of Osteopathy	2.64

[6] Facility cases are excluded.

[7] A profession was included if there was at least one case during the period. Note that only closed cases applied to the violation rate.

Profession	Complaint Rate/1KLic	Profession	Violation Rate/1KLic
Physician Selling Drugs	30.67	Assisted Living Facility Administrator	2.9
Lic. Marriage & Family Therapist	31.41	Nursing Home Administrator	3.01
Lic. Practical Nurse	37.18	Medicine & Surgery	3.33
Physician Assistant	37.78	Autonomous Lic Nurse Practitioner	3.35
Lic Nurse Practitioner	39.76	Lic. Practical Nurse	3.77
Lic Professional Counselor	44.03	Radiologic Technologist	4.05
Medication Aide	45.59	Pharmacist	4.27
TPA Optometrist	48.83	Sex Offender Tx Provider	4.47
Lic. Clinical Psychologist	59.56	Genetic Counselor Temp	4.68
Funeral Service Intern	70.18	Dentist	4.76
Doctor of Osteopathy	70.96	Lic Massage Therapist	4.95
Chiropractor	71.47	Lic Acupuncturist	5.22
Funeral Service Licensee	71.93	Medication Aide	6.32
Sex Offender Tx Provider	76.06	Funeral Service Licensee	6.37
Autonomous Lic Nurse Practitioner	89.69	Chiropractor	6.81
Medicine & Surgery	92.85	Veterinarian	7.59
Assisted Living Facility Administrator – Administrator-in-Training	93.02	Pharmacy Technician	10.12
Assisted Living Administrator	97.1	Polysomnographic Technologist	12.17
Nursing Home Administrator	107.54	Physician Selling Drugs	12.27
Veterinarian	125.06	Podiatrist	12.64
Dentist	131.41	Restricted Volunteer	15.15
Podiatrist	158.84	Funeral Service Intern	17.54
Genetic Counselor Temp	222.2	Assisted Living Facility Administrator— Administrator-in-Training	46.51

The complaint rate per 1,000 licensees ranges from 1.87 for Limited Radiologic Technologist to 222.2 for Genetic Counselor Temporary. Note that the violation rate is lower, with a range of near 0 for Limited Radiologic Technologist to 46.51 for Assisted Living Administrator – Administrator-in-Training. The respective average (mean) for each measure is 43.68 and 4.66. Note the arrows indicating the approximate locations of these means in the rankings above.

For Autonomous Licensed Nurse Practitioner, the complaint rate is 89.84 and violation rate is 3.36. This is higher than average complaint rate but lower than average violation rate. These rates are similar to Medicine & Surgery (M.D.s) where the complaint rate is 92.85 and violation rate is 3.33.

Case Categories

As indicated earlier, staff also analyzed the categories among cases with a finding of violation.

For Autonomous Licensed Nurse Practitioners, see the summary on page 1 for the details. They involve Inability to Safely Practice and Drug-Related, Patient Care.

The following information enables comparison at the agency, board, and profession level. For the sake of simplicity, the board and profession levels narrow to the Board of Nursing, Board of Medicine, Licensed Nurse Practitioner (with collaborative practice), Registered Nurses and Medicine & Surgery (MDs). Other boards and professions can be included in subsequent reports if desired.

AGENCY

The top ten (10) categories across all boards are ranked below. Those that respectively constitute 5% or more are highlighted. It is important to note that only three (3) are considered "complaints" in that the licensing boards, themselves, docket cases with categories related to license issuance or renewal (i.e., continuing education, reinstatement, and eligibility) and compliance cases in follow up to previous orders.

1. **Business Practice Issues**
2. **Inability to Safely Practice**
3. ~~**Continuing Education**~~
4. ~~**Reinstatement**~~
5. **Drug-Related, Patient Care**
6. ~~**Eligibility**~~
7. Abuse, Abandonment & Neglect
8. Criminal Activity
9. Unlicensed Activity
10. Standard of Care – Diagnosis/Treatment

NOTE: The remaining lists only include the categories that constitute 5% or more of the cases.

BOARD OF NURSING (excluding CNAs)

1. **Inability to Safely Practice**
2. ~~**Reinstatement**~~
3. ~~**Eligibility**~~
4. **Drug-Related, Patient Care**
5. **Abuse, Abandonment & Neglect**
6. **Criminal Activity**
7. **Action by Another Board – Patient Care**
8. ~~**Compliance**~~

BOARD OF MEDICINE

1. **Unlicensed Activity**
2. **Inability to Safely Practice**
3. **Drug-Related-Patient Care**
4. **Standard of Care-Diagnosis/Treatment**
5. **Abuse, Abandonment & Neglect**
6. ~~**Reinstatement**~~
7. **Criminal Activity**

LICENSED NURSE PRACTITIONER (COLLABORATIVE ONLY)

1. **Drug-Related-Patient Care**
2. **Inability to Safely Practice**
3. ~~**Reinstatement**~~
4. **Action-by-Another Board, Patient Care**
5. **Criminal Activity**
6. ~~**Eligibility**~~

REGISTERED NURSES

1. **Inability to Safely Practice**
2. ~~**Reinstatement**~~
3. **Action by Another Board, Patient Care**
4. **Criminal Activity**
5. **Abuse, Abandonment & Neglect**
6. ~~**Eligibility**~~

MEDICINE & SURGERY (M.D)

1. **Inability to Safely Practice**
2. **Drug-Related, Patient Care**
3. **Standard of Care, Diagnosis/Treatment**
4. **Criminal Activity**
5. **Reinstatement**
6. **Abuse/Abandonment/Neglect**
7. **Standard of Care, Surgery**

Staff will review this draft with the Joint Board of Nursing and Medicine at the June 16, 2021 as part of a presentation that also includes a separate statistical report on Autonomous Licensed Nurse Practitioners specialties and geographic distribution.

Neither report is final at this time. Any future report(s) will incorporate the Joint Board's feedback.

Applying DISCIPLINE Complaint Types in MLO

Every disciplinary case entered in MLO must be assigned at least one *Complaint Type.* Most cases will require only one, but others will need several types to accurately reflect all aspects of the case. There is no limit on the number of complaint types that can be entered. Users entering the complaint types in MLO should include as many of the **Patient Care Complaint Types** and **Non-Patient Care Complaint Types** as are active concerns. Many of the numbered complaint types have one or more **subtypes** which are identified by a + symbol. Users should also include as many of the subtypes that are active concerns. Complaint types and subtypes must be **reviewed and changed** when needed to accurately address the current issues in each case as it proceeds through *Intake, Investigation, Probable Cause Review, Administrative Proceedings* and *Closure.*

Follow these rules for entering multiple case types:

1. Enter **all** applicable **Patient Care Complaint Types.** Enter the types in numerical order.
2. When **+ symbols and subtypes** are shown, use one or more of the sub-types as applicable to the case.
3. Enter any **Non-Patient Care Complaint Types and subtypes.** Enter the types in numerical order.

PATIENT CARE Complaint types: #1-14

1. **INABILITY TO SAFELY PRACTICE:** Impairment due to use of alcohol, illegal substances, or prescription drugs or incapacitation due to mental, physical or medical conditions.
   - + **Death associated**

2. **DRUG RELATED – PATIENT CARE:** Dispensing in violation of DCA (to include dispensing for non-medicinal purposes, excessive prescribing, not in accordance with dosage, filling an invalid prescription, or dispensing without a relationship), prescription forgery, drug adulteration, patient deprivation, stealing drugs from patients, or personal use.
   - + **Improper compounding or MDR** (mixing/diluting/reconstituting formulation)
   - + **Death associated**

3. **ABUSE/ABANDONMENT/NEGLECT:** Any sexual assault, mistreatment of a patient, inappropriate termination of provider/patient relationship, leaving a patient unattended in a health-care environment, failure to do what a reasonable person would do in a similar situation.
   - + **Sexual misconduct involved**
   - + **Death associated**

4. **STANDARD OF CARE – SURGERY:** Improper/unnecessary performance of surgery, improper patient management, and other surgery-related issues.
   - + **Death associated**
   - + **Sedation/Anesthesia associated**

5. **STANDARD OF CARE – DIAGNOSIS/TREATMENT:** Instances in which the diagnosis/treatment was improper, delayed, or unsatisfactory. Also includes failure to diagnose/treat as well as other diagnosis/treatment related issues.
   - + **Death associated**

6. **STANDARD OF CARE – MEDICATION/PRESCRIPTION:** Prescribing, labeling, dispensing, and administration errors. Also includes improper management of patient regimen and failure to provide counseling as well as other medication/prescription related issues.
   - + **Death associated**

7. **STANDARD OF CARE – MALPRACTICE REPORTS:** a judgment or settlement as well as other malpractice related issues.
   - + **Death associated**

8. **STANDARD OF CARE – EXCEEDING SCOPE:** practicing outside the permitted functions of license granted.
   - + **Death associated**

9. **STANDARD OF CARE – OTHER:** cases involving patient care that cannot fit adequately into any other standard of care case type. *Must have supervisor's approval before using this code.*
   - + **Sexual misconduct involved**

10. **INAPPROPRIATE RELATIONSHIP:** Dual, sexual or other boundary issue. Including inappropriate touching and written or oral communications.

11. **UNLICENSED ACTIVITY:** Practicing a profession or occupation without holding a valid license as required by statute or regulation to include: practicing on a revoked, suspended, lapsed, non-existent or expired license, as well as aiding and abetting the practice of unlicensed activity.
    - + **Expired license**
    - + **Suspended/revoked license**
    - + **No license**
    - + **Delegation to unlicensed staff**

12. **MISAPPROPRIATION OF PATIENT PROPERTY:** stealing or use of patient property without authorization.

    + **Fraudulent documentation**

13. **FRAUD – PATIENT CARE:** Performing unwarranted/unjust services or the falsification/alteration of patient records.

    + **Fraudulent documentation**

14. **ACTION BY ANOTHER BOARD – PATIENT CARE:** Disciplinary action by another state or jurisdiction when the underlying act is a patient care case as defined above. This code must be accompanied by another patient care case code that best describes the underlying offense.

    + **Death associated**

NON-PATIENT CARE Complaint types: #50-64

50. **CRIMINAL ACTIVITY:** Felony or misdemeanor arrest, charges pending, or conviction.

    + **Death associated**

51. **HPMP:** Dismissal, vacated stay and non-compliance.

52. **DRUG RELATED- NON-PATIENT CARE:** Theft or diversion of drugs when a patient is not involved (e.g., pharmacies, hospitals, or facilities).

53. **FRAUD – NON-PATIENT CARE:** Improper patient billing, mishandling of pre-need funds, fee splitting, and falsification of licensing/renewal documents.

    + **Fraudulent documentation**

54. **BUSINESS PRACTICE ISSUES:** Advertising, default on guaranteed student loan, solicitation, records, inspections, audits, self-referral of patients, required report not filed, prescription blanks, or disclosure. Using a VA protected title such as MD, without a license, but not practicing in VA.

    + **Failure to address sexual misconduct**
    + **Failure to report patient events**
    + **Failure to supervise patient care**
    + **Hospital failure to report**
    + **Nursing home failure to report**
    + **ALF failure to report (Assisted Living Facility)**
    + **Other institution failure to report**
    + **Licensee failure to report**

55. **DRUG RELATED – SECURITY:** Failure to maintain security of controlled substances.

56. **COMPLIANCE:** Violation of a board order term or probation violation.

57. **MISAPPROPRIATION OF PROPERTY – NON-PATIENT CARE:** stealing or use of property that does not belong to a patient without authorization.

58. **CONFIDENTIALITY BREACH:** disclosing unauthorized client information without permission or necessity.

59. **CONTINUING COMPETENCY REQUIREMENT NOT MET:** Failure to obtain or document CE requirements.

60. **DISHONORED CHECK:** Check with insufficient funds submitted to agency.

61. **RECORDS RELEASE:** Failure or delay in the release of patient records. Charging excessive fees for records requests.

62. **ACTION BY ANOTHER BOARD – NON-PATIENT CARE:** Disciplinary action by another state or jurisdiction when the underlying act is a non-patient care case. This code must be accompanied by another non-patient care Complaint Type code that best describes the underlying offense.

Virginia Department of Health Professions

Geographic Distribution and Discipline Data for the Study on Virginia's Autonomous Licensed Nurse Practitioners Pursuant to House Bill 793 (2018)

Rajana Siva
Elizabeth A. Carter
Board of Health Professions/
DHP Healthcare Workforce Data Center

Joint Boards of Nursing and Medicine Meeting
June 16, 2019

Virginia Department of Health Professions

Overview

- Geographic Distribution
- Discipline
- Questions

Virginia Department of Health Professions

Geographic Distribution

- ALNP certified February 2, 2019 to April 30, 2021
- Practice Location(s) & Specialty(ies) with statewide, county & city breakouts
- Results in Tableau online interactive map and table with dropdown menus:
  https://public.tableau.com/profile/rajana.siva#!/vizhome/npspecialtycounts/Story1
- Walkthrough and comparison with Licensed Nurse Practitioner DHP HWDC

Virginia Department of Health Professions

Discipline

- Limited to February 6, 2019 to April 30, 2021 Timeframe
- License Lookup Summary of Actions
- Complaint Rates/1k Licensees
- Violation Rates/1k Licensees (cases received during the period)
- Case Categories

Virginia Department of Health Professions

QUESTIONS?

Virginia Department of Health Professions

QUESTIONS?

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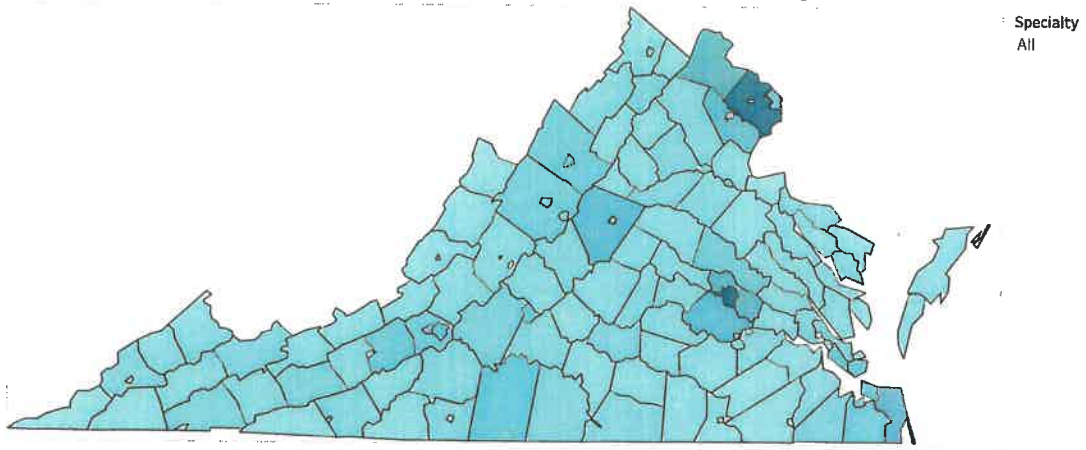
NP headcount

Specialty Breakouts by City | Specialty Breakouts by County

Specialty Breakouts by County



County (group)	Specialty Null	Autonom..	Autonom..	Autonom..	Autonom..	Autonom..	Autonom..	Autonom..	Autonom..	Specialty All
Accomack County		1	0	7	0	0	2	0	0	
Albemarle County		9	5	20	1	1	4	6	0	
Alexandria County		0	4	12	0	0	0	3	0	
Alleghany County	0	0	0	0	0	0	0	0	0	
Amelia County		0	0	1	0	0	0	0	0	
Amherst County		1	1	0	0	0	0	1	0	
Appomattox County		0	0	0	0	0	0	1	0	
Arlington County		3	6	13	0	0	0	4	0	
Augusta County		3	0	15	0	0	0	3	0	
Bath County	0	0	0	0	0	0	0	0	0	
Bedford County		2	2	9	0	0	0	1	0	
Bland County		0	0	1	0	0	0	0	0	
Botetourt County	0	0	0	0	0	0	0	0	0	
Bristol County		0	0	1	0	0	0	0	0	
Brunswick County	0	0	0	0	0	0	0	0	0	
Buchanan County		4	0	6	0	0	0	0	0	
Buckingham County	0	0	0	0	0	0	0	0	0	

The maps and tables on this page and the next are still Snapshots of the what the online Tableau online interactive will look like during the presentation on the geographic distribution of Autonomous Licensed Nurse Practitioners and their specialties.

If you would like to become familiar with this online tool, the current version may be accessed at:

https://public.tableau.com/profile/rajana.siva#!/vizhome/npspecialtycounts/Story1

Tableau allows viewers to select all or a specific specialty in both maps and accompanying tables.

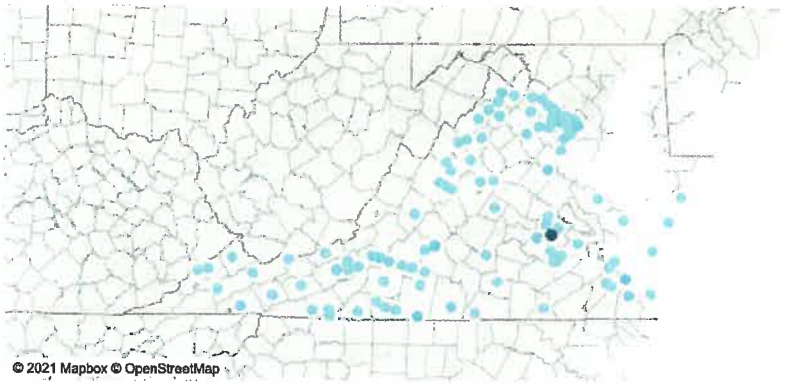
PLEASE NOTE that the mapping is being recolored to better distinguish county-level detail for the reader and should appear clearer at the June 16, 2021 meeting.

Thank you for your patience.

NP headcount

Specialty Breakouts by City | Specialty Breakouts by County

Specialty Breakouts by City



Specialty
All

Sheet 2

	Specialty							
City (group)	Autonomo..	Autonomo..	Autonomo..	Autonomo..	Autonomo..	Autonomo..	Autonomo..	Autonomo..
Abindgon			5				1	
Alexandria		4	12				3	
Alta Vista			3					
Annandale	1							
Ashburn		1	3					
Ashland		1	1					
Axton			1					
Barboursville	2							
Bassett			1					
Berryville			1					
Blackburg		2	2					
Bluefield			2					
Bridgewater			1					
Broadway			2					
Cana			1					
Carrollton			2					

Virginia's Licensed Nurse Practitioner Workforce: 2020

Healthcare Workforce Data Center

November 2020

Virginia Department of Health Professions
Healthcare Workforce Data Center
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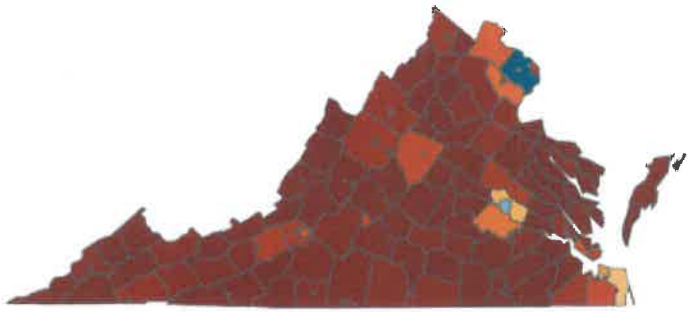
Get a copy of this report from:
http://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/ProfessionReports/

Accessible at: www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/Dashboards/TrendsinHealthcareWorkforceFTEUnits

2020 Healthcare Workforce Full Time Equivalency Units in Virginia

(Drag mouse to select multiple counties from map and select professions from dropdown box)

Professions: Nurse Practitioner



	Year								
unty	2012	2013	2014	2015	2016	2017	2018	2019	2020
comack County	0.0	0.0	16.3	7.9	9.7	12.9	29.4	25.2	32.7
emarle County	0.0	0.0	112.0	129.6	152.1	168.7	168.3	178.7	209.2
xandria City	0.0	0.0	74.5	118.2	147.9	108.1	124.3	196.0	117.6
ghany County	0.0	0.0	17.9	25.0	21.6	9.6	5.7	30.0	11.5
lla County	0.0	0.0	5.5	3.8	3.3	0.0	6.2	0.0	7.6
herst County	0.0	0.0	7.6	9.9	9.6	19.8	4.6	16.7	5.0
pomattox County	0.0	0.0	5.6	0.0	4.8	0.2	0.0	0.0	3.5
ington County	0.0	0.0	108.9	166.2	136.4	159.3	185.6	162.4	172.7
guста County	0.0	0.0	73.0	49.0	65.4	44.1	60.9	59.9	88.5
h County	0.0	0.0	0.4	7.7	4.3	5.4	8.0	26.2	9.7
ford City	0.0	0.0	4.0	6.3	0.0	5.9	1.5	3.9	4.0
ford County	0.0	0.0	17.6	5.4	8.3	9.2	28.7	15.9	22.1
nd County	0.0	0.0	5.0	27.6	2.2	13.2	24.4	16.9	16.4
fsicourt County	0.0	0.0	10.0	2.1	10.7	14.0	6.5	6.8	12.9
ltol City	0.0	0.0	7.8	5.1	40.4	1.9	9.1	6.5	16.3
unswick County	0.0	0.0	10.5	5.9	4.4	2.7	1.8	8.1	4.9
chanan County	0.0	0.0	6.5	11.3	13.9	14.0	17.5	10.8	35.1

VDH VIRGINIA DEPARTMENT OF HEALTH
To protect the health and promote the well-being of all people in Virginia

SHORTAGE DESIGNATION RESOURCES

Shortage Designations

Quick Links

HRSA's Shortage Designation Overview
HPSA Mapping Tool
Find Shortage Areas by Address
Find HPSA's by Locality
Find MUA's by Locality
Virginia HPSA Factsheet

Find Job Openings in Shortage Areas

Shortage Designations

The Division of Social Epidemiology, through the Virginia Primary Care Office, develops reviews and submits applications for federally designated shortage areas. A large and diverse number of state and federal programs reference these shortage areas to determine eligibility, the amount of awards, and for other purposes. There are several types of shortage areas, covering different specialties, and targeting different constituents.

Shortage Area Types:

- Health Professional Shortage Area (HPSA)
- Medically Under-served Areas/Populations (MUA/P)
- Governor Designation

Shortage Area Specialties:

- Primary Care
- Dental Health
- Mental Health

Shortage Area Targets:

- Geographic Areas
- Populations
- Facilities

Examples of Programs that reference shortage areas:

- Medicare Bonus Payment Program
- National Health Service Corps
- Virginia State Loan Repayment
- J-1 Visa Program
- NURSE Corps
- Federally Qualified Health Centers
- Rural Health Clinics

For more information about Virginia's shortage areas contact Anna Riggan at anna.riggan@vdh.virginia.gov.