Executive Committee Meeting

Virginia Board of Medicine

April 7, 2017

8:30 a.m.

Executive Committee

Friday, April 7, 2017 @ 8:30 a.m.
9960 Mayland Drive, Suite 200
Richmond, VA 23230
Board Room 4

Page

Call to Order of the Executive Committee—Barbara Allison-Bryan, MD, President, Chair

Next scheduled meeting: August 4, 2017

Adjournment

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

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

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

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

Board Room 4

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

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--- DRAFT UNAPPROVED --

VIRGINIA BOARD OF MEDICINE
EXECUTIVE COMMITTEE MINUTES

Friday, December 2, 2016 Department of Health Professions Henrico, VA

CALL TO ORDER: The meeting convened at 8:34 a.m.

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

MEMBERS PRESENT:
Barbara Allison-Bryan, MD, President, Chair
Randy Clements, DPM
Lori Conklin, MD
Alvin Edwards, PhD
Jane Hickey, JD
Maxine Lee, MD
Kevin O'Connor, MD, Vice-President
Ray Tuck, DC, Secretary-Treasurer

MEMBERS ABSENT: None

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

OTHERS PRESENT:
The Honorable Todd Pillion, DDS, Delegate-4th District
Tyler Cox, MSV
Lauren Bates-Rowe, MSV
Janice Craft, NARAL Pro-Choice Virginia
Jerry Canaan, JD, HDJN
Ralston King, MSV
S. Hughes Melton, MD, Deputy Commissioner, VDH

EMERGENCY EGRESS INSTRUCTIONS

Dr. O'Connor provided the emergency egress instructions.

ADOPTION OF AGENDA

Dr. Edwards moved to adopt the amended agenda which added item #6 under New Business, *Review and Discussion of Regulations on Mixing, Diluting, or Reconstituting*. The motion was seconded and carried unanimously.

APPROVAL OF MINUTES OF AUGUST 5, 2016

Dr. Edwards moved to approve the meeting minutes of August 5, 2016 as presented. The motion was seconded and carried unanimously.

PUBLIC COMMENT

Dr. Hughes Melton spoke in favor of proper prescribing regulations for opioids. He noted that he had not seen captured in any discussion to date the most recent black box warning on prescribing other opioids with suboxone.

Delegate Pillion expressed his concern about the opioid epidemic. He said the overdose problem leaves children to be raised by grandparents. It also has an economic impact when skilled citizens cannot be hired because they are unable to pass a drug test. Delegate Pillion stated that Suboxone may be the most abused opioid in his area and registered his concern that "we are trading one addiction for another". There should be more focus on collateral therapies, but he is also aware of the thinking that less than appropriate treatment may be better than no treatment at all. He mentioned that the recently published Center for Disease Control guidelines recommend that emergency departments prescribe no more than 3 days of opioids, and under no circumstances more than 7 days. Delegate Pillion stated that he supports controlled substances continuing education for all prescribers. The blame can no longer be placed just on those who abuse substances.

Dr. Conklin moved to accept the letter from the Medical Society of Virginia (MSV) as written comment. MSV also supports continuing education for all prescribers but has concerns about the unintended consequence of creating further barriers to access for those seeking addiction treatment services.

DHP DIRECTOR'S REPORT

Dr. Brown thanked Delegate Pillion for his attendance and focus on the opioid crisis.

Dr. Brown advised that Commissioner Levine is also seeking help on this issue. The number of opioid overdose deaths has climbed dramatically. There were 800 reported opioid deaths last year, and the number is expected to hit 1,200 by the end of this year.

Dr. Brown informed the Committee that legislation was passed earlier this year to allow DHP to docket investigations on licensees that demonstrate unusual patterns or prescribing. The Prescription Monitoring Program (PMP) Regulatory Advisory Panel was able to settle on

several parameters to identify opioid prescribers with unusual patterns. These should be adapted to criteria for buprenorphine prescribing which would allow the PMP to quickly recognize excessive prescribers. Secondly, Dr. Brown asked the members to consider initiating emergency regulations on the proper use of buprenorphine as well as regulations on pain management and proper prescribing.

Dr. Brown acknowledged the concern about placing restrictions on opioids when addressing addiction and said that DMAS has developed, as part of their Addiction and Recovery Treatment Services (ARTS) benefits program, their own guidelines for outpatient opioid treatment. He said that the ARTS benefit is the first step in addressing addiction, In another step forward, the General Assembly is allowing the Department of Behavioral Health to begin certifying peer counselors in substance misuse/abuse.

Dr. Conklin stated that another issue not being addressed is patient satisfaction scores and how they affect physician reimbursement. The Commonwealth has the opportunity to set the example for physicians who have the courage to say "no" and deny a patient the drug sought. The patient may then write a negative comment about the physician. Dr. Conklin stated that, on the other hand, patients who legitimately need longer than 7 days of medication are being punished, so how is it right to limit access with legislation?

Delegate Pillion said that patient scores are directly associated with federal guidelines, so they fall outside the purview of the Commonwealth.

Dr. Clements asked Dr. Brown what he would like the emergency regulations to say, and could the Board use the DMAS ARTS in the development of emergency regulations?

Dr. Brown said it was not for him to say, but he would like to see the work already completed by the Buprenorphine Work Group and DMAS incorporated into the regulations. For a Regulatory Advisory Panel on these issues, he suggested a smaller one rather than a large group of individuals with many different opinions.

Ms. Yeatts then explained the process for adopting emergency regulations.

PRESIDENT'S REPORT

Dr. Allison-Bryan announced that, although Virginia has put their participation in the Compact on hold, she is scheduled to attend The Council of State Governments' National Center for Interstate Compacts meeting on Dec. 12-13, 2016 in Williamsburg, This is the first Summit of the States on Interstate Collaboration, and she will provide a report at the February Board meeting.

Dr. Allison-Bryan also commented on the usefulness of VAAWARE.com, which offers resources for combating prescription drug and heroin abuse at no cost to the practitioner.

NEW BUSINESS

Chart of Regulatory Actions

Ms. Yeatts reviewed the status of 12 pending regulatory matters.

This report was for informational purposes only.

Adoption of Final Regulations for Licensure of Genetic Counselors

Ms. Yeatts advised that, when the proposed regulations were first published for comment, they had strong support. However, some stakeholders had concern about the "conscience clause". The proposed regulations were returned to the Advisory Board for further discussion and possible revision. Following that process, the regulations now have support from all groups, and the Advisory Board of Genetic Counselors is recommending final adoption to the Board.

Ms. Yeatts noted that the law for grandfathering without a Master's degree required application for a license prior to July 1, 2016. Since there was no license to be issued by July 1, 2016, potential applicants and the associations have been encouraged to speak to their legislators about having the grandfathering date changed to 2017 or 2018. The Board does not have the authority to make that change.

Dr. Conklin moved to adopt the final regulations as presented. The motion was seconded and carried unanimously.

Adoption of Fast-Track Action on Certification to the Board for Invasive Procedures by Physician Assistants

Ms. Yeatts said the Advisory Board on Physician Assistants recommended in June 2016 that the requirement to submit the invasive procedure form for approval to the Board be eliminated. The form attests to the physician assistant being competent to perform an invasive procedure without direct supervision. This proposal is consistent with the supervising physician and physician assistant no longer having to submit the practice agreement to the Board for approval. The supervising physician will still need to keep a record that the PA has been observed performing the invasive procedure with skill and competence at least 3 times. The physician assistant should keep a copy of this document as well.

To date there have not been any comments for or against this amendment.

Dr. O'Connor moved to accept the recommended amendment as presented. The motion was seconded and carried unanimously.

Recommendation from the Ad Hoc Committee on Controlled Substances CE

Dr. Conklin gave a brief, informative presentation that provided the number of fatal overdoses involving benzodiazepines, fentanyl and prescription opioids from 2007-2016 along with information on patient utilization management.

Dr. Conklin summarized the discussion by the Ad Hoc Committee on Controlled Substances Continuing Education and advised that, after weighing all the options available, the recommendation is for all Board of Medicine licensees with prescriptive authority to obtain 2 hours of continuing education on pain management, the responsible prescribing of controlled substances, and the diagnosis and management of addiction in the next biennium.

After some discussion, Dr. Edwards moved to mandate 2 hours of continuing education for all prescribers on the above topics. The motion was seconded.

Dr. O'Connor stated that if it is important enough to recommend that practitioners obtain these hours, then the hours should be CAT I (Type 1).

Dr. Conklin offered an amendment to say, prescribers licensed by the Board of Medicine are required to obtain 2 hours of CAT I (Type 1) continuing education on the topics in the motion. It was seconded and carried unanimously.

Buprenorphine Guidance Document and Discussion of Buprenorphine Regulations

Dr. Walker provided a brief history of this topic from the pushback by practitioners in Southwest Virginia on the use of the PMP to the formation of the 2016 Buprenorphine Work Group. He said the Work Group decided not to attempt a document de novo, but rather chose the Federation of State Medical Boards 2013 Model Policy on the treatment of opioid addiction in the medical office. The wide-ranging discussion by the Group addressed the use and misuse of buprenorphine and other opioids.

Dr. Harp commended Dr. Walker for work well done with such a diverse group of members. He stated that the special populations were added after the July 22, 2016 meeting and sent back out to the Work Group members for comment. The members were in support of the document, saying that they thought it was 'solid" and should be well-received by the waivered physician community and others.

Dr. Walker referred to the Executive Summary of Proposed Guidance Document 85-3 entitled "Office-Based Treatment of Opioid Use Disorder" which was provided as a handout.

Proposed Guidance Document 85-3

Office-Based Treatment of Opioid Use Disorder

Executive Summary

Introduction

Gov. McAuliffe established the Governor's Task Force on Prescription Drug and Heroin Abuse in September 2014. In late 2015, the Treatment Work Group of the Task Force made the recommendation that the Board of Medicine convene a work group of physicians with expertise in the treatment of opioid use disorders with buprenorphine to review the literature and make recommendations to the Board of Medicine for consideration of regulations.

Work Group on Buprenorphine

The work group was formed with physicians of different specialties representing a variety of treatment settings from all regions of the Commonwealth. Also included were representatives of state agencies and insurance companies. The work group had its first meeting May 13, 2016 and the second on July 22, 2016. It opted to develop a guidance document for the Board's consideration. To accomplish its mission, it decided to use the Federation of State Medical Boards' "Model Policy on DATA 2000 and Treatment of Opioid Addiction in the Medical Office" as its starting point.

Development of the Guidance Document

With the permission of the Federation of State Medical Boards, the work group set about editing, revising, adding and deleting the language of the Model Policy to fashion a document that was representative of the work group's knowledge and experience of the treatment of opioid use disorders with buprenorphine products in the Commonwealth. It is anticipated that the document will be finalized for review and approval at the February 2017 Board meeting.

Salient Points of the Document

- Treatment of opioid use disorders with buprenorphine requires specialized knowledge
- The course to become a waivered physician provides a foundation which should be further enhanced
- Diligence in all aspects of care is required for safe and competent treatment
- Attention to patients and the processes is paramount
- Special consideration must be given to prevention of abuse and diversion of buprenorphine
- Buprenorphine + naloxone is less likely to be abused or diverted than the mono product
- Buprenorphine treatment is more successful when combined with counseling
- Differential consideration is required for special populations, such as pregnant women, neonates, adolescents, geriatric patients, those with medical and psychiatric comorbidities, chronic pain and recently released individuals

It will be the recommendation of the work group for the Board of Medicine to promulgate regulations from this document. Doing so would provide further guidance for the physicians

that treat opioid substance use disorders, better protect the public, and extend the Board's reach in its enforcement of the standards for this specialized care.

Following a brief discussion, Dr. Edwards moved that the Board convene a small regulatory advisory panel to develop proposed regulations for the use of buprenorphine. The motion was seconded and carried unanimously.

Discussion of Pain Management and Proper Prescribing Regulations

The Committee briefly reviewed the Draft Regulations for Pain Management developed in 2007 which did not come to fruition. It was noted that these draft regulations would be a good starting point for 2017 opioid regulations, with a few additional considerations, such as other modalities to treat pain, the CDC guidelines, and universal precautions.

Ms. Yeatts reminded the Committee of the Board's existing guidance document **85-24** Guidance on the Use of Opioid Analgesics in the Treatment of Chronic Pain, revised October 24, 2013

These regulations will be developed by the aforementioned Regulatory Advisory Panel for the January 2017 Legislative Committee and the full Board in February 2017.

Dr. Lee said that it should be emphasized to non-physicians that pain management is the practice of medicine.

Review and discussion of Regulations on Mixing, Diluting and Reconstituting

Dr. Clements requested that the podiatry profession be added to 18VAC85-20-400.

Dr. Clements also requested that language be added to allow the mixing of local anesthesia and steroids by medical assistants.

Ms. Barrett advised that there would need to be a statutory change in §54.1-3401 to accomplish Dr. Clements proposed revisions.

Ms. Yeatts will follow up on the introduction of legislation.

ANNOUNCEMENTS

Next meeting – April 7, 2017

There were no other announcements.

ADJOURNMENT

With no further business to conduct, the meeting adjourned at 12:32 p.m.

Barbara Allison-Bryan, MD
President, Chair

William L. Harp, MD
Executive Director

Colanthia M. Opher
Recording Secretary

Virginia Department of Health Professions
Cash Balance
As of February 28, 2017

	102- Medicine
Board Cash Balance as of June 30, 2016	$ 10,033,194
YTD FY17 Revenue	6,026,489
Less: YTD FY17 Direct and In-Direct Expenditures	4,999,924
Board Cash Balance as February 28, 2017	11,059,759

Virginia Department of Health Professions
Revenue and Expenditures Summary
Department 10200 - Medicine
For the Period Beginning July 1, 2016 and Ending February 28, 2017

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
4002400	Fee Revenue				
4002401	Application Fee	718,577.00	964,775.00	246,198.00	74.48%
4002402	Examination Fee	1,385.00	-	(1,385.00)	0.00%
4002406	License & Renewal Fee	5,213,230.00	5,822,830.00	609,600.00	89.53%
4002407	Dup. License Certificate Fee	5,295.00	3,375.00	(1,920.00)	156.89%
4002408	Board Endorsement - In	9,392.00	-	(9,392.00)	0.00%
4002409	Board Endorsement - Out	7,355.00	49,820.00	42,465.00	14.76%
4002421	Monetary Penalty & Late Fees	70,173.00	66,450.00	(3,723.00)	105.60%
4002432	Misc. Fee (Bad Check Fee)	105.00	175.00	70.00	60.00%
	Total Fee Revenue	6,025,512.00	6,907,425.00	881,913.00	87.23%
4003000	Sales of Prop. & Commodities				
4003002	Overpayments	350.00	-	(350.00)	0.00%
4003020	Misc. Sales-Dishonored Payments	627.00	-	(627.00)	0.00%
	Total Sales of Prop. & Commodities	977.00	-	(977.00)	0.00%
	Total Revenue	6,026,489.00	6,907,425.00	880,936.00	87.25%
5011110	Employer Retirement Contrib.	112,270.29	169,778.00	57,507.71	66.13%
5011120	Fed Old-Age Ins- Sal St Emp	51,394.55	86,527.00	35,132.45	59.40%
5011140	Group Insurance	10,848.01	16,487.00	5,638.99	65.80%
5011150	Medical/Hospitalization Ins.	137,239.39	228,628.00	91,388.61	60.03%
5011160	Retiree Medical/Hospitalizatn	9,760.35	14,851.00	5,090.65	65.72%
5011170	Long term Disability Ins	4,986.45	8,307.00	3,320.55	60.03%
	Total Employee Benefits	326,499.04	524,578.00	198,078.96	62.24%
5011200	Salaries				
5011230	Salaries, Classified	831,302.25	1,258,544.00	427,241.75	66.05%
5011250	Salaries, Overtime	5,212.99	652.00	(4,560.99)	799.54%
	Total Salaries	836,515.24	1,259,196.00	422,680.76	66.43%
5011300	Special Payments				
5011310	Bonuses and Incentives	92.50	-	(92.50)	0.00%
5011380	Deferred Compnstn Match Pmts	3,660.80	9,298.00	5,637.20	39.37%
	Total Special Payments	3,753.30	9,298.00	5,544.70	40.37%
5011600	Terminatn Personal Svce Costs				
5011620	Salaries, Annual Leave Balanc	561.13	-	(561.13)	0.00%
5011660	Defined Contribution Match - Hy	413.39	-	(413.39)	0.00%
	Total Terminatn Personal Svce Costs	974.52	-	(974.52)	0.00%
5011930	Turnover/Vacancy Benefits		-	-	0.00%
	Total Personal Services	1,167,742.10	1,793,072.00	625,329.90	65.13%
5012000	Contractual Svs				
5012100	Communication Services				
5012110	Express Services	4,732.00	5,997.00	1,265.00	78.91%
5012130	Messenger Services	45.67	-	(45.67)	0.00%
5012140	Postal Services	41,993.40	66,802.00	24,808.60	62.86%
5012150	Printing Services	-	3,026.00	3,026.00	0.00%
5012160	Telecommunications Svcs (VITA)	9,092.09	10,500.00	1,407.91	86.59%
5012170	Telecomm. Svcs (Non-State)	765.00	-	(765.00)	0.00%

Virginia Department of Health Professions
Revenue and Expenditures Summary
Department 10200 - Medicine
For the Period Beginning July 1, 2016 and Ending February 28, 2017

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
5012190	Inbound Freight Services	66.23	35.00	(31.23)	189.23%
	Total Communication Services	56,694.39	86,360.00	29,665.61	65.65%
5012200	Employee Development Services				
5012210	Organization Memberships	8,160.00	7,228.00	(932.00)	112.89%
5012240	Employee Trainng/Workshop/Conf	3,710.00	4,283.00	573.00	86.62%
5012250	Employee Tuition Reimbursement	-	752.00	752.00	0.00%
	Total Employee Development Services	11,870.00	12,263.00	393.00	96.80%
5012300	Health Services				
5012360	X-ray and Laboratory Services	67.36	2,298.00	2,230.64	2.93%
	Total Health Services	67.36	2,298.00	2,230.64	2.93%
5012400	Mgmnt and Informational Svcs	-			
5012420	Fiscal Services	119,676.39	119,963.00	286.61	99.76%
5012440	Management Services	892.07	1,797.00	904.93	49.64%
5012460	Public Infrmtnl & Relatn Svcs	25.00	-	(25.00)	0.00%
5012470	Legal Services	4,950.18	5,579.00	628.82	88.73%
	Total Mgmnt and Informational Svcs	125,543.64	127,339.00	1,795.36	98.59%
5012500	Repair and Maintenance Svcs				
5012510	Custodial Services	4,486.75	-	(4,486.75)	0.00%
5012530	Equipment Repair & Maint Srvc	-	1,705.00	1,705.00	0.00%
	Total Repair and Maintenance Svcs	4,486.75	1,705.00	(2,781.75)	263.15%
5012600	Support Services				
5012630	Clerical Services	75,803.98	67,495.00	(8,308.98)	112.31%
5012640	Food & Dietary Services	8,010.16	12,698.00	4,687.84	63.08%
5012660	Manual Labor Services	13,062.34	24,912.00	11,849.66	52.43%
5012670	Production Services	69,905.35	153,625.00	83,719.65	45.50%
5012680	Skilled Services	245,760.22	531,779.00	286,018.78	46.21%
	Total Support Services	412,542.05	790,509.00	377,966.95	52.19%
5012800	Transportation Services				
5012820	Travel, Personal Vehicle	15,140.11	25,626.00	10,485.89	59.08%
5012830	Travel, Public Carriers	2,762.32	4,170.00	1,407.68	66.24%
5012850	Travel, Subsistence & Lodging	11,330.87	21,524.00	10,193.13	52.64%
5012880	Trvl, Meal Reimb- Not Rprtble	4,674.00	7,407.00	2,733.00	63.10%
	Total Transportation Services	33,907.30	58,727.00	24,819.70	57.74%
	Total Contractual Svs	645,111.49	1,079,201.00	434,089.51	59.78%
5013000	Supplies And Materials				
5013100	Administrative Supplies				
5013120	Office Supplies	16,545.00	14,609.00	(1,936.00)	113.25%
5013130	Stationery and Forms	237.10	3,614.00	3,376.90	6.56%
	Total Administrative Supplies	16,782.10	18,223.00	1,440.90	92.09%
5013300	Manufctrng and Merch Supplies				
5013350	Packaging & Shipping Supplies	-	94.00	94.00	0.00%
	Total Manufctrng and Merch Supplies	-	94.00	94.00	0.00%
5013600	Residential Supplies				
5013620	Food and Dietary Supplies	123.52	528.00	404.48	23.39%
5013630	Food Service Supplies	-	1,129.00	1,129.00	0.00%

Virginia Department of Health Professions
Revenue and Expenditures Summary
Department 10200 - Medicine
For the Period Beginning July 1, 2016 and Ending February 28, 2017

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
	Total Residential Supplies	123.52	1,657.00	1,533.48	7.45%
5013700	Specific Use Supplies				
5013730	Computer Operating Supplies	669.00	166.00	(503.00)	403.01%
	Total Specific Use Supplies	669.00	166.00	(503.00)	403.01%
	Total Supplies And Materials	17,574.62	20,140.00	2,565.38	87.26%
5014000	Transfer Payments				
5014100	Awards, Contrib., and Claims				
5014130	Premiums	592.00	-	(592.00)	0.00%
	Total Awards, Contrib., and Claims	592.00	-	(592.00)	0.00%
	Total Transfer Payments	592.00	-	(592.00)	0.00%
5015000	Continuous Charges				
5015100	Insurance-Fixed Assets				
5015160	Property Insurance	-	485.00	485.00	0.00%
	Total Insurance-Fixed Assets	-	485.00	485.00	0.00%
5015300	Operating Lease Payments				
5015340	Equipment Rentals	4,357.28	7,200.00	2,842.72	60.52%
5015350	Building Rentals	265.11	-	(265.11)	0.00%
5015360	Land Rentals	-	100.00	100.00	0.00%
5015390	Building Rentals - Non State	93,066.43	133,528.00	40,461.57	69.70%
	Total Operating Lease Payments	97,688.82	140,828.00	43,139.18	69.37%
5015500	Insurance-Operations				
5015510	General Liability Insurance	-	1,828.00	1,828.00	0.00%
5015540	Surety Bonds	-	108.00	108.00	0.00%
	Total Insurance-Operations	-	1,936.00	1,936.00	0.00%
	Total Continuous Charges	97,688.82	143,249.00	45,560.18	68.20%
5022000	Equipment				
5022100	Computer Hrdware & Sftware				
5022170	Other Computer Equipment	3,546.73	-	(3,546.73)	0.00%
	Total Computer Hrdware & Sftware	3,546.73	-	(3,546.73)	0.00%
5022200	Educational & Cultural Equip				
5022240	Reference Equipment	141.00	829.00	688.00	17.01%
	Total Educational & Cultural Equip	141.00	829.00	688.00	17.01%
5022600	Office Equipment				
5022610	Office Appurtenances	-	125.00	125.00	0.00%
5022620	Office Furniture	1,359.35	1,857.00	497.65	73.20%
5022640	Office Machines	-	1,250.00	1,250.00	0.00%
5022680	Office Equipment Improvements	-	17.00	17.00	0.00%
	Total Office Equipment	1,359.35	3,249.00	1,889.65	41.84%
5022700	Specific Use Equipment				
5022710	Household Equipment	228.99	-	(228.99)	0.00%
	Total Specific Use Equipment	228.99	-	(228.99)	0.00%
	Total Equipment	5,276.07	4,078.00	(1,198.07)	129.38%
	Total Expenditures	1,933,985.10	3,039,740.00	1,105,754.90	63.62%
	Net Revenue in Excess (Shortfall) of				

Virginia Department of Health Professions
Revenue and Expenditures Summary
Department 10200 - Medicine
For the Period Beginning July 1, 2016 and Ending February 28, 2017

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
	Allocated Expenditures				
30100	Data Center	644,286.30	1,092,171.08	447,884.78	58.99%
30200	Human Resources	66,943.67	202,896.27	135,952.60	32.99%
30300	Finance	229,331.58	307,063.31	77,731.73	74.69%
30400	Director's Office	118,386.26	180,604.71	62,218.45	65.55%
30500	Enforcement	1,243,537.14	1,716,880.52	473,343.38	72.43%
30600	Administrative Proceedings	500,007.82	818,760.24	318,752.41	61.07%
30700	Impaired Practitioners	18,772.77	24,612.76	5,839.98	76.27%
30800	Attorney General	123,155.16	162,067.98	38,912.82	75.99%
30900	Board of Health Professions	53,732.71	119,088.25	65,355.54	45.12%
31100	Maintenance and Repairs	-	3,379.12	3,379.12	0.00%
31300	Emp. Recognition Program	2,205.58	2,596.56	390.98	84.94%
31400	Conference Center	1,787.94	1,776.72	(11.22)	100.63%
31500	Pgm Devlpmnt & Implmentn	63,791.87	92,145.13	28,353.26	69.23%
	Total Allocated Expenditures	3,065,938.80	4,724,042.64	1,658,103.84	64.90%
	Net Revenue in Excess (Shortfall) of Expenditures	$ 1,026,565.10	$ (856,357.64)	$ (1,882,922.74)	119.88%

HPMP Monthly Census Report
Active Cases March 31, 2017

Board	Board Participants	License	Count of ID	% with this license
Nursing	278	LPN	38	8.84
Nursing	278	RN	217	50.47
Nursing	278	LNP	17	3.95
			272	**63.26**
Nursing	5	CNA	4	**0.93**
Nursing	5	RMA	1	**0.23**
Nursing			**5**	
Medicine	110	DO	10	2.33
Medicine	110	Intern/Resident	10	2.33
Medicine	110	MD	67	15.58
Medicine	110	PA	6	1.40
Medicine	110	Lic Rad Tech	2	0.47
Medicine	110	DC	2	0.47
Medicine	110	OT	2	0.47
Medicine	110	RT	5	1.16
Medicine	110	DPM	1	0.23
Medicine	110	LBA	1	0.23
			106	**24.65**
Pharmacy	18	Pharmacist	**18**	4.19
Dentistry	15	DDS	10	2.33
Dentistry	15	DMD	2	0.47
Dentistry	15	RDH	3	0.70
			15	**3.49**
Social Work	4	LCSW	**4**	**0.93**
Psychology	2	LCP	**2**	0.47
Counseling	1	LPC	**1**	0.23
Veterinary Medicine	2	DVM	**2**	**0.47**
Audiology & Speech-Language	1	SLP	**1**	**0.23**
Physical Therapy	4	PT	2	0.47
Physical Therapy	4	PTA	2	0.47
			4	**0.93**
TOTALS			**430.00**	**100.00**

Agenda Item: Regulatory Actions - Chart of Regulatory Actions

As of February 10, 2017

Chapter		Action / Stage Information
[18 VAC 85 - 20]	Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic	Licensure by endorsement [Action 4716] NOIRA - *Register Date: 1/23/17* *Comment closed: 2/22/17*
[18 VAC 85 - 20]	Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic	CE credit for volunteer practice [Action 4703] Fast-Track - *Register Date: 1/23/17* *Effective 3/9/17*
[18 VAC 85 - 21]	Regulations Governing Prescribing of Opioids and Buprenorphine	Initial regulations [Action 4760] Emergency/NOIRA - *Register Date: 4/3/17* *Effective: 3/15/17*
[18 VAC 85 - 40]	Regulations Governing the Practice of Respiratory Therapists	CE credit for volunteer practice and academic course [Action 4706] Fast-Track - *Register Date: 1/23/17* *Effective: 3/9/17*
[18 VAC 85 - 50]	Regulations Governing the Practice of Physician Assistants	Elimination of required submission of certain documents [Action 4629] Fast-Track - *At Governor's Office*
[18 VAC 85 - 80]	Regulations for Licensure of Occupational Therapists	NBCOT certification as option for CE [Action 4461] Proposed - *At Secretary's Office* [Stage 7756]
[18 VAC 85 - 80]	Regulations for Licensure of Occupational Therapists	CE credit for volunteer practice [Action 4702] Fast-Track - *Register Date: 1/23/17* *Effective: 3/9/17*
[18 VAC 85 - 101]	Regulations Governing the Licensure of Radiologic Technology	CE credit for volunteer practice [Action 4704] Fast-Track - *Register Date: 1/23/17* *Effective: 3/9/17*
[18 VAC 85 - 101]	Regulations Governing the Licensure of Radiologic Technology	Repeal of traineeships [Action 4707] Fast-Track - *Register Date: 1/23/17* *Effective: 3/9/17*
[18 VAC 85 - 140]	Regulations Governing the Practice of Polysomnographic Technologists	CE credit for volunteer practice [Action 4705] Fast-Track - *Register Date: 1/23/17* *Effective: 3/9/17*
[18 VAC 85 - 150]	Regulations Governing the Practice of Behavior Analysis	increase in hours of CE [Action 4331] Final - *Register Date: 2/6/17* *Effective: 3/8/17*
[18 VAC 85 - 170]	Regulations Governing the Practice of Genetic Counselors [under development]	Initial regulations for licensure [Action 4254]

Report of the 2017 General Assembly
Board of Medicine

HB 1484 Occupational therapists; Board of Medicine shall amend regulations governing licensure.

Chief patron: Bell, Richard P.

Board of Medicine to amend regulations governing licensure of occupational therapists to specify Type 1 continuous learning activities. Directs the Board of Medicine to amend regulations governing licensure of occupational therapists to provide that Type 1 continuing learning activities that shall be completed by the practitioner prior to renewal of a license shall consist of an organized program of study, classroom experience, or similar educational experience that is related to a licensee's current or anticipated roles and responsibilities in occupational therapy and approved or provided by one of the following organizations or any of its components: the Virginia Occupational Therapy Association; the American Occupational Therapy Association; the National Board for Certification in Occupational Therapy; a local, state, or federal government agency; a regionally accredited college or university; or a health care organization accredited by a national accrediting organization granted authority by the Centers for Medicare and Medicaid Services to assure compliance with Medicare conditions of participation. Such regulations shall also provide that Type 1 continuing learning activities may also include an American Medical Association Category 1 Continuing Medical Education program. The bill further provides that the Board of Medicine shall not deem maintenance of any certification provided by such organization as sufficient to fulfill continuing learning requirements for occupational therapists.

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

Chief patron: Leftwich

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

HB 1610 Drug Control Act; Schedule I.

Chief patron: Garrett

Drug Control Act; Schedule I. Adds certain chemical substances to Schedule I of the Drug Control Act. The Board of Pharmacy has added these substances to Schedule I in an expedited regulatory process. A substance added via this process is removed from the schedule after 18 months unless a general law is enacted adding the substance to the schedule. The bill also removes two substances, benzylfentanyl and thienylfentanyl, from Schedule I. The bill contains technical amendments. This bill is identical to SB 1546.

HB 2119 Laser hair removal; limits practice.

Chief patron: Keam

Practice of laser hair removal. Limits the practice of laser hair removal to a properly trained person licensed to practice medicine or osteopathic medicine or licensed as a physician assistant or nurse

practitioner or to a properly trained person under the direction and supervision of a licensed doctor of medicine or osteopathic medicine or physician assistant or nurse practitioner.

HB 2153 Durable Do Not Resuscitate Orders; reciprocity.

Chief patron: Rasoul

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

HB 2164 Drugs of concern; drug of concern.

Chief patron: Pillion

Drugs of concern; gabapentin. Adds any material, compound, mixture, or preparation containing any quantity of gabapentin, including any of its salts, to the list of drugs of concern. This bill contains an emergency clause.

EMERGENCY

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

Chief patron: Wexton

Dispensing of naloxone. Allows a person who is authorized by the Department of Behavioral Health and Developmental Services to train individuals on the administration of naloxone for use in opioid overdose reversal and who is acting on behalf of an organization that provides services to individuals at risk of experiencing opioid overdose or training in the administration of naloxone for overdose reversal and that has obtained a controlled substances registration from the Board of Pharmacy pursuant to § 54.1-3423 to dispense naloxone to a person who has completed a training program on the administration of naloxone for opioid overdose reversal, provided that such dispensing is (i) pursuant to a standing order issued by a prescriber, (ii) in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health, and (iii) without charge or compensation. The bill also provides that dispensing may occur at a site other than that of the controlled substance registration, provided that the entity possessing the controlled substance registration maintains records in accordance with regulations of the Board of Pharmacy. The bill further provides that a person who dispenses naloxone shall not be liable for civil damages of ordinary negligence for acts or omissions resulting from the rendering of such treatment if he acts in good faith and that a person to whom naloxone has been dispensed pursuant to the provisions of the bill may possess naloxone and may administer naloxone to a person who is believed to be experiencing or about to experience a life-threatening opioid overdose. The bill contains an emergency clause. This bill is identical to HB 1453.

EMERGENCY

SB 880 Genetic counselors; licensing; grandfather clause.

Chief patron: Howell

Genetic counselors; licensing; grandfather clause. Extends the deadline from July 1, 2016, to December 31, 2018, or to within 90 days of the effective date of the relevant regulations promulgated by the Board, whichever is later, by which individuals who have at least 20 years of documented work experience practicing genetic counseling and meet other certain requirements may receive a waiver from the Board of Medicine of the requirements of a master's degree and American Board of Genetic Counseling or American Board of Medical Genetics certification for licensure as a genetic counselor.

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

Chief patron: Stanley

Charity health care services; liability protection for administrators. Provides that persons who administer, organize, arrange, or promote the rendering of services to patients of certain clinics shall not be liable to patients of such clinics for any civil damages for any act or omission resulting from the rendering of such services unless the act or omission was the result of such persons' or the clinic's gross negligence or willful misconduct. This bill is identical to HB 1748.

SB 1009 Telemedicine, practice of; prescribing controlled substances.

Chief patron: Dunnavant

Practice of telemedicine; prescribing. Provides that a health care practitioner who performs or has performed an appropriate examination of the patient, either physically or by the use of instrumentation and diagnostic equipment, for the purpose of establishing a bona fide practitioner-patient relationship may prescribe Schedule II through VI controlled substances to the patient, provided that the prescribing of such controlled substance is in compliance with federal requirements for the practice of telemedicine. The bill also authorizes the Board of Pharmacy to register an entity at which a patient is treated by the use of instrumentation and diagnostic equipment for the purpose of establishing a bona fide practitioner-patient relationship and is prescribed Schedule II through VI controlled substances to possess and administer Schedule II through VI controlled substances when such prescribing is in compliance with federal requirements for the practice of telemedicine and the patient is not in the physical presence of a practitioner registered with the U.S. Drug Enforcement Administration. The bill contains an emergency clause. This bill is identical to HB 1767.

EMERGENCY

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

Chief patron: Barker

Registration of peer recovery specialists and qualified mental health professionals. Authorizes the registration of peer recovery specialists and qualified mental health professionals by the Board of Counseling. The bill defines "qualified mental health professional" as a person who by education and experience is professionally qualified and registered by the Board of Counseling to provide collaborative mental health services for adults or children. The bill requires that a qualified mental health professional provide such services as an employee or independent contractor of the Department of Behavioral Health and Developmental Services or a provider licensed by the Department of Behavioral Health and Developmental Services. The bill defines "registered peer recovery specialist" as a person who by education and experience is professionally qualified and registered by the Board of Counseling to provide collaborative services to assist individuals in achieving sustained recovery from the effects of addiction or

mental illness, or both. The bill requires that a registered peer recovery specialist provide such services as an employee or independent contractor of the Department of Behavioral Health and Developmental Services, a provider licensed by the Department of Behavioral Health and Developmental Services, a practitioner licensed by or holding a permit issued from the Department of Health Professions, or a facility licensed by the Department of Health. The bill adds qualified mental health professionals and registered peer recovery specialists to the list of mental health providers that are required to take actions to protect third parties under certain circumstances and notify clients of their right to report to the Department of Health Professions any unethical, fraudulent, or unprofessional conduct. The bill directs the Board of Counseling and the Board of Behavioral Health and Developmental Services to promulgate regulations to implement the provisions of the bill within 280 days of its enactment. This bill is identical to HB 2095.

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

Chief patron: Dunnavant

Health care practitioners; reporting disabilities of drivers. Provides that any doctor of medicine, osteopathy, chiropractic, or podiatry or any nurse practitioner, physician assistant, optometrist, physical therapist, or clinical psychologist who reports to the Department of Motor Vehicles the existence, or probable existence, of a mental or physical disability or infirmity of any person licensed to operate a motor vehicle that the reporting individual believes affects such person's ability to operate a motor vehicle safely is not subject to civil liability or deemed to have violated the practitioner-patient privilege unless he has acted in bad faith or with malicious intent. This bill is identical to HB 1514.

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

Chief patron: Marsden

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

EMERGENCY

SB 1046 Board of Medicine; requirements for licensure.

Chief patron: Stanley

Board of Medicine; requirements for licensure. Removes provisions related to licensure of graduates of an institution not approved by an accrediting agency recognized by the Board of Medicine. Under the bill, only graduates of institutions approved by an accrediting agency recognized by the Board of Medicine are eligible for licensure.

SB 1062 Definition of mental health service provider.

Chief patron: Deeds

Definition of mental health service provider. Adds physician assistant to the list of mental health service providers who have a duty to take precautions to protect third parties from violent behavior or other serious harm. This bill is identical to HB 1910.

SB 1178 Buprenorphine without naloxone; prescription limitation.

Chief patron: Chafin

Prescription of buprenorphine without naloxone; limitation. Provides that prescriptions for products containing buprenorphine without naloxone shall be issued only (i) for patients who are pregnant, (ii) when converting a patient from methadone to buprenorphine containing naloxone for a period not to exceed seven days, or (iii) as permitted by regulations of the Board of Medicine or the Board of Nursing. The bill contains an emergency clause and has an expiration date of July 1, 2022. This bill is identical to HB 2163.

EMERGENCY

SB 1179 Opioids; workgroup to establish guidelines for prescribing.

Chief patron: Chafin

Secretary of Health and Human Resources; workgroup to establish educational guidelines for training health care providers in the safe prescribing and appropriate use of opioids. Requires the Secretary of Health and Human Resources to convene a workgroup that shall include representatives of the Departments of Behavioral Health and Developmental Services, Health, and Health Professions as well as representatives of the State Council of Higher Education for Virginia and each of the Commonwealth's medical schools, dental schools, schools of pharmacy, physician assistant education programs, and nursing education programs to develop educational standards and curricula for training health care providers, including physicians, dentists, optometrists, pharmacists, physician assistants, and nurses, in the safe and appropriate use of opioids to treat pain while minimizing the risk of addiction and substance abuse. The workgroup shall report its progress and the outcomes of its activities to the Governor and the General Assembly by December 1, 2017. The bill contains an emergency clause. This bill is identical to HB 2161.

EMERGENCY

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

Chief patron: Chafin

Boards of Dentistry and Medicine; regulations for the prescribing of opioids and buprenorphine. Directs the Boards of Dentistry and Medicine to adopt regulations for the prescribing of opioids and products containing buprenorphine. The bill requires the Prescription Monitoring Program at the Department of Health Professions to annually provide a report to the Joint Commission on Health Care and the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health on the prescribing of opioids and benzodiazepines in the Commonwealth that includes data on reporting of unusual patterns of prescribing or dispensing of a covered substance by an individual prescriber or dispenser or on potential misuse of a covered substance by a recipient. The bill contains an emergency clause.

EMERGENCY

SB 1230 Opiate prescriptions; electronic prescriptions.

Chief patron: Dunnavant

Opiate prescriptions; electronic prescriptions. Requires a prescription for any controlled substance containing an opiate to be issued as an electronic prescription and prohibits a pharmacist from dispensing a controlled substance that contains an opiate unless the prescription is issued as an electronic prescription, beginning July 1, 2020. The bill defines electronic prescription as a written prescription that is generated on an electronic application in accordance with federal regulations and is transmitted to a pharmacy as an electronic data file. The bill requires the Secretary of Health and Human Resources to convene a work group of interested stakeholders to review actions necessary for the implementation of the bill's provisions, to evaluate hardships on prescribers and the inability of prescribers to comply with the deadline for electronic prescribing, and to make recommendations for any extension or exemption processes relative to compliance or disruptions due to natural or manmade disasters or technology gaps, failures, or interruptions of services. The work group shall report on the work group's progress to the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health by November 1, 2017, and a final report to such Chairmen by November 1, 2018.

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

Chief patron: Dunnavant

Limits on prescription of controlled substances containing opioids. Requires a prescriber registered with the Prescription Monitoring Program (the Program) to request information about a patient from the Program upon initiating a new course of treatment that includes the prescribing of opioids anticipated, at the onset of treatment, to last more than seven consecutive days and exempts the prescriber from this requirement if the opioid is prescribed as part of treatment for a surgical or invasive procedure and such prescription is for no more than 14 consecutive days. Current law requires a registered prescriber to request information about a patient from the Program upon initiating a new course of treatment that includes the prescribing of opioids anticipated, at the onset of treatment, to last more than 14 consecutive days and exempts the prescriber from this requirement if the opioid is prescribed as part of a course of treatment for a surgical or invasive procedure and such prescription is not refillable. The bill extends the sunset for this requirement from July 1, 2019, to July 1, 2022.

SB 1321 Ophthalmic prescriptions; definitions, who may provide prescriptions, requirements.

Chief patron: Carrico

Requirements for ophthalmic prescriptions. Requires, for ophthalmic prescriptions written on or after July 1, 2017, that an ophthalmologist or optometrist establish a bona fide provider-patient relationship with a patient prior to prescribing spectacles, eyeglasses, lenses, or contact lenses, and sets out requirements for establishing such relationship, which includes options for examination of the patient either in person or through face-to-face interactive, two-way, real-time communication or store-and-forward technologies. This bill is identical to HB 1497.

SB 1403 Controlled substances; use of FDA-approved substance upon publication of final rule, etc.

Chief patron: Dunnavant

Board of Pharmacy to deschedule or reschedule controlled substances. Authorizes the Board of Pharmacy (Board) to designate, deschedule, or reschedule as a controlled substance any substance 30 days after publication in the Federal Register of a final or interim final order or rule designating such substance as a controlled substance or descheduling or rescheduling such substance. Under current law, the Board may act 120 days from such publication date. The bill also provides that a person is immune from prosecution for prescribing, administering, dispensing, or possessing pursuant to a valid prescription a substance approved as a prescription drug by the U.S. Food and Drug Administration on or after July 1, 2017, in accordance with a final or interim final order or rule despite the fact that such substance has not been scheduled by the Board. The immunity provided by the bill remains in effect until the earlier of (i) nine months from the date of the publication of the interim final order or rule or, if published within nine months of the interim final order or rule, the final order or rule or (ii) the substance is scheduled by the Board or by law. This bill is identical to HB 1799.

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

Chief patron: Hanger

Prescription Monitoring Program. Provides that the information in the possession of the Prescription Monitoring Program disclosed by the Director of Health Professions about a specific recipient who is a member of a Virginia Medicaid managed care program to a physician or pharmacist employed by the Virginia Medicaid managed care program may be disclosed to such physician's or pharmacist's clinical designee who holds a multistate licensure privilege to practice nursing or a license issued by a health regulatory board within the Department of Health Professions and is employed by the Virginia Medicaid managed care program.

Agenda Item: **Regulatory Action – Adoption of Final Regulations for Nurse Practitioners**

Exempt action – fee reduction

Included in agenda package:

Amendments to 18VAC90-30-50 and 18VAC90-40-70 to reduce renewal fees for licensed nurse practitioners and for prescriptive authority.

Staff Note:

A fee reduction was approved by the Board of Nursing for all categories of practitioners but must also be approved by Board of Medicine for nurse practitioners

Board action:

Adoption of final regulation as an exempt action

Fee Reduction for Nurse Practitioners

18VAC90-30-50. Fees.

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

1. Application	$125
2. Biennial licensure renewal	$80
3. Late renewal	$25
4. Reinstatement of licensure	$150
5. Verification of licensure to another jurisdiction	$35
6. Duplicate license	$15
7. Duplicate wall certificate	$25
8. Return check charge	$35
9. Reinstatement of suspended or revoked license	$200

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

Biennial licensure renewal	$60

18VAC90-40-70. Fees for Prescriptive Authority.

A. The following fees have been established by the boards:

1. Initial issuance of prescriptive authority	$75
2. Biennial renewal	$35
3. Late renewal	$15
4. Reinstatement of lapsed authorization	$90
5. Reinstatement of suspended or revoked authorization	$85

6. Duplicate of authorization	$15
7. Return check charge	$35

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

Biennial licensure renewal	$26

Commonwealth of Virginia

REGULATIONS

GOVERNING PRESCRIBING OPIOIDS AND BUPRENORPHINE

VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18 VAC 85-21-10 et seq.

Statutory Authority: § 54.1-2400 and Chapter 29 of Title 54.1 of the *Code of Virginia*

Effective Date: March 15, 2017

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TABLE OF CONTENTS

Part I. General Provisions.

18VAC85-21-10. Applicability.

A. This chapter shall apply to doctors of medicine, osteopathic medicine, and podiatry and to physician assistants.

B. This chapter shall not apply to:

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

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

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

18VAC85-21-20. Definitions.

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

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

"Board" shall mean the Virginia Board of Medicine.

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

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

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

"MME" shall mean morphine milligram equivalent.

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

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

Part II. Management of Acute Pain.

18VAC85-21-30. Evaluation of the acute pain patient.

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

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

18VAC85-21-40. Treatment of acute pain with opioids.

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

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

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

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

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

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

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

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

D. Buprenorphine is not indicated for acute pain in the outpatient setting, except when a prescriber who has obtained a SAMHSA waiver is treating pain in a patient whose primary diagnosis is the disease of addiction.

18VAC85-21-50. Medical records for acute pain.

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

prescribed or administered to include the date, type, dosage, and quantity prescribed or administered.

Part III. Management of Chronic Pain.

18VAC85-21-60. Evaluation of the chronic pain patient.

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

1. The nature and intensity of the pain;

2. Current and past treatments for pain;

3. Underlying or coexisting diseases or conditions;

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

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

6. A urine drug screen or serum medication level;

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

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

9. A request for prior applicable records.

B. Prior to initiating opioid treatment for chronic pain, the practitioner shall discuss with the patient the known risks and benefits of opioid therapy and the responsibilities of the patient during treatment to include securely storing the drug and properly disposing of any unwanted or unused drugs. The practitioner shall also discuss with the patient an exit strategy for the discontinuation of opioids in the event they are not effective.

18VAC85-21-70. Treatment of chronic pain with opioids.

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

B. In initiating and treating with an opioid, the practitioner shall:

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

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

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

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

C. Buprenorphine may be prescribed or administered for chronic pain in formulation and dosages that are FDA-approved for that purpose.

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

E. The practitioner shall regularly evaluate for opioid use disorder and shall initiate specific treatment for opioid use disorder, consult with an appropriate healthcare provider, or refer the patient for evaluation and treatment if indicated.

18VAC85-21-80. Treatment plan for chronic pain.

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

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

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

18VAC85-21-90. Informed consent and agreement for treatment for chronic pain.

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

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

C. The treatment agreement shall include, but not be limited to, notice that the practitioner will query and receive reports from the Prescription Monitoring Program and permission for the practitioner to:

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

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

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

18VAC85-21-100. Opioid therapy for chronic pain.

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

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

C. Practitioners shall check the Prescription Monitoring Program at least every three months after the initiation of treatment.

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

E. The practitioner shall regularly evaluate for opioid use disorder and shall initiate specific treatment for opioid use disorder, consult with an appropriate healthcare provider, or refer the patient for evaluation for treatment if indicated.

18VAC85-21-110. Additional consultations.

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

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

18VAC85-21-120. Medical records for chronic pain.

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

1. The medical history and physical examination;

2. Past medical history;

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

4. Diagnostic, therapeutic and laboratory results;

5. Evaluations and consultations;

6. Treatment goals;

7. Discussion of risks and benefits;

8. Informed consent and agreement for treatment;

9. Treatments;

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

11. Patient instructions; and

12. Periodic reviews.

Part IV. Prescribing of Buprenorphine for Addiction Treatment.

18VAC85-21-130. General provisions pertaining to prescribing of buprenorphine for addiction treatment.

A. Practitioners engaged in office-based opioid addiction treatment with buprenorphine shall have obtained a SAMHSA waiver and the appropriate Drug Enforcement Administration registration.

B. Practitioners shall abide by all federal and state laws and regulations governing the prescribing of buprenorphine for the treatment of opioid use disorder.

C. Physician assistants and nurse practitioners, who have obtained a SAMHSA waiver, shall only prescribe buprenorphine for opioid addiction pursuant to a practice agreement with a waivered doctor of medicine or doctor of osteopathic medicine.

D. Practitioners engaged in medication-assisted treatment shall either provide counseling in their practice or refer the patient to a mental health service provider, as defined in § 54.1-2400.1 of the Code of Virginia, who has the education and experience to provide substance abuse counseling. The practitioner shall document provision of counseling or referral in the medical record.

18VAC85-21-140. Patient assessment and treatment planning for addiction treatment.

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

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

18VAC85-21-150. Treatment with buprenorphine for addiction.

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

1. When a patient is pregnant;

2. When converting a patient from methadone or buprenorphine mono-product to buprenorphine containing naloxone for a period not to exceed seven days; or

3. In formulations other than tablet form for indications approved by the FDA.

B. Buprenorphine mono-product tablets may be administered directly to patients in federally licensed opioid treatment programs (OTPs). With the exception of those conditions listed in subsection A, only the buprenorphine product containing naloxone shall be prescribed or dispensed for use offsite from the program.

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

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

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

F. During the induction phase, except for medically indicated circumstances as documented in the medical record, patients should be started on no more than 8 mg. of buprenorphine per day. The patient shall be seen by the prescriber at least once a week.

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

H. Practitioners shall take steps to reduce the chances of buprenorphine diversion by using the lowest effective dose, appropriate frequency of office visits, pill counts, and checks of the Prescription Monitoring Program. The practitioner shall also require urine drug screens or serum medication levels at least every three months for the first year of treatment and at least every six months thereafter.

I. Documentation of the rationale for prescribed doses exceeding 16 mg. of buprenorphine per day shall be placed in the medical record. Dosages exceeding 24 mg. of buprenorphine per day shall not be prescribed.

J. The practitioner shall incorporate relapse prevention strategies into counseling or assure that they are addressed by a mental health service provider, as defined in § 54.1-2400.1 of the Code of Virginia, who has the education and experience to provide substance abuse counseling.

18VAC85-21-160. Special populations in addiction treatment.

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

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

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

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

E. Practitioners shall not undertake buprenorphine treatment with a patient who has psychiatric comorbidities and that is not stable. A patient who is determined by the prescriber to be psychiatrically unstable shall be referred for psychiatric evaluation and treatment prior to initiating medication-assisted treatment.

18VAC85-21-170. Medical records for opioid addiction treatment.

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

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

C. Confidentiality requirements of 42 CFR, Part 2 shall be followed.

D. Compliance with Board of Medicine Regulation 18VAC85-20-27, which prohibits willful or negligent breach of confidentiality or unauthorized disclosure of confidential Prescription Monitoring Program information, shall be maintained.

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

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

May 10, 2017