FINAL APPROVED

VIRGINIA BOARD OF MEDICINE

LEGISLATIVE COMMITTEE MINUTES

Friday, May 19, 2017 Department of Health Professions Henrico, VA

CALL TO ORDER: The meeting convened at 8:31 a.m.

ROLL CALL: Mr. Heaberlin called the roll; a quorum was established.

MEMBERS PRESENT:
Kevin O'Connor, MD, Vice-President, Chair
Syed Salman Ali, MD
Wayne Reynolds, DO
Svinder Toor, MD
The Honorable Jasmine Gore

MEMBERS ABSENT
Barbara Allison-Bryan, MD, President
David Giammittorio, MD

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
David Brown, DC, DHP Director
Erin Barrett, JD, Assistant Attorney General

OTHERS PRESENT:
W. Scott Johnson, JD, HDJN & MSV
Ralston King, MSV
Carey Cox, VATAC
Sara Heisler, VHHA

EMERGENCY EGRESS INSTRUCTIONS

Dr. O'Connor provided the emergency egress instructions.

APPROVAL OF MINUTES of January 27, 2017

Dr. Ali moved to accept the meeting minutes as presented. The motion was seconded and carried.

ADOPTION OF AGENDA

Dr. Toor made a motion to accept the agenda as presented.

The motion was seconded and carried unanimously.

PUBLIC COMMENT

There was no public comment.

DHP DIRECTOR'S REPORT

Dr. Brown provided a brief report. He said that, in calendar year 2016, Virginia deaths related to opioid overdose were up 40% over calendar year 2015 and noted that there is no sign of this problem slowing. He commended the Regulatory Advisory Panel (RAP) for their work on the opioid regulations. He also noted that the workgroup of educators meeting next door with Dr. Hazel should be a great help in reducing opioid overdose death through prescriber education.

EXECUTIVE DIRECTOR'S REPORT

Dr. Harp did not have a report.

NEW BUSINESS

1. **Chart of Board of Medicine Regulatory Actions**

Elaine Yeatts provided a brief overview of this item. No action was required.

2. **Consideration of Recommendations from the Regulatory Advisory Panel, Supporting Documents, and Public Comment.**

Dr. O'Connor began by noting that he does not want to change the regulations based on anecdotal information.

Ms. Yeatts explained the different processes required to amend the emergency regulations and final regulations. The full Board in June will re-adopt the emergency regulations and move to adopt the full regulations to replace the emergency regulations upon their expiration. She then led the Committee through the recommendations from the RAP that met May 15, 2017.

18VAC85-21-70(C). After a brief discussion Dr. Ali moved to strike the first sentence of subsection C in the emergency regulations and to substitute the language, "Buprenorphine mono-product in tablet form shall not be prescribed for chronic pain." The motion was seconded and carried unanimously.

18VAC85-21-150(4). The Committee discussed how prescribers would be monitored to ensure they did not exceed 5% of patients being prescribed the mono-product. Dr. Harp, Dr. Brown and Ms. Deschenes all noted that the Prescription Monitoring Program (PMP) could be used to conduct prescriber audits. It was reported that Ralph Orr, PMP Director, could fashion a program to identify those that exceeded the established threshold.

Dr. Toor stated that he would like documentation on the patient's prescription that he/she is allergic to naloxone. He further asked for clarification on how the RAP chose 5% of patients as a threshold.

Dr. Harp stated that this number was agreed to by the RAP, which had believers and skeptics regarding naloxone intolerance. He stated that a member of the RAP noted his patients that were unable to tolerate the bi-product was around 5% of his total number of MAT patients.

Dr. Brown explained that having a clear percentage of patients in the regulations strengthens the hand of the Board. It will allow the PMP Advisory Panel to set the threshold for prescribers that are to be referred for investigation. A clear standard in the regulations will serve as a concrete basis for such referrals.

Dr. Ali asked Dr. Harp if the 5% number is necessary, and if it is his general belief that it is accurate that 5% of patients have problems with naloxone-containing product.

Dr. Harp stated that, according to the RAP, naloxone intolerance occurs in less than 5% of the patient population and that financial hardship is greater than 5%.

Dr. O'Connor stated that it is not the Board's purview to determine financial hardship. He favors reducing the 5% number to 3% and to strike "financial hardship" from the suggested revision. He further stated that a prescriber needs to have significant documentation in the medical record supporting why the mono-product is being prescribed.

Ms. Gore noted that she believed financial hardship should be included in the regulations. Financial hardship and the patient's ability to pay is a significant part of seeking and obtaining health care.

The Committee agreed that a 3% threshold would be enough to cover naloxone intolerance. Dr Toor made a motion to revise 18VAC85-21-150(4) to read, "For patients who have a demonstrated allergy or intolerance to naloxone, prescriptions for the mono-product shall not exceed 3% of the total prescriptions for buprenorphine written by the prescriber. Such exceptions must be clearly documented in the patient's medical record."

The motion was seconded and carried unanimously.

18VAC85-21-160(A).

Dr. Toor moved to change “shall” to “may.” The motion was seconded and carried.

The Committee then began to review suggested edits to the final regulations that arose from the RAP’s discussion.

18VAC85-21-10(2). The edit to include correctional facilities was discussed. Ms. Deschenes reviewed the reasons for including the revised language including correctional facilities, noting that the particular subsection dealt with acute and chronic pain, not addiction.

Dr. Ali noted that this particular population is already prone to drug-seeking behavior and exempting correctional facilities from the regulations is counterintuitive.

Ms. Deschenes said that patients in correctional facilities are administered the medication by a nurse who ensures that it is taken as prescribed.

Dr. Brown noted that the agency had not been contacted by any correctional facilities seeking such an exception.

By consensus, it was determined not to include the suggested revision in the final regulations.

18VAC85-21-30(B). A discussion was held regarding the feasibility of removing the specific Code language from this regulation.

Ms. Yeatts noted that striking the Code section language would require physicians to check the PMP if even one opioid tablet was prescribed.

The Committee agreed that this would result in an undue burden for physicians.

Dr. Brown told the Committee that the General Assembly had made it a standard to check the PMP when a prescription is written for a 7 day or greater supply of opioids.

By consensus, it was determined to leave this regulation as written.

180VAC85-21-40 & 18VAC85-21-70(5). Dr. Harp explained that the Board had gotten questions from pharmacists who have to call physicians in order to determine if the opioid prescriptions being written were legitimate, since allowable supplies differ for acute, surgical and chronic pain.

Dr. O’Connor stated that this recommendation appears to open an avenue for more complaints to the Board about physicians rather than improving patient care.

Dr. Brown noted that this particular revision is part of the final regulations which still must

go out for another comment period. He noted that, without the proposed language, more calls will be made to prescribers by pharmacists who want to double-check why a prescription is being written.

Dr. Ali noted that this would be difficult to implement with physicians who write prescriptions electronically. It would be particularly difficult to document the type of pain on prescriptions generated in electronic medical records (EMR).

Dr. O'Connor said that this is not an issue about which people are complaining.

Dr. Toor moved not to include the revised language in the final regulations.

The motion was seconded and carried.

18VAC85-21-40(A)(C). This revision was requested because tramadol is an opioid and having it named separately in the regulation creates ambiguity. Dr. O'Connor said that there is no downside to leaving tramadol in the regulation as written, and by consensus it was decided tramadol would stay.

18VAC85-21-70(A)(3) & 18VAC85-21-80(C). After a brief discussion, Dr. Toor moved to strike "abuse" in the first regulation above and replace it with "misuse". He moved to strike the word "abuse" from the second regulation as well, replacing it with "misuse". The motion was seconded and carried.

3. **Draft Regulations for Licensure by Endorsement.**

Dr. Harp reviewed the "Draft Elements for Licensure by Endorsement" with the Committee.

Items under section 1 and 2 were agreed upon by consensus with no discussion.

Regarding section 3, a discussion was held on the period of practice a physician must attest to in order to be eligible for licensure by endorsement. Mr. Heaberlin suggested that, based upon his review of other states' regulations for licensure by endorsement, the Board should require 5 years of "continuous" or "active" practice defined as an average of 20 hours/week, or 640 hours a year.

Dr. Ali asked if residency and fellowships could be included in the 5 years of continuous or active practice.

Mr. Heaberlin noted that licensure by endorsement is intended to expedite licensure for physicians who have been practicing for several years and who already have a practice history. Physicians coming out of residency or fellowship are already expedited since there is less work history to be verified.

On section 4, Dr. Harp explained that North Carolina and other states that have licensure

by endorsement accept the Canadian Board certifications as equivalent to the U.S. Board certifications.

For section 5, Dr. Harp explained the elements in a National Practitioner Data Bank report. The report includes medical malpractice payments, medical board history, licensure history and disciplinary actions taken by hospitals.

Dr. Ali noted the report was easy to obtain.

Dr. Harp asked if, since the NPDB report is so inclusive, would it be acceptable to the Board if only one license verification was required to document the 5 years of continuous licensure.

The Committee agreed that only one license verification would be needed. Dr. Toor also noted that the application should ask the applicant if he has ever resigned from a position or is under investigation by any other Board.

Dr. Toor moved to accept the "Draft Elements for Licensure by Endorsement" as reviewed by the Committee. The motion was seconded and carried unanimously.

ANNOUNCEMENTS

Please have your travel vouchers in by May 22nd.

The next Legislative Committee meeting will be September 8, 2017.

ADJOURNMENT

All business being completed, Dr. O'Connor adjourned the meeting at 10:07 a.m.

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Kevin O'Connor, MD
Vice-President, Chair

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William L. Harp, MD
Executive Director

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Alan Heaberlin, Deputy Director, Licensing
Recording Secretary