Executive Committee Meeting

Virginia Board of Medicine

December 7, 2018

8:30 a.m.

Executive Committee

Friday, December 7, 2018 @ 8:30 a.m.
9960 Mayland Drive, Suite 200
Richmond, VA 23230
Board Room 4

Page

Convening of a Public Hearing on Regulations on Laser Hair Removal

Call to Order of the Executive Committee—Kevin O'Connor, MD, President, Chair

Emergency Egress Procedures ..... **i**

Roll Call

Approval of Minutes – August 3, 2018 1

Adoption of Agenda

Public Comment on Agenda Items

DHP Director's Report – David Brown, DC

President's Report - Kevin O'Connor, MD

Executive Director's Report – William L. Harp, MD 12

NEW BUSINESS:

1. Regulatory Actions – Ms. Yeatts

    - Chart of Regulatory Actions as of November 30, 2018 16
    - Preliminary report on 2019 legislation 17

2. Recommendation of the Ad Hoc Committee on Controlled Substances Continuing Education 24

3. Approval of Instructions and Applications for Licensure by Endorsement 48

Announcements

Next scheduled meeting: April 5, 2019

Adjournment

--- DRAFT UNAPPROVED --

VIRGINIA BOARD OF MEDICINE
EXECUTIVE COMMITTEE MINUTES

Friday, August 3, 2018 | Department of Health Professions | Henrico, VA

CALL TO ORDER: Dr. O'Connor called the meeting to order at 8:32 a.m.

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

MEMBERS PRESENT:
Kevin O'Connor, MD, President
Nathaniel Tuck, Jr., DC, Vice-President
David Archer, MD
Alvin Edwards, MDiv, PhD
Jane Hickey, JD
Kenneth Walker, MD

MEMBERS ABSENT:
Syed Salman Ali, MD
Lori Conklin, MD, Secretary-Treasurer

STAFF PRESENT:
William L. Harp, MD, Executive Director
Jennifer Deschenes, JD, Deputy Director, Discipline
Colanthia Morton Opher, Deputy Director, Administration
Barbara Matusiak, MD, Medical Review Coordinator
David Brown, DC, DHP Director
Barbara Allison-Bryan, MD, DHP Deputy Director
Elaine Yeatts, DHP Senior Policy Analyst
Erin Barrett, JD, Assistant Attorney General

OTHERS PRESENT:
Kurt Elward, MD, President, MSV
Ralston King, MSV
W. Scott Johnson, JD, MSV
Cynthia Fagan, VCNP
Morgan McDowell, VCNP
Mary Baker, VCNP
Brekk MacPherson, VCNP
Rebekah Compton, VCNP
Richard Grossman, VCNP
Ryan LaMura, VHHA
Sara Heisler, VHHA
Aimee Perron Seibert, VA College of Emergency Physicians
Del Bolin, VAFP & VCOM
Hunter Jamerson, VAFP
Rosie Taylor-Lewis, VCNP
Sam Bartle, MD, VA Chapter, American Academy of Pediatrics

EMERGENCY EGRESS INSTRUCTIONS

Dr. Tuck provided the emergency egress instructions.

APPROVAL OF MINUTES OF APRIL 13, 2018

Dr. Edwards moved to approve the meeting minutes of April 13, 2018 as presented. The motion was seconded and carried unanimously.

ADOPTION OF AGENDA

Dr. Tuck moved to adopt the agenda as presented. The motion was seconded and carried unanimously.

PUBLIC COMMENT

Prior to opening the floor for comment, Dr. O'Connor announced that the comment period for the Regulations for Autonomous Practice by Nurse Practitioners had closed. No comment would be received at this meeting on the NP regulations.

There was no public comment.

DHP DIRECTOR'S REPORT

Dr. Brown gave a quick summary of projects that Dr. Allison-Bryan has been working on over the past several months. He stated that, as Chief Deputy, she has increased the bandwidth of the Director's office. He noted that Dr. Allison-Bryan came into the position with a strong background on the opioid crisis, its challenges and the opioid regulations. She has continued her work on the crisis with other agencies and the Deputy Secretary. He noted Dr. Allison-Bryan's strong presentation abilities, as acknowledged by the correspondence from Carilion in the agenda packet. Additionally, she has been involved with reviewing and developing security measures for the agency.

Dr. Allison-Bryan gave an update on the work that she's been doing with the Henrico Police and the Virginia State Police to address safety issues and security concerns for the building, personnel and the public. She acknowledged that the work performed by the Board members can be very threatening, especially when the respondent's livelihood hangs in the balance. She stated that they had completed one walk-through and discussed placement of security cameras to create a safer work environment.

Dr. Allison-Bryan informed the members about the launch of Virginia's Emergency Department Care Coordination (EDCC) Program and stated that every physician will be touched by it. As of June 30th, all 122 emergency departments across Virginia were connected, giving them the ability of near real-time communication and collaboration among health care providers. Dr. Allison-Bryan added that when a patient presents to the ER, a NarxCare ribbon will appear with the patient's EMR and PMP history, providing an abuse risk score. NarxCare should be helpful in identifying potential drug misuse and abuse.

Dr. Allison-Bryan also spoke to the interoperability and integration of the PMP and noted that Virginia is up to 30 states and counting. The Commonwealth has a model PMP and, in conjunction with the Department of Health, will be producing 5 short videos that will provide an important resource to the deans of medical schools. Updates on this effort will be provided as the project progresses.

PRESIDENT'S REPORT

Dr. O'Connor reported that the licensing of art therapists is under consideration by the Board of Health Professions. A decision will be made at the next BHP meeting.

EXECUTIVE DIRECTOR'S REPORT

Revenue and Expenditures

Dr. Harp reported that the Board is solid in its budgeting, revenues, and expenditures. He stated that the Board has voted to reduce renewal fees across all professions for the last three biennia.

Committee Appointments

Dr. Harp announced the appointment of new Board members.

- James Arnold, DPM of Winchester succeeding Randy Clements
- Manjit Dhillon, MD, succeeding David Taminger in the 4th District
- L. Blanton Marchese of Chesterfield, succeeding James Jenkins as citizen member
- Karen Ransone, MD succeeding Barbara Allison-Bryan in the 1st District
- Brenda Stokes, MD succeeding Maxine Lee in the 6th District
- David Taminger, MD succeeding Ike Koziol in the 7th District

Committee Appointments

Dr. Harp reviewed the appointments to the Executive, Legislative and Credentials Committees. He noted that all new Board members start out on Credentials. However, Dr. Ransone, with her experience as a past president of the Board of Medicine, has been appointed to the Legislative Committee.

Letter from Dr. Koziol

Dr. Harp read to the Committee Dr. Koziol's letter regarding his decision to resign from the Board. Dr. Koziol had very kind words for his colleagues at the Board.

Letter from Virginia Tech Carilion

Dr. Harp said that he would like to follow up on Dr. Brown's kudos to Dr. Allison-Bryan; she was a hit at Carilion. Dr. Clements, former podiatrist on the Board, helped facilitate participation in Carilion's Grand Rounds for faculty and housestaff, as well as the incoming

residents' orientation. Dr. Allison-Bryan and Dr. Harp were impressed with what the school is doing to educate students, residents, faculty and staff, not only about opioids, but all areas of medicine.

Case Review

Dr. Harp announced that Dr. Matusiak is requesting the assistance of any available Board members for probable cause review after the meeting.

NEW BUSINESS

Chart of Regulatory Actions

Ms. Yeatts reviewed the Chart of Regulatory Actions as of July 17, 2018.

She reported that the final Regulations Governing Prescribing of Opioids and Buprenorphine will go into effect August 8, 2018. The Licensure by Endorsement regulations will go into effect September 5, 2018.

This report was for informational purposes only.

Regulatory Action – Adoption of Exempt Actions to conform to changes in the Code of Virginia

Polysomnographic Technologists

Ms. Yeatts reviewed the legislation passed by the 2018 General Assembly and the proposed amendments to conform the regulations to the changes in the Code for polysomnographic technologists.

Part II - Requirements for Licensure as a Polysomnographic Technologist

A student enrolled in an educational program in polysomnographic technology or a person engaged in a traineeship from the practice of polysomnographic technology, provided that such student or trainee is under the direct supervision of a licensed polysomnographic technologist or a licensed doctor of medicine or osteopathic medicine.

1. Any such student or trainee shall be identified to patients as a student or trainee in polysomnographic technology.
2. Such student or trainee shall be required to have a license to practice after 18 months from the start of the educational program or traineeship or six months from the conclusion of such program or traineeship, whichever is earlier.

MOTION: Dr. Edwards moved to adopt the new section as presented such that the regulations conform to the language of the law. The motion was seconded and carried unanimously.

Surgical Assistants

Ms. Yeatts reviewed the legislation passed by the 2018 General Assembly and the proposed amendments to conform the regulations to the changes in the Code for surgical assistants.

18VAC85-160-60-Renewal of registration for a surgical assistant

A surgical assistant who was registered based on a credential as a surgical assistant or surgical first assistant issued by the National Board of Surgical Technology and Surgical Assisting, the National Surgical Assistant Association, or the National Commission for the Certification of Surgical Assistants or their successors shall attest that the credential is current at the time of renewal.

MOTION: Dr. Edwards moved to adopt the new language as presented so that the regulations conform to the language of the law. The motion was seconded and carried unanimously.

Regulatory – Emergency Action on regulations for autonomous practice for nurse practitioners

Dr. O'Connor introduced the topic by advising that "the law is the law" and the Regulatory Advisory Panel and the Board of Nursing have vetted the language that is now before the Committee. At this time, the Board of Medicine's responsibility is to craft, with some specificity, the definition of full-time employment.

Ms. Yeatts explained the regulatory process and said that the Board of Nursing has already adopted the draft regulations in the packet; the Board of Medicine can adopt as them as presented or consider amendments. If there are proposed amendments, they would be revisited at the next meeting of the Board of Nursing and at the October Board of Medicine meeting.

Ms. Yeatts walked the members through the proposed regulations and the following summary of the public comment.

SUMMARY – PUBLIC COMMENT ON 5-17-17 DRAFT NP REGS (HB793)

Virginia Healthcare Foundation

- Encourage a regulatory approach for transition to practice that does not exceed a total of 5 years of collaboration for an NP who is licensed in more than one specialty area (category)

- Customized/individualized approach when reviewing applications - Develop a framework for review when considering each NP's individual level of training, credentials and work experience
- Wants a system that promotes NP's adding an additional licensure category, especially for categories that are needed to expand access to care, such as Psych MHNP

Medical Society of Virginia

- 10,000 hours – ½ the time a medical resident practices in 5 years
- 2nd specialty attestation – limit past hours to 10% (or 1,000 hours)
- Detail needed re "specialty area and/or patient population must be aligned" between patient care team physician and NP while under practice agreement – Specialty crosswalk provided
- Adherence to National *Specialty* Certifications
- Prescribing Limitations – proper/education/training and experience prior to prescribing
- Attestation – Give physician the option to provide a rationale for their refusal to sign
- Core Competencies – nothing in the draft that ensures an NP has achieved the basic competencies for autonomous practice – Robust standard needed to define competencies

Virginia Academy of Family Physicians

- Shares MSV concerns
- 2,000 year/10,000 total hours – same as MSV
- Patient population and specialty/category alignment – regulations need to spell out how aligned while under the collaborative Practice Agreement – same as MSV
- Prescribing Limitations – same as MSV
- Attestation – same as MSV
- Guidance document identifying the core competencies that should be met prior to autonomous practice

Virginia Hospital and Healthcare Association

- Definition of FT experience – supports 1,600 year/8,000 total hours
- Content of attestation – supports an approach that limits the attestation to those elements required by the statute
- Other evidence – provide examples of other evidence that would demonstrate applicant met requirements

UVA Health System

- Multiple Attestations – Paragraph D 18VAC90-30-86 is confusing—"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 towards a 2nd attestation."
    - Possible Interpretations: 5 years in each attestation area, or one 5-year period could apply concurrently for each attestation area. Clarity needed. Maybe a minimum amount of time?

  - Suggest open-ended question on attestation form to describe the populations and practice areas worked
  - Specify patient population and practice area on the license
  - System to share information with hiring entities and credentials by secure electronic means

- Licensure by endorsement –
  - Virginia doesn't currently issue a separate RN license to nurses with multistate privilege. Can a RN with multi-state privilege be the basis for issuing an autonomous NP license?
  - Will NP under supervision in another state impact endorsement?
- Practice Agreements – Provides editorial changes to 18VAC90-30-120 A & C (page 2 of letter)
- Consider substituting "independent" for "autonomous", i.e. "licensed independent practitioners"

American Academy of Pediatrics

- Amendment: "While a party to such practice agreement, the patient care team physician routinely practiced with a patient population *and in a primary care or specialty practice area* included within the category, as specified in 18VAC90-30-70 . . ."
- Reverse FT – should be 2,000/10,000 hours
- NPs need to show proficiency before they transition – need for ongoing competency and how that is measured, i.e. continuing education

Virginia College of Emergency Physicians

- 5 years FT should be 2,000 year/10,000 total hours
- Specifications for MD specialty and NP licensure – "patient population" is not clear enough Acute/emergent/primary/chronic/preventative? Clear guidelines needed
- Requesting an amendment with same verbiage as American Academy of Pediatrics re: primary/specialty practice
- Attestation of 5 years – clear, objective, and reproducible – NP's need board certification exams like those of MD's

80 Letters from Physicians/Medical Students

- Same as MSV list of 6 areas of concern

70 other commenters (numerous NP's) in support of current regulations – no further barriers to practice – support regulations as recommended by the RAP

Dr. O'Connor advised that he, Dr. Conklin, and Dr. Mackler were the only physicians on the RAP, which enjoyed a robust discussion that covered all the topics in the summary. The members of the RAP agreed with the dual hours, but where the rubber met the road was with the 5-year requirement.

Dr. Archer said that his concern is with the attestation and its validity. He said that in a residency, you have years of opportunity to evaluate a practitioner's competency. With the nurse practitioner, there doesn't appear to be anything substantial, therefore it is not a quantitative approach.

Ms. Yeatts stated that, first, the nurse practitioner's competency is established when they are issued a license to practice. They would have had to provide adequate proof of examination, national credentialing, board certification, to be jointly licensed by the Board of Medicine and Nursing. Second, there is nothing in the law that requires a patient care team physician to attest to the nurse practitioner's competency.

Dr. Archer stated that, when a student graduates from medical school, he/she serves a 1 year internship, followed by 3-5 years in a residency/fellowship program. All along the way, his/her clinical knowledge is being assessed by multiple physicians. So why aren't the nurse practitioners held to the same standard? He would like some objective documentation that they are competent.

Ms. Barrett said that ship has sailed. The General Assembly has already determined what the physician and nurse practitioner can do, and there is no option to go beyond it. As per the law, the physician and nurse practitioner are limited to:

> (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.

Dr. Walker asked if it would be advantageous to go through each of the comments listed in the summary.

Dr. O'Connor said that the Committee has that option. However, what's on the table is the total number of hours per week that constitutes Full-Time, and what constitutes 5 years of training.

Dr. Walker asked whether the Committee has the ability to substitute "independent" for "autonomous".

Dr. Allison-Bryan said that there is no correct word. Independent implies that you work alone, and autonomy is a matter of substance.

Dr. Walker said that if we are unable to make any other changes to the regulations, then he withdraws his question.

Dr. Brown noted that the public comment covered many things. And though there is no need to discuss every comment, if a concern strikes a chord, it should be identified for discussion. In the same vein, there should be some hesitancy to set a precedent to discuss all comments for any issue.

Dr. O'Connor stated that the battle was lost when the Governor signed the bill.

Ms. Barrett reminded the members that this might not be the last time these draft regulations come before the Board of Medicine. She said that both Medicine and Nursing must adopt the same regulations. But if that does not happen, they will bounce between the two boards until a version or compromise that each can live with is adopted.

Dr. O'Connor said that if the regulations were accepted as presented today, then the emergency regulations are done. The definition of 5 years as noted in the regulations and ability to do cross-attestation would be fixed.

Ms. Hickey asked if the number of hours could be supplemented over more than a 5-year span.

Ms. Yeatts stated that the rationale for the number of hours being considered is based on the fact that, in a hospital setting, 32 hours per week is viewed as full-time. That equates to 1,600 work hours a year, accounting for 2 weeks off.

Ms. Hickey clarified that, if the proposed hours were changed to 40 hours weekly and the nurse practitioner worked 35 hours, they would be required to work 5 ½ years to accomplish the total number of hours required before being able to practice autonomously. She felt that those parameters were acceptable.

Dr. O'Connor said that the physicians on the RAP felt strongly that 40 hours should be the requirement; however, there was no spirit of compromise from other members of the Panel.

Dr Archer agreed that 5 years is arbitrary, but adequate; it is full-time employment. He said that he didn't think that 32 hours per week was enough, and 40 may be too much to ask. He said that 36 should be the logical option.

Dr. O'Connor stated that an offered compromise was rejected. Neither the physicians, nor the nurse practitioners were happy, so it was probably the right choice.

Dr. Tuck agreed.

Dr. Archer said while there's an agreement that the average number of work hours is 2,000 per year, no one works that.

Dr. Walker said that 5 years isn't sufficient, and 10 years is way too much. Personally, he can live with something between 6-10 years.

Dr. O'Connor advised that 9,000 hours is five years.

Dr. Tuck stated that 9,000 hours is a reasonable compromise.

By acclamation, all the members agreed that 9,000 hours should be the proposed amendment.

Dr. O'Connor advised that the second issue up for discussion is how overlapping practice hours can be used for attestation of a second specialty category. The RAP proposal is to use them all.

Ms. Hickey questioned how the hours are calculated if a patient is working in family practice and sees psychiatric patients.

Dr. O'Connor advised that the team physician attests that the hours performed were mental health hours.

Ms. Hickey asked if a nurse practitioner with a certification in psychiatry works in family medicine, and 30% of the patient population is mental health, would she need to work more than 5 years before practicing autonomously?

Ms. Yeatts confirmed that the attestation is dependent on the patient population as to whether or not the hours would count.

Dr. Walker asked if a family NP strictly worked for an ENT practice for 5 years and then returns to a family practice, is there a mechanism to address competency?

Ms. Barrett advised that, you as a practitioner licensed in medicine and surgery, have no limitation on your license and nothing to prevent you from changing specialties. Similarly, there is nothing in the Code that authorizes you to ask for proof of the nurse practitioner's competency. If the licensee wishes to be certified as an autonomous family NP, then he/she would have to practice for 5 years.

Ms. Yeatts referred to the draft regulations that a NP can only practice within the scope of his/her clinical/professional training, limits of knowledge and experience, and consistent with the applicable standards of care.

MOTION: Dr. Edwards moved to amend the existing emergency regulations to indicate that 5 years of clinical training equates to 9,000 hours. The motion was seconded and opened for discussion.

Dr. Archer stated his dissatisfaction with requiring a licensee to go back and obtain additional hours if he/she wants to change specialties.

Dr. Allison-Bryan said that, to become at Medication-Assisted Treatment (MAT) provider, one would need to obtain a waiver, which can only be obtained by taking a SAMHSA-approved course. Then, and only then, can a NP provide MAT in a collaborative practice.

Dr. Archer asked if the entire 5 years are accepted or just a portion.

Ms. Yeatts stated that the situation is dependent on whether there is overlap with the family practice attestation.

After some additional discussion, the motion passed 4 to 2, with Dr. Archer and Dr. Edward opposing.

Executive Director Note: Although discussed above, no motion was made to amend the recommendation of the RAP concerning acceptance of 100% of applicable hours on an attestation for a second specialty.

Consideration of Statutory Amendments

Ms. Yeatts advised that Code Section 54.1-2923.1 refers to an outdated program for impaired practitioners.

MOTION: Dr. Edwards moved to recommend deletion of 54.1-2923.1. The motion was seconded and carried unanimously.

ANNOUNCEMENTS

The next meeting of the Committee will be December 7, 2018 at 8:30 a.m.

ADJOURNMENT

With no additional business, the meeting adjourned at 9:58 a.m.

Kevin O'Connor, MD
President, Chair

William L. Harp, MD
Executive Director

Colanthia M. Opher
Recording Secretary

Virginia Department of Health Professions
Cash Balance
As of September 30, 2018

	102- Medicine
Board Cash Balance as June 30, 2018	$ 10,185,518
YTD FY19 Revenue	3,104,168
Less: YTD FY19 Direct and Allocated Expenditures	2,343,524
Board Cash Balance as September 30, 2018	10,946,162

Virginia Department of Health Professions

Input of Case Hours by Department
For Use in Allocation of Department 305- *Enforcement* Costs
For the Fiscal Year Ended June 30, 2019

	Fiscal Month No.	1	2	3	4	5	6	7	8	9	10	11	12	Annual
	Month Name	July	August	September	October	November	December	January	February	March	April	May	June	Total
Dept. No.	Dept. Name													
101	Nursing	1,729.00	1,758.25	1,716.50	1,952.13									7,155.88
102	Medicine	1,881.00	2,274.33	1,606.30	1,640.00									7,401.63
103	Dentistry	421.00	632.75	500.05	479.25									2,033.05
104	Funeral Directors and Emba	138.00	154.00	103.00	133.03									528.03
105	Optometry	46.75	12.25	45.50	10.00									114.50
106	Veterinary Medicine	345.25	341.58	273.00	392.38									1,352.21
107	Pharmacy	1,236.65	1,549.13	1,163.35	1,446.68									5,395.81
108	Psychology	52.00	41.75	46.00	104.25									244.00
109	Professional Counselors	191.50	216.25	179.50	201.99									789.24
110	Social Work	121.50	118.00	76.75	66.25									382.50
112	Cerified Nurse Aids (State	612.50	480.50	388.70	374.75									1,856.45
114	Nursing Home Administrator	105.75	108.75	136.50	116.00									467.00
115	Audiology and Speech Lang	13.50	18.00	32.00	30.50									94.00
116	Physical Therapy	21.75	36.25	55.00	68.00									181.00
118	Va. Pharm Processor Pgm	-	-	-	-									-
	Total	6,916.15	7,741.79	6,322.15	7,015.21	-	-	-	-	-	-	-	-	27,995.300

Description of Allocation Method

Sources & Notes
Note: Number of hours = Investigative Hours + Manpower Analysis Hours (#'s come from monthly statistical reports from Enforcment (Tamika)
The source for these numbers is a VDHP spreadsheet titled *Allocation 305 & 306.xls*

Maximus report of April 11, 2002 recommended using the average of the current and two prior months in computing the allocation factor.

Virginia Department of Health Professions

Input of Case Hours by Department
For Use in Allocation of Department 306- *Administrative Proceedings* Costs
For the Fiscal Year Ended June 30, 2019

	Fiscal Month No.	1	2	3	4	5	6	7	8	9	10	11	12	Annual
	Month Name	July	August	September	October	November	December	January	February	March	April	May	June	Total
Dept. No.	Dept. Name													
101	Nursing	427.25	572.50	623.50	492.25									
102	Medicine	929.95	959.00	903.75	997.00									
103	Dentistry	84.25	72.00	89.00	150.25									
104	Funeral Directors and Emba	7.00	25.50	53.00	54.25									
105	Optometry	18.50	0.75	0.25	6.50									
106	Veterinary Medicine	46.25	20.25	36.75	55.25									
107	Pharmacy	246.25	239.50	194.75	190.75									
108	Psychology	22.50	74.50	15.00	58.00									
109	Professional Counselors	89.25	8.00	74.00	15.50									
110	Social Work	17.50	0.00	0.00	6.50									
112	Cerified Nurse Aids (State	111.25	114.25	91.00	132.05									
114	Nursing Home Administrator	29.50	27.25	18.50	62.50									
115	Audiology and Speech Lang	11.50	14.25	14.75	4.00									
116	Physical Therapy	5.25	30.50	23.25	12.50									
118	Va. Pharm Processor Pgm													
	Total	2,046.20	2,158.25	2,137.50	2,237.30	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Description of Allocation Method

Notes & Sources
Number of Hours = weekly log sheet totals provided monthly by APD - Susan Brooks
The source for these numbers is a VDHP spreadsheet titled *Allocation 305 & 306.xls*

Note 10/22/17- Set up 118 with $1

Virginia Department of Health Professions

Input of Case Hours by Department

For Use in Allocation of Department 307- ***Health Practitioners Monitoring Program*** Costs

For the Fiscal Year Ended June 30, 2019

	Fiscal Month No.	1	2	3	4	5	6	7	8	9	10	11	12	Total for
	Month Name	July	August	September	October	November	December	January	February	March	April	May	June	All Months
Dept. No.	Dept. Name													
101	Nursing	284.00	283.00	289.00	281.00									
102	Medicine	119.00	119.00	120.00	115.00									
103	Dentistry	14.00	14.00	14.00	15.00									
104	Funeral Directors and Emba		-	-	-									
105	Optometry	2.00	2.00	2.00	2.00									
106	Veterinary Medicine	1.00	1.00	1.00	3.00									
107	Pharmacy	15.00	17.00	17.00	16.00									
108	Psychology	3.00	3.00	3.00	2.00									
109	Professional Counselors		-	0.00	0.00									
110	Social Work	4.00	3.00	3.00	3.00									
112	Cerified Nurse Aids (State	7.00	7.00	7.00	7.00									
114	Nursing Home Administrator		-	-	-									
115	Audiology and Speech Lang	1.00	1.00	1.00	1.00									
116	Physical Therapy	4.00	4.00	4.00	4.00									
118	Va. Pharm Processor Pgm	-	-	0.00										
	Total	454.00	454.00	461.00	449.00	-	-	-	-	-	-	-	-	-

Description of Allocation Method

Notes & Sources

From Worksheet provided by Charles Giles entitled FY02StatsBobby.xls

Note 10/22/17- Set up 118 with $1

Agenda Item: Regulatory Actions - Chart of Regulatory Actions
As of November 30, 2018

Chapter		Action / Stage Information
[18 VAC 85 - 20]	Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic	Supervision and direction for laser hair removal [Action 4860] Proposed - *Register Date: 10/29/18 Comment period closes: 12/28/18*
[18 VAC 85 - 20]	Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic	Result of periodic review [Action 5167] Fast-Track - *At Secretary's Office for 1 day*
[18 VAC 85 - 20]	Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic	Electronic renewal notices [Action 5171] Fast-Track - *At Secretary's Office for 2 days*
[18 VAC 85 - 50]	Regulations Governing the Practice of Physician Assistants	Result of periodic review [Action 5168] Fast-Track - *DPB Review in progress* [Stage 8450]
[18 VAC 85 - 110]	Regulations Governing the Practice of Licensed Acupuncturists	Result of periodic review [Action 5169] Fast-Track - *DPB Review in progress* [Stage 8451]
[18 VAC 85 - 120]	Regulations Governing the Licensure of Athletic Trainers	Result of periodic review [Action 5170] Fast-Track - *DPB Review in progress* [Stage 8452]
[18 VAC 85 - 140]	Regulations Governing the Practice of Polysomnographic Technologists	(E) Exemption for student/intern in polysomnographic technology [Action 5120] Final - *Register Date: 10/15/18 Effective: 11/14/18*
[18 VAC 85 - 160]	Regulations Governing the Registration of Surgical Assistants and Surgical Technologists	(E) Requirement for renewal of registration for surgical assistants [Action 5119] Final - *Register Date: 10/15/18 Effective: 11/14/18*
[18 VAC 85 - 170]	Regulations Governing the Practice of Genetic Counselors	Temporary licensure [Action 5066] Fast-Track - *Register Date: 12/24/18 Effective: 2/10/19*

Agenda Item:

Preliminary report on 2019 legislation

DHP Legislation approved for introduction in 2019 General Assembly

#822 Physical Therapy Licensure Compact

#823 Correct circular mandatory suspensions

#924 Implement e-prescribing (**bill attached**)

#925 Authority to seize drugs

#817 Dental hygienists; Schedule VI drugs

#913 Board composition (**bill attached**)

#824 Disclosure of information on nursing education to DOE and SCHEV (pending)

DRAFT Legislation

2019 Session of the General Assembly

A BILL to amend the *Code of Virginia* by amending §§ 54.1-3408.02 and 54.1-3410 of the Code of Virginia relating to electronic prescribing of a controlled substance containing an opiate.

Be it enacted by the General Assembly of Virginia:

1. **That § 54.1-3408.02 and 54.1-3410 of the *Code of Virginia* are amended and reenacted as follows:**

§ 54.1-3408.02. (Effective July 1, 2020) Transmission of prescriptions.

A. Consistent with federal law and in accordance with regulations promulgated by the Board, prescriptions may be transmitted to a pharmacy as an electronic prescription or by facsimile machine and shall be treated as valid original prescriptions.

B. Any prescription for a controlled substance that contains an opiate shall be issued as an electronic prescription with the following exceptions:

1. A prescriber who dispenses the opiate directly to the patient or patient's agent;

2. A prescription for a controlled substance containing an opiate for a person residing in a hospital, assisted living facility, nursing home, or residential healthcare facility or receiving services from a hospice provider or outpatient dialysis facility;

3. A prescriber who experiences temporary technological or electrical failure or other temporary extenuating circumstance that prevents the prescription from being transmitted electronically, provided the prescriber documents the reason for this exception in the patient's medical record;

4. A prescriber who writes a prescription to be dispensed by a pharmacy located on federal property, provided the prescriber documents the reason for this exception in the patient's medical record;

5. A prescriber who writes a low volume of prescriptions, defined as less than 25 prescriptions during the most recent twelve-month period with a maximum of a seven-day supply for each prescription;

6. A prescription issued by a veterinarian;

7. A prescription for a drug for which the Food and Drug Administration requires a prescription to contain elements that are not able to be included in electronic prescribing.

such as a drug with risk evaluation and mitigation strategies that include elements to assure safe use;

8. A prescription issued for an opiate under a research protocol;

9. A prescription issued in accordance with an Executive Order of the Governor for a declared emergency; and

10. A prescription that cannot be issued electronically in a timely manner and the patient's condition is at risk, provided the prescriber documents the reason for this exception in the patient's medical record.

C. In accordance with regulations adopted by the licensing board for a prescriber, a waiver may be granted for a period not to exceed one year of the requirement that any prescription for a controlled substance that contains an opiate be issued as an electronic prescription due to demonstrated economic hardship, technological limitations that are not reasonably within the control of the prescriber, or other exceptional circumstance demonstrated by the prescriber.

§ 54.1-3410. When pharmacist may sell and dispense drugs.

A. A pharmacist, acting in good faith, may sell and dispense drugs and devices to any person pursuant to a prescription of a prescriber as follows:

1. A drug listed in Schedule II shall be dispensed only upon receipt of a written prescription that is properly executed, dated and signed by the person prescribing on the day when issued and bearing the full name and address of the patient for whom, or of the owner of the animal for which, the drug is dispensed, and the full name, address, and registry number under the federal laws of the person prescribing, if he is required by those laws to be so registered. If the prescription is for an animal, it shall state the species of animal for which the drug is prescribed;

2. In emergency situations, Schedule II drugs may be dispensed pursuant to an oral prescription in accordance with the Board's regulations;

3. Whenever a pharmacist dispenses any drug listed within Schedule II on a prescription issued by a prescriber, he shall affix to the container in which such drug is dispensed, a label showing the prescription serial number or name of the drug; the date of initial filling; his name and address, or the name and address of the pharmacy; the name of the patient or, if the patient is an animal, the name of the owner of the animal and the species of the animal; the name of the prescriber by whom the prescription was written, except for those drugs dispensed to a patient in a hospital pursuant to a chart order; and such directions as may be stated on the prescription.

B. A drug controlled by Schedules III through VI or a device controlled by Schedule VI shall be dispensed upon receipt of a written or oral prescription as follows:

1. If the prescription is written, it shall be properly executed, dated and signed by the person prescribing on the day when issued and bear the full name and address of the patient for whom,

or of the owner of the animal for which, the drug is dispensed, and the full name and address of the person prescribing. If the prescription is for an animal, it shall state the species of animal for which the drug is prescribed.

2. If the prescription is oral, the prescriber shall furnish the pharmacist with the same information as is required by law in the case of a written prescription for drugs and devices, except for the signature of the prescriber.

A pharmacist who dispenses a Schedule III through VI drug or device shall label the drug or device as required in subdivision A 3 of this section.

C. A drug controlled by Schedule VI may be refilled without authorization from the prescriber if, after reasonable effort has been made to contact him, the pharmacist ascertains that he is not available and the patient's health would be in imminent danger without the benefits of the drug. The refill shall be made in compliance with the provisions of § 54.1-3411.
If the written or oral prescription is for a Schedule VI drug or device and does not contain the address or registry number of the prescriber, or the address of the patient, the pharmacist need not reduce such information to writing if such information is readily retrievable within the pharmacy.

D. Pursuant to authorization of the prescriber, an agent of the prescriber on his behalf may orally transmit a prescription for a drug classified in Schedules III through VI if, in such cases, the written record of the prescription required by this subsection specifies the full name of the agent of the prescriber transmitting the prescription.

E. (Effective July 1, 2020) ~~No pharmacist shall dispense a controlled substance that contains an opiate unless the prescription for such controlled substance is issued as an electronic prescription.~~ A dispenser is not required to verify that a prescriber properly falls under one of the exceptions specified in § 54.1-3408.02 for electronic prescribing prior to dispensing a controlled substance containing an opiate. A dispenser may continue to dispense a controlled substance containing an opiate from valid written, oral, or facsimile prescriptions that are otherwise consistent with applicable laws.

2. That the Boards of Medicine, Nursing, Dentistry, and Optometry shall promulgate regulations for issuing or renewing a temporary waiver for a prescriber within 280 days of enactment of this Act.

3. That the Secretary of Health and Human Resources shall convene a work group within two years of the effective date of this Act of interested stakeholders, including the Medical Society of Virginia, the Virginia Hospital and Healthcare Association, the Virginia Dental Association, the Virginia Association of Health Plans, and the Virginia Pharmacists Association to evaluate the implementation of this Act and shall make a 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. The workgroup's evaluation shall identify successes and challenges with the mandate, and offer possible recommendations for increasing the electronic prescribing of controlled substances.

Department of Health Professions

2019 Session of the General Assembly

A BILL to amend the *Code of Virginia* by amending §§ 54.1-3002 and 54.1-3603 of the Code of Virginia relating to the composition of the Boards of Nursing and Psychology; and to stagger terms of expiration for certain members of health regulatory boards.

Be it enacted by the General Assembly of Virginia:

1. **That §§ 54.1-3002 and 54.1-3603 of the *Code of Virginia* are amended and reenacted as follows:**

§ 54.1-3002. Board of Nursing; membership; terms; meetings; quorum; administrative officer.

The Board of Nursing shall consist of 14 members as follows: eight registered nurses, at least two of whom are licensed nurse practitioners; ~~three~~ two licensed practical nurses; ~~and~~ three citizen members; and one member who shall be a registered nurse or a licensed practical nurse. The terms of office of the Board shall be four years.

The Board shall meet ~~each January~~ at least annually and shall elect officers from its membership ~~a president, a vice-president, and a secretary~~. It may hold such other meetings as may be necessary to perform its duties. A majority of the Board including one of its officers shall constitute a quorum for the conduct of business at any meeting. Special meetings of the Board shall be called by the administrative officer upon written request of two members.

The Board shall have an administrative officer who shall be a registered nurse.

That appointments to the Board of Nursing shall be staggered, with one licensed registered nurses and one licensed practical nurses to be appointed for a term of one year beginning on July 1, 2021. Thereafter, all such appointments shall be for terms of four years.

§ 54.1-3603. Board of Psychology; membership.

The Board of Psychology shall regulate the practice of psychology. The membership of the Board shall be representative of the practices of psychology and shall consist of nine members as follows: five persons who are licensed as clinical psychologists, one person licensed as a school psychologist, one person licensed ~~as an applied psychologist~~ in any category of psychology and two citizen members. At least one of the seven psychologist members of the Board shall be a member of the faculty at an accredited institution of higher education in the Commonwealth

actively engaged in teaching psychology. The terms of the members of the Board shall be four years.

That the terms of two psychologists to the Board of Psychology, that are set to begin on July 1, 2020, shall be staggered, with one member appointed for a term of one year, and one member appointed for a term of two years. Thereafter, all such appointments shall be for terms of four years.

2. The terms of appointment for members of health regulatory boards within the Department of Health Professions shall be adjusted as follows:

A. That the terms of the two dental hygienists appointed to the Board of Dentistry pursuant to §54.1-2702, that are set to begin on July 1, 2020, shall be staggered, with one member appointed for a term of one year, and one member appointed for a term of two years. Thereafter, all such appointments shall be for terms of four years.

B. That appointments to the Board of Long Term Care Administrators pursuant to §54.1-3101, shall be staggered, with the term of one of the licensed nursing home administrators and one of the assisted living facility administrators that are set to begin on July 1, 2019, be for one year. Thereafter, all such appointments shall be for terms of four years.

C. That appointments to the Board of Medicine pursuant to §54.1-2911, shall be staggered, with three seats whose terms are set to begin on July 1, 2020, appointed for a term of two years. Thereafter, all such appointments shall be for terms of four years.

D. That the term of the citizen member appointed to the Board of Veterinary Medicine pursuant to §54.1-3802, that is set to begin on July 1, 2019, shall be for a term of three years. Thereafter, all such appointments shall be for terms of four years.

E. That the term of one of the speech-language pathologists to the Board of Audiology and Speech-Language Pathology pursuant to §54.1-2602, that is set to begin on July 1, 2022, shall be appointed for a term of two years. Thereafter, all such appointments shall be for terms of four years.

F. That appointments to the Board of Pharmacy pursuant to §54.1-3305, shall be staggered, with the term of the citizen member and one of the pharmacists that are set to begin on

July 1, 2022, be for three years. Thereafter, all such appointments shall be for terms of four years.

G. That the terms of three of the licensed professional counselors appointed to the Board of Counseling pursuant to §54.1-3503, that are set to begin on July 1, 2021, shall be staggered, with one member appointed for a term of two years, and two members appointed for a term of three years. Thereafter, all such appointments shall be for terms of four years.

Agenda Item: Recommendation of the Ad Hoc Committee on Controlled Substances Continuing Education

Staff Note: Code Section 54.1-2912.1 authorizes the Board of Medicine to require 2 hours of continuing education on opioids each biennium. The topics included in the law are those related to pain management, the responsible prescribing of controlled substances, and the diagnosis and management of addiction. The Board is to notify its licensees subject to the 2-hour requirement prior to January 1 of each odd-numbered year. The Ad Hoc Committee met on November 27, 2018 and developed a recommendation for the next biennium for the Board's consideration.

The Committee thought the Board should offer a "package" of continuing education that would satisfy the 2-hour requirement. It also endorsed the principle that licensees should be able to select activities they deemed valuable to their day-to-day practice.

The "package" would include:

- Reading the Board of Medicine Regulations Governing Prescribing Opioids and Buprenorphine
- Reading the Board's FAQ's on Opioids and Buprenorphine
- Viewing the PMP video on NarxCare (Generic Navigation-6 minutes & 51 seconds)
- Taking the Stanford University course on "How to Taper Patients Off of Chronic Opioid Therapy" which provides 1.25 hours of Category I AMA PRA credit

Action: To approve the recommendation of the Ad Hoc Committee to provide both a 2-hour "package" on the Board's website and the option for licensees to pick their 2 hours of opioid continuing education activities

Commonwealth of Virginia

REGULATIONS

GOVERNING PRESCRIBING OF 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*

Revised Date: August 8, 2018

9960 Mayland Drive, Suite 300
Henrico, VA 23233-2463

(804) 367-4600 (TEL)
(804) 527-4426 (FAX)
email: medbd@dhp.virginia.gov

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 (i) cancer, (ii) sickle cell, (iii) a patient in hospice care, or (iii) a patient in palliative care;

2. The treatment of acute or chronic pain during an inpatient hospital admission or 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" means 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" means the Virginia Board of Medicine.

"Chronic pain" means nonmalignant 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" means drugs listed in The Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia) in Schedules II through IV.

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

"MME" means morphine milligram equivalent.

"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.

Part II
Management of Acute Pain

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

A. Nonpharmacologic 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 § 54.1-2522.1 of the Code of Virginia, and conduct an assessment of the patient's history and risk of substance misuse.

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 misuse, 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 (an atypical opioid), 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 misuse history of the patient and any family history of addiction or substance misuse;

6. A urine drug screen or serum medication level;

7. A query of 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 misuse; 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. Nonpharmacologic 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 misuse, 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 mono-product in tablet form shall not be prescribed for chronic pain.

D. Due to a higher risk of fatal overdose when opioids, including buprenorphine, are given with other opioids, benzodiazepines, sedative hypnotics, carisoprodol, and tramadol (an atypical opioid), 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 health care 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 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 record the presence or absence of any indicators for medication misuse 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 that will result in referral to a higher level of care, cessation of treatment, or dismissal from care.

C. The treatment agreement shall include 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. The practitioner shall check the Prescription Monitoring Program at least every three months after the initiation of treatment.

D. The practitioner shall order and review a urine drug screen or serum medication levels at the initiation of chronic pain management and thereafter randomly at the discretion of the practitioner, but at least once a year.

E. The practitioner (i) shall regularly evaluate the patient for opioid use disorder and (ii) shall initiate specific treatment for opioid use disorder, consult with an appropriate health care 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 or any documentation of attempts to obtain those records;

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 U.S. 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 misuse 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 misuse 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 human immunodeficiency virus, hepatitis B, hepatitis C, and tuberculosis.

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;

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

4. For patients who have a demonstrated intolerance to naloxone, such prescriptions for the mono-product shall not exceed 3.0% of the total prescriptions for buprenorphine written by the prescriber, and the exception shall be clearly documented in the patient's medical record.

B. Buprenorphine mono-product tablets may be administered directly to patients in federally licensed opioid treatment programs. With the exception of those conditions listed in subsection A of this section, only the buprenorphine product containing naloxone shall be prescribed or dispensed for use off site 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 (an atypical opioid), 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 eight milligrams 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 milligrams of buprenorphine per day shall be placed in the medical record. Dosages exceeding 24 milligrams 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 misuse counseling.

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

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

B. Patients younger than 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 that can be identified, quantified, and independently verified.

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

E. Practitioners shall not undertake buprenorphine treatment with a patient who has psychiatric comorbidities and is not stable. 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 18VAC85-20-27, which prohibits willful or negligent breach of confidentiality or unauthorized disclosure of confidential Prescription Monitoring Program information, shall be maintained.

Virginia Board of Medicine

Frequently Asked Questions about the Prescribing of Opioids for Pain

1. **Do I need to refer a patient being treated for chronic pain to a pain management specialist before exceeding 120 MME/day?**

The regulations require the prescriber to document the reasonable justification for the increase OR refer to or consult with a pain management specialist.

2. **If a patient being treated for chronic pain admits to occasional marijuana use or has a positive screen, what should I do?**

This issue is not addressed in the regulations. The Board of Medicine expects physicians to use good judgement in their care of patients and fully document what you do and why in the chart.

3. **If a patient I am treating for chronic pain is on a benzodiazepine from another provider, must I prescribe naloxone?**

YES. The regulations are meant to save lives. There would need to be coordination with the other practitioner so that you are on the same page. Controlled substances from more than one prescriber could lead to an inadvertent overdose. There is a provision for "extenuating circumstances" in the regulations, in case the benzo is absolutely essential to the patient's well-being.

4. **What if the benzodiazepine is only PRN?**

The Board of Medicine cannot recommend deviation from the regulations.

5. **What formulation of naloxone do I prescribe?**

The prescribing of naloxone required by these regulations is intended to rescue those who are in the midst of an overdose or anticipated to be in overdose. The regulations do not require a specific formulation. Here are the options in the Pharmacy guidance document. http://www.dhp.virginia.gov/Pharmacy/guidelines/110-44.docx

6. **Do I have to ensure that a patient fills the prescription for naloxone?**

NO, the prescriber's responsibility is to prescribe the naloxone, but the regulations do not require that the prescriber ensures that the patient gets it filled. However, a prescriber may wish to revisit the dose of opioid prescribed, if warranted.

7. **Can a pharmacist fill an opioid prescription exceeding 120 MME/day, or with concomitant benzodiazepine, if a patient does not present a naloxone prescription?**

The answer is YES, but it would be within your discretion to call the prescriber to ask if that is what he/she intended.

8. Must naloxone be prescribed for lower doses of opioids in the presence of benzodiazepines?

YES, the regulations state that is the case.

9. Must I drug screen all patients that I will be putting on opioids for chronic pain?

YES, a drug screen is required initially upon beginning chronic pain management, and at least once a year thereafter.

10. What is the Board's policy on PRN pain medications?

The regulations require drug screens for patients on chronic opioid medications. The Board cannot recommend deviation from the regulations. The Board would make the determination about the standard of care in such a case, based upon the documentation of the treatment.

11. Is it true that I can only prescribe 1 week of opioid for acute pain?

Prescribing is limited to a 7-day supply unless "extenuating circumstances are clearly documented in the medical record."

12. Can I write for more than 14 days for post-operative pain?
Prescribing is limited to a 14-day supply unless "extenuating circumstances are clearly documented in the medical record."

13. Is tramadol an opioid?

YES. It is an opioid and a Schedule IV drug.

14. Is tramadol subject to these regulations?

YES.

15. How can a pharmacist determine that a physician is prescribing for acute pain, post-op pain, or chronic pain?

It has been suggested that prescribers put a notation on the prescription as to whether the drug is for acute pain, post-op pain, or chronic pain. The Board sees this as an excellent communication between professionals involved in the patient's care.

16. Does the Board of Medicine have a list of "sedative hypnotics"?

NO

17. Must patients that have been stable on their current dose of opioid analgesic for a long time be drug tested?

YES, the regulations require testing at least once a year.

18. Can I use Subutex and Suboxone off-label for the treatment of pain?

The amended emergency regulations that became effective August 24, 2017 allow Suboxone, or any naloxone-containing tablet, to be used to treat chronic pain. Subutex cannot be used for chronic pain. Buprenorphine products are not indicated for acute pain.

19. Does the physician have to see pain patients every 3 months or can a nurse practitioner or a physician assistant see a patient, assess the opioid therapy, evaluate for opioid use disorder and document findings in the medical record?

The regulations use the term "practitioner" and state these issues need to be addressed every 3 months. Nurse practitioners and physician assistants can perform acts of medicine through a practice agreement with a physician. As long as the NP and PA are trained and competent to accomplish the assessments required, and the physician maintains responsibility for patient care, it would appear that the requirements of the law would be met.

20. If a patient is held in the ED or other part of the hospital for 24-48 hours, do the regulations apply?

The regulations do not apply to pain treated during an inpatient hospital admission. Observation is an administrative status for a patient that is under clinical watch and care within the hospital, therefore the regulations would not apply. However, when the patient is discharged, the regulations would apply in regards to the 7-day limit of opioid or more if extenuating circumstances are documented.

21. Are there any exemptions to the requirements of these regulations?

Yes, patients with cancer, sickle cell, and those in hospice and palliative care are exempt from these regulations.

Virginia Board of Medicine

Frequently Asked Questions about the Prescribing of Buprenorphine for Addiction

1. **Can I continue to prescribe mono-product for my patients that have a demonstrated intolerance to naloxone –containing products?**

The amended emergency regulations that became effective August 24, 2017 read as follows: *For patients who have a demonstrated intolerance to naloxone; such prescriptions for the mono-product shall not exceed 3% of the total prescriptions for buprenorphine written by the prescriber, and the exception shall be clearly documented in the patient's medical record.* So 3% of buprenorphine prescriptions that will be administered off-site can be for mono-product, and the rest must be for naloxone-containing products. The 3% restriction does not apply to injectable formulations of buprenorphine mono-product administered directly to patients in a waivered physician's office, a clinic staffed by a waivered provider, or in a federally licensed opioid treatment program or to mono-product tablets administered directly to patients in federally licensed opioid treatment programs.

2. **What alternatives to buprenorphine mono-product are there that contain no or low-dose naloxone?**

This is not an endorsement for a particular medication, and there may be other alternatives unknown to the Board at this time. The only other mono-products currently FDA-approved for the treatment of addiction are the Probuphine implant and Sublocade extended-release injection. Formulations with low-dose naloxone include Zubsolv sublingual tablets and Bunavail buccal film. Methadone and Vivitrol are also options.

3. **Is there a grace period for switching patients to a naloxone-containing product?**

It is lawful to prescribe up to 7 days of mono-product in the switching of a patient from methadone to a naloxone-containing product or for 7 days in switching a patient from the mono-product to a naloxone-containing product.

4. **Is there a grace period for tapering patients off the mono-product if they choose not to take a naloxone-containing product?**

There is no grace period in the regulations, other than what is stated above. The Board does expect that sound medical judgement and safety of the patient will be paramount in the tapering process.

5. **Are buprenorphine and naloxone safe for mothers and their breastfeeding infants?**

The American Society of Addiction Medicine National Practice Guideline adopted June 2015 stated, "It was shown that the amount of buprenorphine metabolites secreted in breastmilk are so low that they pose little risk to breastfeeding infants." In the May 11, 2016 issue of the ASAM Magazine, a question about breastfeeding was

addressed by a Providers' Clinical Support System expert, "While buprenorphine levels transfer to breastmilk in very low levels, naloxone is even much less detectable, if at all." An August 2016 article from the Journal of Human Lactation confirmed that infant plasma levels were low or undetectable. A consultant to the Board, an OB-GYN who provides MAT, opines that naloxone-containing products prescribed to the mother can be considered safe for breastfeeding infants.

6. Is the prescribing of tramadol subject to these regulations?

YES, tramadol is an opioid and is therefore subject to these regulations.

7. Can I use the mono-product for induction and then switch to the naloxone-containing product?

The regulations do not speak to induction with the mono-product and then switching to a naloxone-containing product. The regulations state that 7 days of mono-product can be written in the switching from mono-product to a naloxone containing product.

8. Can a pharmacist dispense a prescription of the mono-product for a non-pregnant individual after March 15, 2017?

A pharmacist should dispense mono-product in keeping with the 3% rule for prescribers described in #1.

9. Can my staff see the patient during the induction phase?

The regulations require that the patient be seen "by the prescriber" at least once a week during induction.

10. Does the Board have a list of "sedative hypnotics"?

No.

11. Can I continue to prescribe benzodiazepines with buprenorphine?

The regulations allow for benzodiazepines in the lowest effective dose required for the treatment of co-morbid conditions. Extenuating circumstances must be documented in the medical record to support the prescriber's rationale.

12. Is there an exception for financial hardship that allows a patient to take Subutex instead of Suboxone?

NO. There is no such exception in the regulations. However, the Medical Society of Virginia has developed the following list of resources for patients that may need help with the expenses of treatment with naloxone-containing products. https://www.msv.org/sites/default/files/patient_assistance_resources.pdf

PMP Home
About PMP
Laws and Regulations
Forms
News Releases
Education Toolkit
Reports and Statistics
HIPAA Applicability
Reporting Requirements
Committee Members
Committee Calendar
Staff Directory
Board of Pharmacy
Board of Medicine

Virginia Prescription Monitoring Program

Virginia's Prescription Monitoring Program (PMP) is a 24/7 database containing information on dispensed controlled substances included in Schedule II, III and IV; those in Schedule V for which a prescription is required; naloxone, and all other drugs of concern. The primary purpose of the PMP is to promote safe prescribing and dispensing practices for covered substances by providing timely and essential information to healthcare providers. Law enforcement and health profession licensing boards use the PMP to support investigations related to doctor shopping, diversion, and inappropriate prescribing and dispensing.

New Information

2018 Annual Report

2018 Annual Report of the Prescription Monitoring Program

Download the Virginia Data Submission Dispenser Guide for more details about the current submission requirements effective beginning July 1, 2018.

NarxCare User Tutorials

An Overview of Virginia's Prescription Monitoring Program - YouTube

Download our latest brochure

Prescription Monitoring Program

Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463
Directions

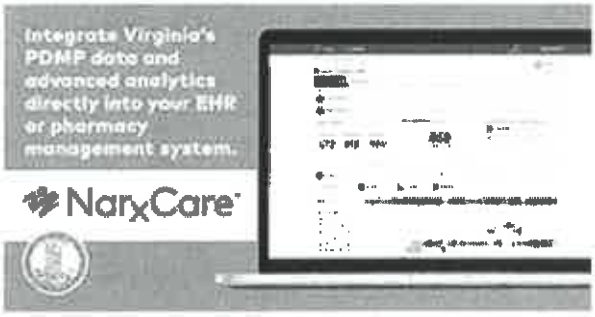
Email pmp@dhp.virginia.gov
Telephone: 804-367-4514
Fax number: 804-527-4470

Hours: Mon-Fri 8:15 to 5:00 except Holidays

PMP users can learn how to navigate and better understand the NarxCare platform with interactive tutorials from Appriss. Follow along with Generic Navigation or NarxCare Interpretation to get familiar with Virginia's PMP.

Grant funding is available for integration of prescription information into electronic medical records and pharmacy software systems. Read the Governor's news release.

Click on the image below to request more information.



Learn more about the public-private partnership working to integrate the Virginia PMP and NarxCare into your clinical workflow.

How to Access the Virginia PMP:

- Navigate to: https://virginia.pmpaware.net.

Users may want to review the User Support Manual for in depth details.

For Technical Assistance: Contact Appriss at 1-855-4VA-4PMP (1-855-482-4767) Or submit a support request at:

https://apprisspmp.zendesk.com/hc/en-us/requests/new

Should you have any questions, you may contact the Virginia Prescription Monitoring Program at (804) 367-4514 or by email at pmp@dhp.virginia.gov.

Prescription Monitoring Program
Email pmp@dhp.virginia.gov
Ralph A. Orr, Director

REGISTER

Sign in

Opioid Therapy

ENROLL IN 045

How to Taper Patients Off Of Chronic Opioid Therapy

Internet Enduring Material Sponsored by:

Stanford University School of Medicine

Stanford MEDICINE

Presented by:

The Department of Psychiatry and Behavioral Sciences at Stanford University School of Medicine

Course Number	**045**
Classes Start	**Aug 2, 2018**
Classes End	**Aug 31, 2021**
Estimated Effort	**1.25 hours**
Price	**Free**

Course Description

This CME activity will enable doctors to recognize when risks of chronic opioid therapy outweigh benefits, and how to safely and compassionately taper patients off of chronic opioid therapy (including the use of buprenorphine to make this transition). A real life patient case scenario will be used to illustrate these principles in practice, including what to say to patients to communicate risks and provide support through the difficult period of withdrawal. When to refer for addiction treatment will also be discussed.

Intended Audience

This course is designed to meet the educational needs of physicians and nurses in primary care, family practice, internal medicine, neurology, oncology, psychiatry, addiction medicine, and interested Allied Health Professionals.

Dates, Duration & Fee

- Release Date: August 2, 2018
- Expiration Date: August 2, 2021
- Estimated Time to Complete: 1.25 hours
- CME Credits Offered: 1.25
- Registration Fee: FREE

To Obtain CME Credits

- Review the information below and complete the entire activity.
- Complete the CME Post-test, CME Evaluation Survey, and CME Activity Completion Statement at the end of the activity.
- You must receive a score of 75% or higher on the post-test in order to receive a certificate. You will have two attempts to answer each multiple-choice question (or one attempt for questions with only two options) to pass the post-test.
- Once you attest to completing the entire online activity and have scored 75% or higher on the post-test, your certificate will be generated automatically and will be available on your Dashboard page.
- Physicians will be awarded *AMA PRA Category 1 Credit™*. All other participants will receive a Certificate of Participation.

Learning Objectives

At the conclusion of this activity, participants should be able to:

- Recognize when risks of chronic opioid therapy outweigh benefits and effectively communicate this information to patients.
- Employ language to prepare patients in advance for the opioid taper, and to provide emotional support in the midst of withdrawal.
- Integrate the key features of a successful outpatient taper off of chronic opioid therapy: go slowly, take breaks, never go backwards.
- Distinguish the signs and symptoms of opioid use disorder (addiction), and intervene with compassion

when, in the process of a taper, an opioid use disorder comes to light.
- Counsel patients on non-opioid alternatives to chronic pain.

Table of Contents

Disclosures

The following planner, speaker and author has indicated that she has no relationships with industry to disclose relative to the content of this activity:

Anna Lembke, MD
Associate Professor of Psychiatry and Behavioral Sciences
Program Director for the Stanford University Addiction Medicine Fellowship
Chief of the Stanford Addiction Medicine Dual Diagnosis Clinic
Stanford University School of Medicine
Course Director
Speaker/Author

Laura
Speaker
The patient in the course, using the pseudonym Laura, has indicated that she has no relationships with industry to disclose relative to the content of this activity.

Technical Design and Development

Stanford IRT EdTech

Stanford Online

Hardware/Software Requirements

- Computer with Internet connection
- Current version of Chrome, Firefox or Safari browser. You must have javascript enabled.

Accreditation and Designation of Credits

The Stanford University School of Medicine is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The Stanford University School of Medicine designates this enduring material for a maximum of 1.25 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

The American Nurses Credentialing Center (ANCC) accepts *AMA PRA Category 1 Credits™* from organizations accredited by the ACCME. Please check with your state's credentialing board for their requirements.

Commercial Support Acknowledgement

The Stanford University School of Medicine has received and has used undesignated program funding from Pfizer, Inc. to facilitate the development of innovative CME activities designed to enhance physician competence and performance and to implement advanced technology. **A portion of this funding supports this activity.**

Cultural and Linguistic Competency

California Assembly Bill 1195 requires continuing medical education activities with patient care components to include curriculum in the subjects of cultural and linguistic competency. It is the intent of the bill, which went into effect July 1, 2006, to encourage physicians and surgeons, CME providers in the State of California and the Accreditation Council for Continuing Medical Education to meet the cultural and linguistic concerns of a diverse patient population through appropriate professional development. The planners and speakers of this CME activity have been encouraged to address cultural issues relevant to their topic area. The Stanford University School of Medicine Multicultural Health Portal also contains many useful cultural and linguistic competency tools including culture guides, language access information and pertinent state and federal laws. You are encouraged to visit the portal:

http://lane.stanford.edu/portals/cultural.html

CME Privacy Policy

Click here to review the Stanford Center for CME Privacy Policy.

Contact Information

If you are having technical problems or have questions related to CME credit, requirements or course content, contact the CME Online support team at cmeonline@stanford.edu

Bibliography

Selemon LD. A role for synaptic plasticity in the adolescent development of executive function. Transl Psychiatry. 2013;3:e238.

Steketee JD, Kalivas PW. Drug wanting: behavioral sensitization and relapse to drug-seeking behavior. Pharmacol Rev. 2011;63(2):348-365.

Substance Abuse and Mental Health Services Administration. Drug Abuse Warning Network, 2011: National Estimates of Drug-Related Emergency Department Visits. Rockville, MD; 2013.

Sullivan MD, Howe CQ. Opioid therapy for chronic pain in the United States: promises and perils. Pain. 2013;154 Suppl :S94-S100.

For a complete list, please view the References/Bibliography Module in the Course.

Agenda Item: Approval of Instructions and Applications for Licensure by Endorsement

Staff Note: The regulations for licensure by endorsement are now in effect. To implement the process, there must be an application consistent with the regulations and instructions for the applicants to follow. Board staff has worked with DHP DATA to craft the necessary online documents, which will also be available by hard copy for those that are technically challenged. Board staff would appreciate the review and approval of the Executive Committee to ensure that the application accurately reflects what is required by the regulations, no more and no less.

Action: Approve the instructions and applications as they are, or approve with amendments.

Est. 12/18

INSTRUCTIONS FOR COMPLETING AN APPLICATION FOR LICENSURE BY ENDORSEMENT

APPLYING FOR A LICENSE BY ENDORSEMENT IS SIGNIFICANTLY DIFFERENT FROM APPLYING FOR A LICENSE THROUGH THE TRADITIONAL PATHWAY.

TO BE ELIGIBLE FOR LICENSURE BY ENDORSEMENT, YOU MUST MEET THE FOLLOWING CRITERIA.

1. Hold at least one current, unrestricted license in a United States jurisdiction or Canada for the five years immediately preceding application to the board;

2. Have been engaged in active practice, defined as an average of 20 hours per week or 640 hours per year, for five years after postgraduate training and immediately preceding application;

3. Verify that all licenses held in another United States jurisdiction or in Canada are in good standing, defined as current and unrestricted, or if lapsed, eligible for renewal or reinstatement;

4. Hold current certification by one of the following:

   a. American Board of Medical Specialties;

   b. Bureau of Osteopathic Specialists;

   c. American Board of Foot and Ankle Surgery;

   d. Fellowship of Royal College of Physicians of Canada;

   e. Fellowship of the Royal College of Surgeons of Canada; or

   f. College of Family Physicians of Canada;

5. Submit a current report from the U.S. Department of Health and Human Services National Practitioner Data Bank; and

6. Have no grounds for denial based on provisions of § 54.1-2915 of the Code of Virginia or regulations of the board.

BASED ON #2 ABOVE, LICENSURE BY ENDORSEMENT IS NOT AVAILABLE TO A PHYSICIAN WITH LESS THAN 5 YEARS OF PRACTICE AFTER FINISHING ALL POSTGRADUATE TRAINING, BE IT AN INTERNSHIP, A RESIDENCY, OR A FELLOWSHIP.

BASED ON #6 ABOVE, IF YOU HAVE CONVICTIONS, BOARD ACTIONS, OR IMPAIRMENT, YOU ARE NOT ELIGIBLE FOR LICENSURE BY ENDORSMENT. YOU ARE NOT ELIGIBLE IS YOU HAVE MALPRACTICE PAID CLAIS IN THE LAST 10 YEARS. OTHER ADVERSE INFORMATION DISCLOSED IN THE QUESTIONS MAY BE DISQUALIFYING FOR LICENSURE BY ENDORSEMENT, DEPENDING UPON THE NARRATIVE EXPLANATION THAT YOU SUBMIT.

IF YOU DO NOT MEET THE CRITERIA, YOU MUST APPLY THROUGH THE TRADITIONAL PATHWAY AT: https://www.dhp.virginia.gov/medicine/medicine_forms.htm#MedicineandSurgery

IF YOU BELIEVE YOU MEET THE CRITERIA FOR LICENSURE BY ENDORSEMENT, THEN FINISH READING THESE INSTRUCTIONS PRIOR TO PROCEEDING TO THE APPLICATION.

BE AWARE THAT IF THE BOARD DEEMS ANY OF THE REQUIRED CRITERIA UNMET, YOUR APPLICATION WILL BE ROUTED TO THE TRADITIONAL PATHWAY, WHICH REQUIRES SIGNIFICANTLY MORE SUPPORTING DOCUMENTATION AND TAKES SIGNIFICANTLY MORE TIME.

APPLICATION FEES ARE NONREFUNDABLE, INCLUDING IF YOU WISH TO WITHDRAW YOUR APPLICATION FOR ANY REASON.

IF YOU WISH TO PROCEED, THE FOLLOWING WILL BE EXPECTED OF YOU.

1) *Complete the online application.* https://www.license.dhp.virginia.gov/apply/ which includes paying the nonrefundable application fee of $302.00. Application fees may only be paid using Visa, MasterCard or Discover.

2) Provide a chronology of your work for the 5 years prior to application with the estimated time spent (*in hours*) practicing medicine.

3) Request that verifications for all licenses you have held in the United States or Canada be forwarded to the Board by the other jurisdiction or VeriDoc.

   Verification of medical licenses from all jurisdictions within the United States, its territories and possessions or Canada in which you have been issued a full license must be received by the Board. The Board does not require verification of training licenses. **Please contact the applicable jurisdiction where you have been issued a license to practice medicine to inquire about having documentation forwarded to the Virginia Board of Medicine.** Verification must come from the jurisdiction and may be sent by email to medbd@dhp.virginia.gov, faxed to (804) 527-4426 or mailed. **This documentation is NOT provided by the Federation Credentials Verification Service (FCVS). Many medical boards use www.veridoc.org to send their license verifications. Check with VeriDoc to see if your other state licensing boards use its services.**

4) Request that your certification from the appropriate entity listed in #4 above be sent directly to the Board.

5) Request a report from the National Practitioner Data Bank that you send to the Board in accordance with the following instructions:

   NPDB Self Query **– Complete the online Place a Self-Query Order form.** Be ready to provide:
   - Identifying information such as name, date of birth, Social Security number
   - State health care license information
   - Credit or debit card information for the fee

   The Board does not accept emailed copies of the NPDB report. When you receive your report in the mail from NPDB, **DO NOT OPEN IT. Place your unopened NPDB report in an oversized envelope and forward it to the Virginia Board of Medicine. The Board**

recommends using Fed EX or UPS for tracking purposes. The Board of Medicine is unable to track any mail or other package that is sent via the United States Postal Service.

6) Provide answers to the questions in the online or paper application.

NOTE: FOR ANY "YES" ANSWERS FOR QUESTIONS 4-17, YOU MUST PROVIDE A NARRATIVE IN THE SPACE PROVIDED.

BASED ON #6 ABOVE, IF YOU HAVE CONVICTIONS, PAST OR CURRENT BOARD ACTIONS, IMPAIRMENT, OR MALPRACTICE PAID CLAIMS, YOU ARE NOT ELIGIBLE FOR LICENSURE BY ENDORSMENT.

The Board works as efficiently as possible to process applications. The time from filing an application with the Board until the issuance of a license is dependent upon entities over which the Board has no control. It is the applicant's responsibility to ensure that outside entities send the necessary documentation to the Board in a timely manner.

The Virginia Board of Medicine accepts the verified documentation provided by FCVS, in case you choose to engage its services to help you with your application. http://www.fsmb.org/licensure/fcvs/

The Board provides an electronic checklist for your convenience in tracking your application. You should allow approximately 10 business days for your application checklist to appear on the Board's website. Supporting documentation will be added to your checklist as it is received. Processing of documents may take up to 10 business days after they are received. If you find your checklist does not exist or indicates that documents have not been posted in accordance with the timeframes noted, e-mail the Board at medbd@dhp.virginia.gov with "Application Question" in the subject line. E-mails will be answered within 2 business days.

The Board of Medicine discourages the use of the US Postal Service to send documents. If possible, you are encouraged to have your documents sent by pdf attachment, FAX, FED EX or UPS. The Board cannot trace documents that were to be delivered by the US Mail.

► The Board's mailing address is:

The Virginia Board of Medicine
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233

►E-mail inquiries are normally responded to within 2 business days. Send your e-mail inquiries to **medbd@DHP.Virginia.gov.**

Virginia DHP
Initial Applications

Application

You have selected to begin an initial application to practice Medicine & Surgery by Endorsement. If this license type is incorrect, please contact us at (804) 367-4444 for assistance.

- **NOTE:** This application is not for graduates of osteopathic medical schools. If you are a graduate of an osteopathic medical school and submit this application, it will not be processed and you will be asked to submit the correct application.
- Applicants for licensure by **Endorsement** must: Hold at least one current, unrestricted license in a United States jurisdiction or Canada for the five years immediately preceding application to the board; Have been engaged in active practice, defined as an average of 20 hours per week or 640 hours per year, for five years after postgraduate training and immediately preceding application; and hold current certification by the American Board of Medical Specialties or Bureau of Osteopathic Specialists, American Board of Foot and Ankle Surgery, Fellowship of Royal College of Physicians of Canada, Fellowship of the Royal College of Surgeons of Canada; **or** College of Family Physicians of Canada.
- In addition to completing this online process applicants may be required to complete additional steps, CLICK HERE for the full instructions. You will be given another opportunity at the conclusion of the application process to download this form and instructions.

Instructions for All Applicants:

You will need to complete each of the steps listed on the Initial Application Menu on the left. To begin, please click the Start button below.

Please use the Next and Back buttons at the bottom of each step to navigate through the initial application process. You may click the "Save and finish later" button at any time during the application process. This will allow you to log out of the application, then log back in at a later time without losing any of the information that you have provided.

After completing all of the items in the Initial Application Menu, you will be directed to a brief Workforce Survey, then you will be able to submit your payment.

Your application will not be forwarded to the Board of Medicine until you have submitted your payment. The Board must then receive all required information relative to your application. Once all information has been received, review will be done in 30 days or less. The Board may ask for further information to explain extraordinary aspects, which will lengthen the process.

Start

Virginia DHP
Initial Applications

Application
Demographics

INSTRUCTIONS:
This is the most current information we have on file for you. Please modify any incorrect information that is displayed.
Required fields are denoted with an asterisk (*).

Personal Information
SSN/Virginia DMV #
ex. 123456789: *
Date of Birth *(mm/dd/yyyy)*: *
Maiden Name / Other Name(s) *(if applicable)*:

Published Address Information
This address is subject to public disclosure under the Freedom of Information Act. You may provide an address other than a residence, such as a Post Office Box or a practice location if you wish.

Is your current address within the United States? *
Address Line 1 *(ex. 123 Fourth St.)*: *
Address Line 2 *(ex. Apt. 100)*:
Address Line 3:
Phone: (xxx-xxx-xxxx)
Email:

Virginia DHP
Initial Applications

Application

Address of Record

The address information you provide below is your address of record with the Board. Please be advised that all notices from the board, to include renewal notices, licenses, and other legal documents, will be sent to the address of record provided. If you provided a different public address in the Demographics step this address is not subject to public disclosure under the Freedom of Information Act and will not be sold or distributed for any other purpose. Please modify any incorrect information for your mailing address. Required fields are denoted with an asterisk (*).

Is your current address within the United States?	*
Address Line 1 *(ex. 123 Fourth St.)*:	*
Address Line 2 *(ex. Apt. 100)*:	
Address Line 3:	
Daytime Phone:	*(xxx-xxx-xxxx)
Other Phone:	(xxx-xxx-xxxx)
Email:	*

Virginia DHP
Initial Applications

Application

Education

I hereby certify that I studied medicine and received a degree in medicine from the school listed below:

School Name: *

Date Graduated *(mm/dd/yyyy)*: *

Virginia DHP
Initial Applications

Application
Work History

List in chronological order all professional activities for the last five years.

Beginning Date *(mm/dd/yyyy)* : *
End Date *(mm/dd/yyyy)* :
Employer Name: *
Location: *
Position Held: *
Practice Hours *(At least 640 hours per year)* : *

To add this record click "**Add**".
To edit a record, select the record, make the desired changes and click "**Save**".
To delete a record, select the record and click "**Delete**".
To clear the form, click "**Clear**".

Employment Activity					
Begin Date	End Date	Employer Name	Location	Position Held	640 Hours
No data available					

Virginia DHP
Initial Applications

Application

Licensure History

Have you ever been issued a full license to practice medicine in any jurisdiction? *

Virginia DHP
Initial Applications

Application
Licensure Questions

Any supporting documentation related to the questions below should be submitted to the Virginia Board of Medicine at:
Virginia Board of Medicine
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233
Fax – (804) 527-4426
Email – medbd@dhp.virginia.gov

1. Have you held at lease one current, unrestricted license in a Unites States Jurisdiction or Canada for the 5 years preceding application to the Board? *

2. Have you been engaged in active practice, defined as an average of 20 hours per week or 640 hours per year, for five years after postgraduate training and immediately preceding application? *

3. Are you certified by one of the following?
- *American Board of Medical Specialties;*
- *Bureau of Osteopathic Specialists;*
- *American Board of Foot and Ankle Surgery;*
- *Fellowship of Royal College of Physicians of Canada;*
- *Fellowship of the Royal College of Surgeons of Canada;*
- *College of Family Physicians of Canada* *

4. Have you ever been denied a license or the privilege of taking a licensure/competency examination by any testing entity or licensing authority? *

5. Have you ever been convicted of a violation of local, state or federal statute, regulation or ordinance, or entered into any plea agreement relating to a felony or misdemeanor? (Exclude traffic violations, except convictions for driving under the influence and reckless driving.) *

6. Have you ever been denied clinical privileges or voluntarily surrendered your clinical privileges for any reason? *

7. Have you ever been placed on a corrective action plan, placed on probation or been dismissed or suspended or requested to withdraw from any professional school, training program, hospital, etc? *

8. Have you ever been terminated from employment or resigned in lieu of termination from any training program, hospital, healthcare facility, healthcare provider, provider network or malpractice insurance carrier? *

9. Do you have any pending disciplinary actions against your professional license/certification/permit/registration related to your practice of medicine? *

10. Have you voluntarily withdrawn from any professional society while under investigation? *

11. Have you had any malpractice suits brought against you in the past ten (10) years? *

Additional Licensure Questions

12. Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner? *

13. Within the past five years, have you been disciplined by any entity? *

14. Do you currently have any physical condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing physician. *

15. Do you currently have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing physician. *

16. Do you currently have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing physician. *

18. Within the past 5 years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? *

Military Service

19. Are you the spouse of a member of the U. S. military who has been transferred to Virginia and who had to leave employment to accompany your spouse to Virginia? *

20. Are you active-duty military? *

Virginia DHP
Initial Applications

Application
Demographics

INSTRUCTIONS:

This is the most current information we have on file for you. Please modify any incorrect information that is displayed.
Required fields are denoted with an asterisk (*).

Personal Information
SSN/Virginia DMV #
ex. 123456789:
Date of Birth *(mm/dd/yyyy)*:
Maiden Name / Other Name(s) *(if applicable)*:

Published Address Information

This address is subject to public disclosure under the Freedom of Information Act. You may provide an address other than a residence, such as a Post Office Box or a practice location if you wish.

Is your current address within the United States?
Address Line 1 *(ex. 123 Fourth St.)*:
Address Line 2 *(ex. Apt. 100)*:
Address Line 3:
Phone:
Email:

Address of Record

The address information you provide below is your address of record with the Board. Please be advised that all notices from the board, to include renewal notices, licenses, and other legal documents, will be sent to the address of record provided. If you provided a different public address in the Demographics step this address is not subject to public disclosure under the Freedom of Information Act and will not be sold or distributed for any other purpose. Please modify any incorrect information for your mailing address. Required fields are denoted with an asterisk (*).

Is your current address within the United States?
Address Line 1 *(ex. 123 Fourth St.)*:
Address Line 2 *(ex. Apt. 100)*:
Address Line 3:
Daytime Phone:
Other Phone:
Email:

4. Have you ever been denied a license or the privilege of taking a licensure/competency examination by any testing entity or licensing authority?

5. Have you ever been convicted of a violation of local, state or federal statute, regulation or ordinance, or entered into any plea agreement relating to a felony or misdemeanor? (Exclude traffic violations, except convictions for driving under the influence and reckless driving.)

6. Have you ever been denied clinical privileges or voluntarily surrendered your clinical privileges for any reason?

7. Have you ever been placed on a corrective action plan, placed on probation or been dismissed or suspended or requested to withdraw from any professional school, training program, hospital, etc?

8. Have you ever been terminated from employment or resigned in lieu of termination from any training program, hospital, healthcare facility, healthcare provider, provider network or malpractice insurance carrier?

9. Do you have any pending disciplinary actions against your professional license/certification/permit/registration related to your practice of medicine?

10. Have you voluntarily withdrawn from any professional society while under investigation?

11. Have you had any malpractice suits brought against you in the past ten (10) years?

Additional Licensure Questions

12. Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner?

13. Within the past five years, have you been disciplined by any entity?

14. Do you currently have any physical condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing physician.

15. Do you currently have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing physician.

16. Do you currently have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing physician.

18. Within the past 5 years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity?

Military Service

19. Are you the spouse of a member of the U. S. military who has been transferred to Virginia and who had to leave employment to accompany your spouse to Virginia?

20. Are you active-duty military?

Certification

I certify by entering my electronic signature below: I am the person applying for licensure/certification/registration and meet the qualifications required by Virginia law and regulations. Further, I certify the information provided in this application has been personally provided and reviewed by me, and that statements made on the application are true and complete. I understand that providing false or misleading information, as well as omitting information, in response to information requested in this application or as part of the application process is considered falsification of the application and may be grounds for denial of or taking disciplinary action against an existing license/certificate/registration.

Electronic Signature (Full Legal Name): [ ] *

☐ I agree to the above certification

Click the **"Finish"** button at the bottom of the page to continue with your application.
To return to the profile sections click the **"Back"** button.

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

January 7, 2018