

**Committee of Joint Boards of Nursing and Medicine
and Advisory Committee of Joint Boards of Nursing and Medicine**

Department of Health Professions
Perimeter Center - 9960 Mayland Drive, Conference Center, Suite 201, Henrico, Virginia 23233

**Business Meeting Agenda
June 7, 2017 at 9:00 A.M. in Board Room 2**

Call To Order - Louise Hershkowitz, CRNA, MSHA; Chair

Establishment of Quorum

Review of Minutes

- February 8, 2017 Business Meeting
- February 8, 2017 Formal Hearing
- April 12, 2017 Business Meeting

Public Comment

Dialogue with Agency Director

Old Business:

- Regulatory Update – **Ms. Yeatts**
- Pain Management Emergency Regulations – **Ms. Yeatts**
- Expert Witness – **Ms. Mitchell**
- Update on Board Counsel review of Statutory limitations related to proposal of eliminating prescriptive authority license – **Ms. Douglas/Ms. Mitchell**

New Business

- Appointment of Joint Boards Advisory Committee Member, Dr. Thokozeni Lipato – **Ms. Hershkowitz**
- Board of Nursing Executive Director Report – **Ms. Douglas**
- NOIRA for supervision and direction of laser hair removal – **Ms. Yeatts**
- Adoption of Guidance Document on the Telemedicine for Nurse Practitioners – **Ms. Yeatts**
- “*Chronic Pain Case Study*” presentation – **Dr. Cathy A. Harrison, DNAP, MSN, CRNA**

Agency Subordinate Recommendation

- Karen Beatty, LNP (171816)
- Jason A. Panek, LNP (175050)

Consideration of Consent Order - Joint Boards Members Only

- Paul Howard Werbin, LNP

1:00 P.M – Joint Boards Informal Conference

- Kathleen Tauer, RN, LNP (180095/171802)

Adjourn

**VIRGINIA BOARD OF NURSING
COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
BUSINESS MEETING MINUTES
February 8, 2017**

TIME AND PLACE: The meeting of the Committee of the Joint Boards of Nursing and Medicine was convened at 9:00 A.M., February 8, 2017 in Board Room 2, Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

MEMBERS PRESENT: Louise Hershkowitz, CRNA, MSHA; Chair
Marie Gerardo, MS, RN, ANP-BC
Rebecca Poston, PhD, RN, CPNP
Wayne Reynolds, DO
Kenneth Walker, MD

MEMBERS ABSENT: Lori D. Conklin, MD

ADVISORY COMMITTEE MEMBERS PRESENT:
Joseph F. Borzelleca, Jr., MD, MPH
Kevin E. Brigle, RN, NP
Mark Coles, RN, BA, MSN, NP-C
Wendy Dotson, CNM, MSN
Cathy A. Harrison, DNAP, CRNA
Sarah E. Hobgood, MD
Stuart F. Mackler, MD

STAFF PRESENT: Jay P. Douglas, MSM, RN, CSAC, FRE; Executive Director; Board of Nursing
Jodi P. Power, RN, JD; Deputy Executive Director; Board of Nursing
Stephanie Willinger, Deputy Executive Director; Board of Nursing
Huong Vu, Executive Assistant; Board of Nursing

OTHERS PRESENT: Erin Barrett, Assistant Attorney General; Board Counsel
David Brown, DC; Director; Department of Health Professions
Elaine Yeatts, Senior Policy Analyst, Department of Health Professions
William L. Harp, MD, Executive Director; Board of Medicine

IN THE AUDIENCE: W. Scott Johnson, Medical Society of Virginia (MSV)
Julie Galloway, Medical Society of Virginia (MSV)
Lynn Poole, FNP-BC
Joyce A. Hahn, PhD, RN, NEA-BC, FNAP, Board of Nursing President
Mary Duggan, American Association of Nurse Practitioners (AANP) State Representative
Caroline Perrin, MWC
Sarah Heisler, Virginia Hospital and Healthcare Association (VHHA)
Letha Fisher, RN, Public Health Nursing Director; Virginia Department of Health (VDH)
Hughes Melton, MD, MBA, FAAFP, FABAM, Chief Deputy Commissioner, Office of the Commissioner, Virginia Department of Health (VDH)

Virginia Board of Nursing
Committee of the Joint Boards of Nursing and Medicine Minutes
February 8, 2017

INTRODUCTIONS: Committee members, Advisory Committee members and staff members introduced themselves.

Dr. Borzelleca stated that he will be retiring soon and asked the Committee of the Joint Boards to consider the nomination of Tholozeni Lipato, MD as his replacement. Ms. Hershkowitz said the Committee will consider this matter at its next meeting and thanked Dr. Borzelleca for his service.

ESTABLISHMENT OF A QUORUM:

Ms. Hershkowitz called the meeting to order and established a quorum was present.

REVIEW OF MINUTES: The minutes of December 7, 2016 was reviewed. Ms. Gerardo moved to accept the minutes as presented. The motion was seconded and carried unanimously.

PUBLIC COMMENT: There was no one present that wished to address the Board.

**DIALOGUE WITH
AGENCY DIRECTOR:**

Opioid Crisis – Dr. Brown reported that the fatalities from opioid overdose in 2016 are closed to 1100 and over prescribing is the major part of the problem. Dr. Reynolds asked what percentage of the fatalities in 2016 was due to heroin overdose. Dr. Brown said he did not have the breakdown but he could ask.

Dr. Brown stated that there are many bills providing guidelines on controlled substance prescribing and treating opioid addiction that the current General Assembly is considering.

OLD BUSINESS:

Revision of Guidance Document (GD) 90-56 (Practice Agreements):

Ms. Yeatts noted that Ms. Douglas prepared the GD 90-56 time line which includes modification by Board of Medicine, revision by Committee of the Joint Boards of Nursing and Medicine at its last meeting, and amendment by Board of Nursing at its January 2017 meeting. She added that the current version includes changes in highlighted languages as suggested by Wendy Dotson, representing the Virginia Affiliate of the American College of Nurse Midwives, and is presented to the Committee of Joint Boards of Nursing and Medicine for consideration. She noted that it will be presented to the Board of Medicine at its February meeting for adoption.

Dr. Reynolds moved to adopt the GD as presented. The motion was seconded and passed unanimously.

Board of Medicine FAQ's related to Controlled Substances CE requirements for Nurse Practitioners:

Ms. Douglas referred to Dr. Harp for clarification. Dr. Harp stated that the FAQ's was sent to all practitioners who prescribe controlled substances to notify them of CE requirements. He noted that over 1,000 inquiries were made of which maybe

three were from Nurse Practitioners. He added that this is also posted at Board of Medicine website.

NEW BUSINESS:

The Opioid Public Health Crisis and the CARA Act, Implications for Virginia:

Dr. Melton, Chief Deputy Commissioner, Office of the Commissioner, VDH, provided three handouts regarding Virginia's Plan for Well-Being Measures and the Role of the Nurse in Addiction Disease Management. He commented that:

- Substance use disorder (SUD) diagnosis of members enrolled in Medicaid is spread across Virginia
- Southwest area is reported having largest Hepatitis C population with SUD diagnosis
- Distribution of treatment resources in Virginia is not uniform

Ms. Fisher, Public Health Nursing Director, VDH, said that addiction is treated as chronic disease. She noted that recovery of chronic illness management is a long process and relapse is expected. Ms. Fisher added that the American Nurses Association (ANA) encourages comprehensive pharmacology education for nurses practicing in all settings to ensure safe and appropriate prescription of drugs.

Dr. Melton stated that CARA 2016 makes it possible for physician assistants (PA) and nurse practitioners (NP) to obtain a waiver to use buprenorphine to treat opioid addiction. PA's and NP's must complete 24 hours of education on buprenorphine and obtain a waiver from the Substance Abuse Mental Health Service Administration (SAMHSA) before treating patients. Dr. Melton added that currently there are 28 educational sessions scheduled throughout Virginia and 800 practitioners have signed up already. He noted that he will provide the detail of the training sessions to Ms. Douglas.

Ms. Dotson asked if certified nurse midwives are included in the training sessions. Dr. Melton said that he will check and communicate with Ms. Douglas regarding the findings.

Ms. Hershkowitz commented that she received the training email from VDH and has signed up for the training session.

Dr. Walker asked if the training session is qualified for the required two CE hours. Dr. Melton said yes.

Dr. Harrison commented appreciation for the information provided.

Dr. Hahn, Board of Nursing President, asked if these training sessions are available to NP students. Dr. Melton replied yes.

Ms. Hershkowitz suggested the Advisory members to pass on the information to respective associations.

RECESS: The Committee recessed at 9:43 A.M.

RECONVENTION: The Committee reconvened at 9:57 A.M.

Regulatory Update and 2017 General Assembly Report:

Ms. Yeatts reviewed the Bills that are currently considered by the General Assembly including:

HB 1885 (Opioids; limit on amount prescribed) – requiring a prescriber to obtain information from PMP at the time of initiating a new course of treatment that includes the prescribing of opioids anticipated to last more than seven consecutive days.

HB 2119 (Laser hair removal; limits practice) – adding nurse practitioners.

HB 2164 (Drugs of concern; gabapentin) – adding any material, compound, mixture, or preparation containing any quantity of gabapentin, including any of its salts, to the list of drugs of concerns.

SB 848 (Naloxone; dispensing for use in opioid overdose reversal, etc.) – allowing a person who is authorized by the Department of Behavioral Health and Developmental Services (DBHDS) to train individuals on the administration of naloxone for use in opioid overdose reversal.

SB 1020 (Registration of peer recovery specialist and qualified mental health professionals) – authorizing the registration of peer recovery specialists and qualified mental professionals by the Board of Counseling at the DHP. It is collaboration between DHP, DBHDS, and Department of Medical Assistance Services (DMAS).

SB 1180 (Opioids and Buprenorphine; Board of Dentistry (BOD) and Board of Medicine (BOM) to adopt regulations for prescribing) – directing BOD and BOM to adopt regulations for the prescribing of opioids and products containing Buprenorphine. BOM is working on regulations of two hours mandated continuing education (CEs) for opioid prescribing.

SB 1230 (Opiate prescriptions; electronic prescriptions) - requiring a prescription for any controlled substance containing an opiate to be issued as an electronic prescription and prohibits a pharmacist from dispensing a controlled substance that contains an opiate unless the prescription is issued as an electronic prescription, beginning July 1, 2020. Ms. Yeatts added that this is the Governor's Bill and there will be a work group to discuss how to implement.

SB 1232 (Controlled substances; limits on prescription containing opioids) – prohibiting a prescriber from providing treatment for a patient in an emergency department of a corporation, facility, or institution licensed, owned, or operated

by the Commonwealth to provide health care from prescribing a controlled substance containing an opioid in a quantity greater than a three-day supply. This bill is also applied to a pharmacist who dispenses.

Emergency Regulations for Nurse Practitioners with Prescriptive Authority: Pain Management, Opioid Treatment, use of Buprenorphine:

Ms. Yeatts stated that on November 21, 2016, the Commissioner of Health declared a statewide Public Health Emergency for Virginia as a result of the opioid addiction epidemic. The Board of Medicine (BOM) convened a Regulatory Advisory Panel (RAP) with four addiction specialists to draft regulations for prescribing of opioids and buprenorphine. The proposed amendments to prescriptive authority regulations in the agenda package are virtually identical to the regulations recommended by the BOM Legislative Committee which will be adopted as emergency regulations by the BOM on February 16th.

Ms. Yeatts noted that once the emergency regulations are adopted, there is no public comment required and the regulations remain in effective for up to 18 months during which the permanent regulations must be prepared for adoption.

Ms. Yeatts said the task today is for the Committee to review and to make changes to the draft regulations as presented. The draft regulations will be presented at the BON meeting in March 2017 for adoption and are forwarded to BOM Executive Committee for adoption in April 2017.

Ms. Yeatts then went through the proposed amendments to prescriptive authority regulations noting the Committee comments and suggestions:

18VAC90-40-150. Evaluation of the patient for acute pain –

Section A – Ms. Gerardo asked if homecare patients can be added to this section. Ms. Yeatts said that she will check.

Part VI. Management of Chronic Pain – Dr. Walker stated that too many requirements for primary providers to treat patient with chronic pain, it is better to refer to a specialist. Ms. Gerardo stated that urine tests on elderly patients are prone to more infection. Dr. Reynolds stated that the requirement of urine test every three months is a burden.

Dr. Brown asked Committee members to provide more specific suggestions that will promote good practices and deter bad practices. Ms. Barrett reminded Committee members that this is a chance for the Committee to provide input.

Dr. Harp suggested requiring urine test every three months for the first year then requiring twice or once per year after that. Ms. Yeatts asked Committee members to send her comments before February 16th. Ms. Barret asked that comments are sent to Ms. Yeatts only and not copied others.

Part VII. Prescribing of Buprenorphine –

18VAC90-40-260.D – Ms. Douglas suggested adding other practitioners (QMHP, CNS, CSAC) who can provide counseling other than licensed mental health professional for counseling.

18VAC90-30-220(8) and (9) – these languages should be added to 18VAC90-40-130 also.

Ms. Dotson asked if the public will be educated regarding the new requirements and available training. Dr. Brown stated that the Virginia Department of Health is taking the lead on this task and media campaign discussion is at state level.

Ms. Hershkowitz said that consistency between regulations are valuable and asked the Committee members to send comments to Ms. Yeatts as soon as possible. Ms. Hershkowitz asked if the Committee wishes to meet after the BOM meeting on February 16th and prior to BON March meeting. The consensus was no. Ms. Hershkowitz thanked Ms. Yeatts for the information.

Information Only Materials:

- NCSBN CARA Implementation: Educational Opportunities for Meeting Federal Requirements
- DEA Advisory regarding renewal of DEA numbers
- Changes in name of certifying body AANPCP to AANPCB
- NCSBN Annual APRN Certification Examination Report Data
- NCSBN APRN Roundtable Meeting, April 4, 2017, in Rosemont, IL – Ms. Hershkowitz attending
- Veterans Administration APRN Revised Rules – Ms. Hershkowitz notes that the rules include changes to APRN supervising language and did not include CRNA

Ms. Hershkowitz reminded available Board Members that assistance was needed with probable cause review following the meeting.

ADJOURNMENT:

As there was no additional business, the meeting was adjourned at 11:26 A.M.

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

**VIRGINIA BOARD OF NURSING
COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
FORMAL HEARING MINUTES
February 8, 2017**

TIME AND PLACE: The meeting of the Committee of the Joint Boards of Nursing and Medicine was convened at 12:55 P.M., February 8, 2017 in Board Room 2, Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

CHAIR: Louise Hershkowitz, CRNA, MSHA; Chair

COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE MEMBERS PRESENT:
Marie Gerardo, MS, RN, ANP-BC, Board of Nursing, Joint Board Member
Rebecca Poston, PhD, RN, CPNP, Board of Nursing, Joint Board Member
Wayne Reynolds, DO, Board of Medicine, Joint Board Member
Kenneth Walker, MD, Board of Medicine, Joint Board Member

BOARD OF NURSING MEMBERS PRESENT:
Guia Caliwagan, RN, MAN, EdS
Joyce Hahn, PhD, RN, NEA-BC, FNAP
William Traynham, LPN, CSAC

STAFF PRESENT: Jay P. Douglas, MSM, RN, CSAC, FRE; Executive Director; Board of Nursing
Jodi P. Power, RN, JD; Deputy Executive Director
Darlene Graham, Senior Discipline Specialist; Board of Nursing

OTHERS PRESENT: Erin Barrett, Assistant Attorney General; Board Counsel
Amy Weiss, Adjudication Specialist (joined later)

CONSIDERATION OF AGENCY SUBORDINATE RECOMMENDATION:

CLOSED MEETING: Dr. Poston moved that the Committee of the Joint Board of Nursing and Medicine convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 1:00 P.M., for the purpose of consideration of agency subordinate recommendations. Additionally, Dr. Poston moved that Ms. Douglas, Ms. Power, Ms. Graham and Ms. Barrett attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and carried unanimously.

RECONVENTION: The Board reconvened in open session at 1:20 P.M.

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

Cherish Van Schaik, LNP 0024-171314; Prescriptive Authority 0017-141362
Ms. Schaik did not appear.

Ms. Gerardo moved that the Committee of the Joint Boards of Nursing and Medicine modify the recommended decision of the agency subordinate to reprimand Cherish Van Schaik and to place her on probation with terms for at least one year of active employment as a nurse practitioner in the Commonwealth of Virginia. The motion was seconded and carried unanimously.

Lee Caswell Hughes, LNP 0024-169677; Prescriptive Authority 0017-140240
Ms. Hughes did not appear.

Dr. Walker moved that the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate to reprimand Lee Caswell Hughes, to assess a monetary penalty of \$500.00 to be paid to the Board within 90 days from the date of entry of the Order, and to order Ms. Hughes to undergo a chemical dependency evaluation conducted by a Committee-approved specialist who holds an unrestricted license, and have a written report of the evaluation, including a diagnosis, recommended course of therapy, prognosis, and any other recommendations sent to the Committee, within 90 days of the entry of the Order. The motion was seconded and carried unanimously.

Ms. Power left at 1:30 P.M.

Ms. Weiss joined the hearing at 1:32 P.M.

**ESTABLISHMENT OF
A QUORUM:**

With five members of the Committee of the Joint Boards present, a quorum was established. Additionally there were three members of Board of Nursing present with two members of the Board of Nursing serving in dual capacity.

FORMAL HEARING:

Julie Maria Hall Megaro, RN 0001-217867; LNP 00024-0024168815
Ms. Megaro appeared accompanied by Kristin Paudling, Esquire.

Amy Weiss, Adjudication Specialist, represented the Commonwealth. Ms. Barret was legal counsel for the Committee of Joint Boards and Board of Nursing. Mary Tretar, court reporter from Crane Snead and Associates, recorded the proceedings.

Lane Raker, Senior Investigator, Department of Health Professions, and Amy Vinson, Office Manager, OB/GYN Physicians Inc., were present and testified

CLOSED MEETING:

Dr. Poston moved that the Committee of the Joint Boards of Nursing and Medicine and panel of the Board of Nursing convene a closed meeting pursuant to §2.2-3711(A)(28) of the *Code of Virginia* at 2:57 P.M., for the purpose to reach a

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decision in the matter of Ms. Megaro. Additionally, Dr. Poston moved that Ms. Douglas, Ms. Graham and Ms. Barrett attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and carried unanimously.

RECONVENTION: The Board reconvened in open session at 3:34 P.M.

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

ACTION: Mr. Traynham moved that the Board of Nursing accept the findings of fact and conclusions of law as presented by Ms. Weiss and amended by the Board.

Dr. Hahn moved that the Board of Nursing reprimand Julie Maria Hall Megaro and place her on probation with terms for a period of not less than two years of active employment as a professional nurse in the Commonwealth of Virginia. The motion was seconded and carried unanimously.

Ms. Gerardo moved that the Committee of the Joint Boards of Nursing and Medicine accept the findings of fact and conclusions of law as presented by Ms. Weiss.

Dr. Walker moved that the Committee of the Joint Boards of Nursing and Medicine reprimand Julie Maria Hall Megaro and place her on probation with terms for a period of not less than two years of active employment as a nurse practitioner in the Commonwealth of Virginia. The motion was seconded and carried unanimously.

ADJOURNMENT: The meeting was adjourned at 3:38 P.M.

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

**VIRGINIA BOARD OF NURSING
COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
BUSINESS MEETING MINUTES
April 12, 2017**

TIME AND PLACE: The meeting of the Committee of the Joint Boards of Nursing and Medicine was convened at 9:30 A.M., April 12, 2017 in Board Room 4, Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

MEMBERS PRESENT: Louise Hershkowitz, CRNA, MSHA; Chair
Marie Gerardo, MS, RN, ANP-BC
Kenneth Walker, MD

MEMBERS ABSENT: Lori D. Conklin, MD
Rebecca Poston, PhD, RN, CPNP
Wayne Reynolds, DO

ADVISORY COMMITTEE MEMBERS PRESENT:
Joseph F. Borzelleca, Jr., MD, MPH
Kevin E. Brigle, RN, NP
Mark Coles, RN, BA, MSN, NP-C
Wendy Dotson, CNM, MSN
David A. Ellington, MD
Cathy A. Harrison, DNAP, CRNA
Sarah E. Hobgood, MD
Stuart F. Mackler, MD

STAFF PRESENT: Jay P. Douglas, MSM, RN, CSAC, FRE; Executive Director; Board of Nursing
Stephanie Willinger, Deputy Executive Director; Board of Nursing
Darlene Graham, Senior Discipline Specialist; Board of Nursing

OTHERS PRESENT: Erin Barrett, Assistant Attorney General; Board Counsel
David Brown, DC; Director; Department of Health Professions
Elaine Yeatts, Senior Policy Analyst, Department of Health Professions
William L. Harp, MD, Executive Director; Board of Medicine

IN THE AUDIENCE: W. Scott Johnson, Medical Society of Virginia (MSV)
Richard Grossman, Virginia Council of Nurse Practitioners (VCNP)
Lynn Poole, FNP-BC
Mary Duggan, American Association of Nurse Practitioners (AANP) State Representative
Sarah Heisler, Virginia Hospital and Healthcare Association (VHHA)

INTRODUCTIONS: Committee members, Advisory Committee members and staff members introduced themselves.

ESTABLISHMENT OF A QUORUM: Ms. Hershkowitz noted that there was not enough Committee members to establish a quorum. She added that the following items are deferred at the next meeting for action:

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- Adoption of February 8, 2017 Business meeting and Formal Hearings minutes
- Appointment of Joint Boards Advisory Committee Member, Dr. Thokozeni Lipato
- Ms. Barrett's discussion of establishing a standard for expert witnesses will go directly to Board of Medicine and Board of Nursing with a recommendation from the Committee of the Joint Boards of Nursing and Medicine.

PUBLIC COMMENT: There was no one present that wished to address the Board.

DIALOGUE WITH
AGENCY DIRECTOR:

Opioid Crisis – Dr. Brown reported the followings:

- Virginia has a 30% increase from 2015 in deaths due to heroin and fentanyl overdoses.
- 80% heroin users reported starting journey with prescription.
- 2017 General Assembly many opioid related bills such as:
 - Requiring prescribers to obtain information from Prescription Monitoring Program (PMP) if anticipating prescribing of opioids more than seven consecutive days
 - Mandating electronic prescription of opioids by 2020 to help eliminate prescription fraud (technology issues require delay)
 - Authorizing the registration of Peer Recovery Specialist
 - Facilitating Naloxone distribution and training by the Department of Behavioral Health and Development Services (DBHDS)
 - Convening workgroups by Secretary to educate health care practitioners;
 - Limiting Buprenorphine for pain management

Dr. Walker noted that the BOM has approved regulations on opioid and buprenorphine prescribing and the BOM has established a task force.

Dr. Harp said that the basis for pain management regulations was from CDC Guidelines.

Dr. Brown stated that prescribers need to review regulations and best practice techniques for dealing with overprescribing through pain management. Dr. Ellington questioned who determines “best practices” for licensed specialists and recommended that when regulations are distributed, it would be helpful to explain the background. Ms. Douglas stated that all nurse practitioners will be notified of new regulations via e-mail once they are effective. Both Dr. Harp and Dr. Brown stated that regulations/guidelines are in place and forthcoming along with education for health care providers and establishing guidelines for training health care providers in the safe prescribing and appropriate use of opioids. Dr. Harp stated he has begun to receive telephone calls regarding concerns of referrals to pain management specialist.

Dr. Hobgood stated that her experience is that the pain management regulations for physicians (identical to nurse practitioner regulations) have been beneficial so far.

Dr. Walker stated that he was aware that in some practices the strategy is to “hand off” pain management to nurse practitioners and physician assistants.

OLD BUSINESS:

Nurse Practitioners Regulations on Pain Management and Prescribing of Buprenorphine:

Ms. Yeatts reviewed the regulations that have been adopted by BOM and BON. She indicated that no additional changes were made after the March BON meeting as anticipated. She added that the regulations are now in the Governor’s office for approval.

Expert Witness:

Ms. Barrett stated there will be no action on this item due to lack of a quorum and will be deferred to the next meeting.

Final Report on 2017 General Assembly Legislation:

Ms. Yeatts reported of Bills affecting nurse practitioners to include:

- HB 2119 (**Laser hair removal, limits practice**)
- HB 2301 (**Nurses, licensed practical; administration of vaccinations**) – the “*immediate and direct*” requirement of supervision of LPNs by RNs for PPD and vaccine administration was.

Update on Board Counsel review of Statutory limitations related to proposal of eliminating prescriptive authority license:

Ms. Douglas stated that a full report will be presented at the next meeting, Ms. Mitchell, Board Counsel, is currently reviewing the matters.

CARA Waiver from SAMHSA:

Ms. Herhkowitz stated that this is provided as information only.

NEW BUSINESS:

Report of the March 9, 2017 “Addiction Disease Management” training provided by Virginia Department of Health (VDH):

Ms. Hershkowitz provided a summary of the training and stated that it was beneficial. She added that her written report was sent to Ms. Douglas via e-mail on April 11, 2017.

Report of National Council State Board of Nursing (NCSBN) Advance Practice Registered Nurses (APRN) Roundtable on April 4, 2017:

Ms. Hershkowitz provided a brief summary of the meeting.

Written report submitted.

Board of Nursing Executive Director Report:

Ms. Douglas reported the followings:

March 13-15, 2017 NCSBN Mid-Year Meeting - attention and focus on the opioid epidemic/crisis and more research and collaboration with the U.S. Public Health Service. The U.S. Surgeon General is engaged in a public awareness campaign regarding the opioid crisis in the U.S., “Turn the Tide RX” and more information is available on their website.

NURSYS Update - working to implement data on advance practice licensee’s in our data system, to include information regarding national certifications issued to licensee’s by recognized credentialing agencies.

APRN Compact - 3 states have adopted the consensus model and passed legislation: Iowa, North Dakota, West Virginia.

Veteran’s Affairs New Rule - NCSBN is doing work with Veteran’s Affairs Administration regarding expanding the scope of practice of APRNs and Board’s access to information necessary for investigations.

2018 Proposed Meeting Dates - Ms. Hershkowitz noted the schedule of meeting dates for 2018.

Ms. Hershkowitz appointed BON members to serve as Joint Boards Committee members for purpose of consideration of Agency Subordinate recommendations.

Ms. Jeanne Holmes, BON Citizen Member, and Dr. Dustin Ross, BON Board Member, joined the meeting at 11:30 A.M.

RECOMMENDATIONS FOR CONSIDERATION

CLOSED MEETING: Ms. Gerardo moved that the Committee of the Joint Boards of Nursing and Medicine and the Board of Nursing convene a closed meeting pursuant to Section 2.2-3711(A)(27) of the *Code of Virginia* at 11:35 A.M. for the purpose of deliberation to consider Agency Subordinate recommendations. Additionally, Ms. Gerardo moved that Ms. Holmes, Dr. Ross, Ms. Douglas, Ms. Willinger, Ms. Graham, and Ms. Barrett attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and carried unanimously.

RECONVENTION: The Board reconvened in open session at 11:37 P.M.
Ms. Gerardo moved that the Committee of the Joint Boards of Nursing and Medicine and the Board of Nursing certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business

matters as were identified in the motion by which the closed meeting was convened. The motion was seconded and carried unanimously.

Ann Cibuzar McTernan, LNP 0024-075991

Mr. Gerardo moved to accept the Agency Subordinate recommendation to indefinitely suspend the license of Ann Cibuzar McTernan to practice as a nurse practitioner in the Commonwealth of Virginia. The motion was seconded and carried unanimously.

Dr. Ross left the meeting at 11:12 A.M.

Traci M. Colley, LNP 0024-165103

Ms. Gerardo moved to modify the Agency Subordinate recommendation as follow:

- To reprimand Traci M. Colley;
- To indefinitely suspend her license to practice as a nurse practitioner in the Commonwealth of Virginia;
- Said suspension is stayed upon proof of Ms. Colley's re-entry into a Contract with the Virginia Health Practitioners' Monitoring Program (HPMP) and comply with terms and conditions of the HPMP for the period specified by the HPMP;
- To require Ms. Colley to provide to the Board proof of current professional certification in nurse anesthesia from a certifying agency designated in 18VAC90-30-90 or to complete at least 40 hours of continuing education in the area of nurse anesthesia approved by one of the certifying entities designated in 18VAC90-30-90 prior to her suspension being stayed or prior to reinstatement.

The motion was seconded and carried unanimously.

Ms. Hershkowitz reminded available Board Members that assistance was needed with probable cause review following the meeting.

ADJOURNMENT:

As there was no additional business, the meeting was adjourned at 11:14 A.M.

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

Expert admissibility standards to consider:

Traditional Virginia Standard:

To qualify to serve as an expert witness, an individual:

must possess sufficient knowledge, skill, or experience regarding the subject matter of the testimony to assist the trier of fact in the search for the truth. Generally, a witness possesses sufficient expertise when, through experience, study or observation the witness acquires knowledge of a subject beyond that of persons of common intelligence and ordinary experience.

Virginia Medical Malpractice Standard:

To qualify to serve as an expert witness, an individual:

[a]ny health care provider who is licensed to practice in Virginia shall be presumed to know the statewide standard of care in the specialty or field of practice in which he is qualified and certified....A witness shall be qualified to testify as an expert on the standard of care if he demonstrates expert knowledge of the standards of the defendant's specialty and of what conduct conforms or fails to conform to those standards and if he has had active clinical practice in either the defendant's specialty or a related field of medicine within one year of the date of the alleged act or omission forming the basis of the action.



COMMONWEALTH of VIRGINIA

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Executive Director

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

TO: Jay P. Douglas
Executive Director

FROM: Stephanie H. Willinger 
Deputy Executive Director

DATE: May 31, 2017

RE: Possible elimination of separate license for prescriptive authority: LNPs

PURPOSE:

The purpose of this memorandum is address the implications of eliminating a separate license issued to nurse practitioners for prescriptive authority, as discussed at several Joint Board meetings from April 15, 2016 to present.

BACKGROUND:

Virginia nursing regulation(s) require a separate application, fee and license (#0017) for an LNP to be authorized to prescribe (See [18 VAC 90-40-30](#) and [18 VAC 90-40-40](#)). To be eligible for a prescriptive authority license, in pertinent part, an applicant must have a current unrestricted LNP in Virginia and provide evidence of meeting at least one (1) of the four listed requirements (e.g. current professional certification required for LNP, graduate level coursework in pharmacology/pharmacotherapeutics, etc.). Since there is a separate application for a LNP to be authorized to prescribe, a separate license (#0017) is issued.

Currently, there are 6,605 LNPs with prescriptive authority licenses. From January 1, 2016 through December 31, 2016, there were 954 online applications filed with the VBON for prescriptive authority. For this same time period, there were 974 licenses issued for prescriptive authority¹.

Information was collected through NCSBN regarding other states with a single license issued for Nurse Practitioners (LNPs or APRNs) that also have prescriptive authority. The following states issue a single license to LNPs/APRNs combined with prescriptive authority: AK, AZ, AR, CA, DE, HI, MI, MS, MT, NC, NH, ND, OR, WA, WY. NCSBN reported that a single (LNP or APRN) license that includes prescriptive authority is more common in states with Boards of Nursing issuing the 'practice and prescribing' authority and in 'full practice' states. Additionally, the prescribing authority (or restrictions) in some of

¹ Licenses currently are printed and mailed.

Board of Audiology & Speech - Language Pathology – Board of Counseling – Board of Dentistry – Board of Funeral Directors & Embalmers
Board of Long-Term Care Administrators – Board of Medicine - Board of Nursing – Board of Optometry – Board of Pharmacy
Board of Physical Therapy – Board of Psychology – Board of Social Work – Board of Veterinary Medicine - Board of Health Professions

the sample states appear to be detailed through the LNP/APRN practice or collaborative agreements. (See [NCSBN APRN Pres Auth Report 5/17.docx](#) for more information).

INTERNAL/EXTERNAL IMPACT:

Current license status: LNP licenses are denoted with license #0024 and if an LNP has prescriptive authority, an additional license is denoted as #0017. Both of these license types show up separately through the Department of Health Professions (DHP) License Lookup. The Office of the Attorney General (OAG) has opined that combining our LNP and Prescriptive Authority licenses into a single license does not pose any legal issue/question and are matters to be addressed by agency policy. Therefore, the agency may proceed with changing the requirement to issue a separate license (#0017) for LNPs with prescriptive authority.

Future License Status Options/Impact: If the VBON proceeds to eliminate a separate prescriptive authority license issued to LNPs, the application process may be slightly modified to reflect a single license type with the additional 'option' of prescriptive authority (*RX Authority*). Current licensees may be affected upon renewal and would be converted to a single license (#0024) with the additional *RX Authority*. However, Certified Registered Nurse Anesthetists (CRNAs) would continue to be exempt from obtaining *RX Authority*. Additionally, DHP IT would have to merge current license records for those active LNPs with *RX Authority* and develop the appropriate fields in MLO to reflect those LNPs with *RX Authority*.

The positive internal impact is fewer applications, better efficiency and shorter turnaround times for license application processing for LNPs. The main negative internal impact is that there would be a loss of revenue for elimination of the separate application solely for prescriptive authority license (#0017) which is \$75 per application (LNP application fee is \$125)². However, VBON could consider a 'hybrid' fee by charging a slightly higher fee for an LNP who requests *RX Authority* designated on their license by combining the application processes. For example, the hybrid application fee could be \$150 (\$125 + \$35 included for *RX Authority*). Also, there would be some cost savings from eliminating mailing separate hard copy licenses. An external issue is that employers and other entities, such as the DEA, are used to seeing a separate license (#0017) for prescriptive authority so the VBON would need to develop and publicize information regarding changes to protocols, applications, licenses, license lookup, etc.

A key internal (technical) issue is to ensure proper placement of the *RX Authority* within MLO so that it prints on the license and shows up in *License Lookup*. Other possible alternatives are to add another specialty box, or modify license subtype to include *RX Authority*.

Recommendation(s): The recommendation to the Board of Nursing and the Board of Medicine is to initiate regulatory action and move ahead in collaboration with DHP IT staff, to issue a single license for an LNP with *RX Authority* (#0024).

² Revenue for the past two (2) years was \$126,000 and \$143,000 (See Joint Board Meeting Minutes 12/7/16).

PERSONAL INFORMATION

Name: Thokozeni Lipato
Title: Assistant Professor
Institution Name: Virginia Commonwealth University
Business Address 1: Theater Row, Room 436; 730 East Broad Street; PO BOX 980306
City, State, Zip: Richmond, VA 23298-0306
Business Phone: (804) 628-3628
Business Fax: (804) 828-4862
Business Email: thokozeni.lipato@vcuhealth.org

PROFESSIONAL SUMMARY

Primary Departmental Program Area: General Internal Medicine
Areas of expertise and interest: Sickle cell disease, Addiction Medicine and chronic pain management

EDUCATION

POSTGRADUATE

07/2002 – 06/2004	University of Minnesota, Minneapolis, MN	Internal Medicine Residency
07/2001 – 06/2002	University of Minnesota, Minneapolis, MN	Internal Medicine Internship

GRADUATE

06/1997 – 06/2001	University of Alabama School of Medicine, Birmingham, AL	M.D.
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UNDERGRADUATE

06/1993 – 05/1997	Alabama A&M University, Normal, AL	B.S.
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Honors: Summa cum laude, 1997; Dean's List, 1993 – 1997

CERTIFICATION AND LICENSURE

LICENSURE or REGISTRATION

Virginia medical license; 0101254004; issued /22/2013

USMLE Step 1 – 6/21/1999
USLME Step 2 – 8/15/2000
USLME Step 3 – 12/3/2002

CERTIFICATION

The American Board of Internal Medicine, # 228477, Expires in 2024

HOSPITAL APPOINTMENTS

Virginia Commonwealth University Medical Center

ACADEMIC APPOINTMENT HISTORY

Department of Internal Medicine, School of Medicine, Virginia Commonwealth University, Richmond, Virginia, Assistant Professor. September 2013 – present.

Department of Internal Medicine, School of Medicine, University of Minnesota, Minneapolis, Minnesota, Assistant Professor. July 2009 through June 2013.

EMPLOYMENT HISTORY INCLUDING SIGNIFICANT WORK EXPERIENCE

Staff Physician, Division of General Internal Medicine, Virginia Commonwealth University Medical Center, Richmond, Virginia. September 2013 – present.

Staff Physician, Division of General Internal Medicine, University of Minnesota Medical Center and Community University Healthcare Center, Minneapolis, Minnesota. July 2009 through June 2013.

Medical Director of Barbara McInnis House, Boston Healthcare for the Homeless Program, Boston, Massachusetts. May 2008 through May 2009.

Primary care physician, Boston Healthcare for the Homeless Program, Boston, Massachusetts. August 2005 through May 2009.

Hospitalist (per-diem), Northeast Health System, Beverly, Massachusetts. August 2005 through May 2009.

Primary care physician, Minneapolis VA Medical Center, Minneapolis, Minnesota. July 2004 through July 2005.

SPECIAL AWARDS AND HONORS

Minnesota Veteran's Research Institute's Zieve Award. 2004

2014 – 2015 Research and External Funding (REF) Fellow. The REF academy is supported by the Division for Inclusive Excellence, the Office of Research and Innovation and the Office of the Provost, and is designed to increase external funding opportunities for underrepresented ethnic minority faculty.

MEMBERSHIP IN SCIENTIFIC OR PROFESSIONAL SOCIETIES

Society of General Internal Medicine. 2014

SCIENTIFIC AND SCHOLARLY ACTIVITIES

GRANTS AND CONTRACTS: ACTIVE

1. Phase 1B, Randomized, Double-blind, Placebo-controlled Study to Evaluate the Safety, Tolerability, Pharmacokinetics, and Pharmacodynamics of PF-04447943, Co-Administered with and without Hydroxyurea in subjects with Sickle Cell Disease, B0401016, Wally Smith, Sponsored by Pfizer, Inclusive dates: 03/2015 – 03/2016, Total Direct Costs: \$175,255, Sub I, Percent Effort: 0%
2. Project Title: Enhancing Use of Hydroxyurea in SCD using Patient Navigators R18, HM14641, PI Name: Wally Smith, Source of Funds: NIH/NHLBI sponsored, Inclusive dates: 8/2012-7/2017, Total funding: \$3,000,000.00, Role on Project: Clinical Investigator, Percent Effort: 2%
3. Title: Subjective Responses and Metabolic State During Exercise in Sickle Cell Anemia. PI: Ameringer, Suzanne W. Sponsor: National Institute of Nursing Research/NIH/DHHS. Index: 540645. Award Period: 09/25/2015-07/31/2017. Clinical investigator, Percent Effort: 2%
4. Title: Center for the Study of Tobacco Products. PI: Eissenberg, Thomas E. Sponsor/Award #: National Institute on Drug Abuse/NIH/DHHS - PDA036105B. Index: 548795. Banner Title: 4P50DA036105 04 Proj 3 Internal Med. Award Period: 09/30/2013-08/31/2017. Medically responsible investigator
5. Title: Center for the Study of Tobacco Products. PI: Eissenberg, Thomas E. Sponsor/Award #: National Institute on Drug Abuse/NIH/DHHS - PDA036105A. Index: 548691. Banner Title: 5P50DA036105 03 Proj 2 Internal Med Award Period: 09/30/2013-08/31/2017. Medically responsible investigator
6. Title: Behavior and Toxicant Exposure Among Dual Users of Cigarettes and E-Cigarettes. PI: Cobb, Caroline O. Sponsor/Award #: National Cancer Institute/NIH/DHHS - RCA184634A. Index: 545610. Banner Title: 5R21CA184634 02 Internal Med Sub. Award Period: 09/16/2014-08/31/2017. Total award amount: & 419,352. Medical Responsible Investigator

GRANTS AND CONTRACTS: PAST

1. Title: Evaluation of Purified Ploloxamer 188 in Vaso-Occlusive Crisis of Sickle Cell Disease (EPIC): A Phase 3, Randomized, Double Blind, Placebo-Controlled Multicent Clinical Trail of

MST-188 (purified poloxamer 188) Injection in Subjects with Sickle Cell Disease. PI: Lipato, Thokozeni Sponsor/Award #: Mast Therapeutics, INC. Index: 512726 - Evaluation of Purified Poloxamer 18 Award Period: 08/13/2014-08/12/2016. Total funding: \$169,768, PI, Percent Effort: 4%

2. Enhancing Adherence to Prescribed Opiates in Sickle Cell Disease, Org Code #: 450018, Thokozeni Lipato, Quest Innovation Fund Award, Inclusive dates: 4/2014 – 6/2016, Total funding: \$49, 556,PI, Percent Effort: 9%
3. The role of N-acetyl-L-cysteine (NAC) as an Adjuvant to Opioid Treatment in Patients with Chronic Neuropathic Pain, ClinicalTrials.gov, NCT01840345, Dace Svikis, Inclusive Dates: 12/2013 – 2016, Medical Responsible Investigator, Percent Effort: 0%

RESEARCH ADVISING AND MENTORING

Daniel Sop. Department of Engineering, VCU on a research project - Enhancing Adherence to Prescribed Opiates in Sickle Cell Disease. Earned MS degree in May 2016.

EXTRAMURAL PRESENTATIONS

LOCAL

December 2013. Clinicopathologic Conference. Virginia Commonwealth University, Department of Internal Medicine.

May 2015. Grand Rounds. *Responsible Prescribing of Opioids*. Virginia Commonwealth University, Department of Obstetrics and Gynecology.

May 2016. Grand Rounds. *Sickle Cell Disease*. Virginia Commonwealth University, Department of Surgery.

TEACHING, ADVISING AND MENTORING

July 2009 – June 2013, Attending Physician, Inpatient Service (1 resident, 2 interns, 2 M-3s) University of Minnesota; 8 hours per day, 10 weeks per year.

July 2009 – June 2013, Clinic attending, Primary Care Clinic; University of Minnesota; 4 hours per week.

September 2013 - present, Attending Physician, Inpatient Service (1 resident, 2 interns, 2 M-3s); Virginia Commonwealth University; 8 hours per day, 8 weeks per year.

September 2013 – present, Clinic attending, Primary Care Clinic; Virginia Commonwealth University; 8 hours per week.

Sickle Cell Anemia Case Presentation for First Year Medical Students. 2014 - Present.

PUBLICATIONS

PAPERS PUBLISHED IN PEER REVIEWED JOURNALS

Sawhney MS, **Lipato T**, Nelson DB, Lederle FA, Rector TS, Bond JH. *Should Patients with Anemia and Low Normal and Normal Ferritin Undergo Colonoscopy?* American Journal of Gastroenterology. 2007; 102(1): 82 – 88

Ramoa CP, Hiler MM, Spindle TR, Lopez AA, Karaoghlanian N, **Lipato T**, Breland AB, Shihadeh A, Eissenberg T. *Electronic cigarette nicotine delivery can exceed that of combustible cigarettes: a preliminary report.* Tobacco Control, 2015.

Soule EK, **Lipato T**, Eissenberg T. *Waterpipe tobacco-smoking: a new smoking epidemic among the young?* Current Pulmonology Reports, September 2015.

Lopez AA, Hiler MM, Soule EK, Ramôa CP, Karaoghlanian NV, **Lipato T**, Breland AB, Shihadeh AL, Eissenberg T. *Effects of Electronic Cigarette Liquid Nicotine Concentration on Plasma Nicotine and Puff Topography in Tobacco Cigarette Smokers: A Preliminary Report.* Nicotine Tob Res. 2015 Sep 16.

PAPERS PUBLISHED IN JOURNALS THAT ARE NOT PEER REVIEWED

Lipato T. *Improving the Health of the Homeless.* Minnesota Medicine. 2012; 95 (2): 45 – 50

Agenda Item: Regulatory Actions - Chart of Regulatory Actions

Staff Note: Attached is a chart with the status of regulations for the Board as of May 22, 2017

[18 VAC 90 - 30]	Regulations Governing the Licensure of Nurse Practitioners	<u>Reduction in renewal fees</u> [Action 4795] Final - Register Date: 5/1/17 Effective: July 1, 2017 through June 30, 2019
[18 VAC 90 - 40]	Regulations for Prescriptive Authority for Nurse Practitioners	<u>Prescribing of opioids</u> [Action 4797] Emergency/NOIRA - Register Date: 5/29/17 Emergency effective: 5/8/17 to 11/7/18 Comment on NOIRA: 5/29/17 to 6/28/17

Agenda Item: Regulations Governing Prescribing of Opioids and Buprenorphine

Included in the agenda package:

Copy of regulations for Nurse Practitioners with changes as recommended by the Legislative Committee of the Board of Medicine

Staff note:

The re-adoption of emergency regulations will be adopted by the Board of Medicine on June 22, 2017 – both regulations for MDs, DOs, DPMs and PAs and the regulations for nurse practitioners

Regulations for nurse practitioners will then be adopted by the Board of Nursing at its meeting on July 18, 2017

Action:

Recommendation to the Boards of Medicine and Nursing on nurse practitioner regulations for prescribing of opioids and buprenorphine.

BOARDS OF NURSING AND MEDICINE

EMERGENCY REGULATIONS FOR NURSE PRACTITIONERS

Prescribing of opioids

Part IV

Disciplinary Provisions

18VAC90-30-220. Grounds for disciplinary action against the license of a licensed nurse practitioner.

The boards may deny licensure or relicensure, revoke or suspend the license, or take other disciplinary action upon proof that the nurse practitioner:

1. Has had a license or multistate privilege to practice nursing in this Commonwealth or in another jurisdiction revoked or suspended or otherwise disciplined;
2. Has directly or indirectly represented to the public that the nurse practitioner is a physician, or is able to, or will practice independently of a physician;
3. Has exceeded the authority as a licensed nurse practitioner;
4. Has violated or cooperated in the violation of the laws or regulations governing the practice of medicine, nursing or nurse practitioners;
5. Has become unable to practice with reasonable skill and safety to patients as the result of a physical or mental illness or the excessive use of alcohol, drugs, narcotics, chemicals or any other type of material;
6. Has violated or cooperated with others in violating or attempting to violate any law or regulation, state or federal, relating to the possession, use, dispensing, administration or distribution of drugs; or

7. Has failed to comply with continuing competency requirements as set forth in 18VAC90-30-105;

8. Has willfully or negligently breached the confidentiality between a practitioner and a patient. A breach of confidentiality that is required or permitted by applicable law or beyond the control of the practitioner shall not be considered negligent or willful; or

9. Has engaged in unauthorized use or disclosure of confidential information received from the Prescription Monitoring Program, the electronic system within the Department of Health Professions that monitors the dispensing of certain controlled substances.

Part I

General Provisions

18VAC90-40-10. Definitions.

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

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

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

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

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

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

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

"MME" means morphine milligram equivalent.

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

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

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

"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 V

Management of Acute Pain

18VAC90-40-150. Evaluation of the patient for acute pain.

A. The requirements of this part shall not apply to:

1. The treatment of acute pain related to (i) cancer, (ii) 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, 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.

B. 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.

C. 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 ~~abuse~~ misuse.

18VAC90-40-160. 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 a patient with acute pain shall not prescribe a controlled substance containing an opioid in a quantity that exceeds a seven-day supply as determined by the manufacturer's directions for use, unless extenuating circumstances are clearly documented in the medical record. This shall also apply to prescriptions of a controlled substance containing an opioid upon discharge from an emergency department.

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

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

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

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

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

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

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

18VAC90-40-170. 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 VI

Management of Chronic Pain

18VAC90-40-180. Evaluation of the chronic pain patient.

A. The requirements of this part shall not apply to:

1. The treatment of chronic pain related to (i) cancer, (ii) a patient in hospice care, or (iii) a patient in palliative care;
2. The treatment of 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.

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

1. The nature and intensity of the pain;
2. Current and past treatments for pain;
3. Underlying or coexisting diseases or conditions;
4. The effect of the pain on physical and psychological function, quality of life, and activities of daily living;
5. Psychiatric, addiction and substance ~~abuse~~ misuse history of the patient and any family history of addiction or substance ~~abuse~~ 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 ~~abuse~~ misuse; and

9. A request for prior applicable records.

C. Prior to initiating opioid analgesia 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.

18VAC90-40-190. 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 opioid treatment for all patients, the practitioner shall:

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

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

3. Prescribe naloxone for any patient when risk factors of prior overdose, substance ~~abuse~~ 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 may be prescribed or administered for chronic pain in formulation and dosages that are FDA approved for that purpose.~~ 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, and carisoprodol, ~~and tramadol~~, the prescriber shall only co-prescribe these substances when there are extenuating circumstances and shall document in the medical record a tapering plan to achieve the lowest possible effective doses of these medications if prescribed.

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

18VAC90-40-200. 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 record in the medical records the presence or absence of any indicators for medication misuse, ~~abuse~~, or diversion and take appropriate action.

18VAC90-40-210. Informed consent and agreement for treatment of 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 screen 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.

18VAC90-40-220. 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 or 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 the prescribing. If the patient's progress is unsatisfactory, the practitioner shall assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

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

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

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

18VAC90-40-230. Additional consultation.

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

B. When a practitioner 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.

18VAC90-40-240. Medical records.

The prescriber shall keep current, accurate, and complete records in an accessible manner and 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 VII

Prescribing of Buprenorphine

18VAC90-40-250. General provisions.

A. Practitioners engaged in office-based opioid addiction treatment with buprenorphine shall have obtained a waiver from SAMHSA 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. Nurse practitioners who have obtained a SAMHSA waiver shall only prescribe buprenorphine for opioid addiction pursuant to a practice agreement with a SAMHSA-waivered doctor of medicine or doctor of osteopathic medicine.

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

18VAC90-40-260. Patient assessment and treatment planning.

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

18VAC90-40-270. Treatment with buprenorphine.

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

1. When a patient is pregnant;
2. When converting a patient from methadone or buprenorphine mono-product to buprenorphine containing naloxone for a period not to exceed seven days; or
3. In formulations other than tablet form for indications approved by the FDA; or
4. 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.

B. Buprenorphine mono-product tablets may be administered directly to patients in federally licensed opiate 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, and carisoprodol, ~~and tramadol~~, the prescriber shall only

co-prescribe these substances when there are extenuating circumstances and shall document in the medical record a tapering plan to achieve the lowest possible effective doses if these medications are prescribed.

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

F. During the induction phase, except for medically indicated circumstances as documented in the medical record, patients should be started on no more than 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 abuse counseling.

18VAC90-40-280. Special populations.

A. Pregnant women shall 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, and 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 practitioner to be psychiatrically unstable shall be referred for psychiatric evaluation and treatment prior to initiating medication-assisted treatment.

18VAC90-40-290. 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.

Agenda Item: Adoption of Guidance Document on the Telemedicine for Nurse Practitioners

Included in the agenda package: Draft of Guidance Document 90-64

Staff Note:

With the 2017 amendments to Section 54.1-3303 affecting tele-prescribing, the Guidance Document on Telemedicine needs to be revised. Revisions are shown on the draft document.

Action: Recommend to the Boards of Nursing and Medicine adoption of the document as presented or as amended.

**Virginia Board of Medicine
Virginia Board of Nursing**

Telemedicine for Nurse Practitioners

Introduction:

The Board of Nursing concurs with the Guidance Document adopted by the Board of Medicine for the use of telemedicine in the delivery of medical services for practice by nurse practitioners, as recommended by the Committee of the Joint Boards of Nursing and Medicine.

Section One: Preamble.

The Virginia Board of Medicine ("Board") recognizes that using telemedicine services in the delivery of medical services offers potential benefits in the provision of medical care. The appropriate application of these services can enhance medical care by facilitating communication between practitioners, other health care providers, and their patients, prescribing medication, medication management, obtaining laboratory results, scheduling appointments, monitoring chronic conditions, providing health care information, and clarifying medical advice. With the exception of prescribing controlled substances, the Virginia General Assembly has not established statutory parameters regarding the provision and delivery of telemedicine services. Therefore, practitioners must apply existing laws and regulations to the provision of telemedicine services. The Board issues this guidance document to assist practitioners with the application of current laws to telemedicine service practices.

These guidelines should not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method used to enable practitioner-to-patient communications. ~~For~~ clarity, For the purpose of prescribing controlled substances, a practitioner using telemedicine services in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the practitioner-patient relationship as defined in Virginia Code § 54.1-3303. and A practitioner should conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine services as a component of, or in lieu of, in-person provision of medical care, while others are not. The practitioner is responsible for making this determination, and in doing so must adhere to applicable laws and standards of care.

The Board has developed these guidelines to educate licensees as to the appropriate use of telemedicine services in the practice of medicine. The Board is committed to ensuring patient access to the convenience and benefits afforded by telemedicine services, while promoting the responsible provision of health care services.

It is the expectation of the Board that practitioners who provide medical care, electronically or otherwise, maintain the highest degree of professionalism and should:

- Place the welfare of patients first;
- Maintain acceptable and appropriate standards of practice;
- Adhere to recognized ethical codes governing the applicable profession;
- Adhere to applicable laws and regulations;
- In the case of physicians, properly supervise non-physician clinicians when required to do so by statute; and
- Protect patient confidentiality.

Section Two: Establishing the Practitioner-Patient Relationship.

The practitioner-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation of the Board that practitioners recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a practitioner-patient relationship.

Where an existing practitioner-patient relationship is not present,¹ a practitioner must take appropriate steps to establish a practitioner-patient relationship consistent with the guidelines identified in this document, with Virginia law, and with any other applicable law.² While each circumstance is unique, such practitioner-patient relationships may be established using telemedicine services provided the standard of care is met.

~~Specifically, Virginia Code § 54.1-3303(A) provides the requirements to establish a practitioner-patient relationship. See Va. Code § 54.1-3303(A).~~

A practitioner is discouraged from rendering medical advice and/or care using telemedicine services without (1) fully verifying and authenticating the location and, to the extent possible, confirming the identity of the requesting patient; (2) disclosing and validating the practitioner's identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine services. An appropriate practitioner-patient relationship has not been established when the identity of the practitioner may be unknown to the patient.

Section Three: Guidelines for the Appropriate Use of Telemedicine Services.

The Board has adopted the following guidelines for practitioners utilizing telemedicine services in the delivery of patient care, regardless of an existing practitioner-patient relationship prior to an encounter.

Licensure:

¹ This guidance document is not intended to address existing patient-practitioner relationships established through in-person visits.

² The practitioner must adhere not only to Virginia law defining a practitioner-patient relationship, but the law in any state where a patient is receiving services that defines the practitioner-patient relationship.

The practice of medicine occurs where the patient is located at the time telemedicine services are used, and insurers may issue reimbursements based on where the practitioner is located. Therefore, a practitioner must be licensed by, or under the jurisdiction of, the regulatory board of the state where the patient is located and the state where the practitioner is located. Practitioners who treat or prescribe through online service sites must possess appropriate licensure in all jurisdictions where patients receive care. To ensure appropriate insurance coverage, practitioners must make certain that they are compliant with federal and state laws and policies regarding reimbursements.

Evaluation and Treatment of the Patient:

A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, which treatment includes the issuance of prescriptions, electronically or otherwise. Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional, in-person encounters. Treatment, including issuing a prescription based solely on an online questionnaire, does not constitute an acceptable standard of care. (See section on prescribing)

Informed Consent:

Evidence documenting appropriate patient informed consent for the use of telemedicine services must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following:

- Identification of the patient, the practitioner, and the practitioner's credentials;
- Types of activities permitted using telemedicine services (e.g. prescription refills, appointment scheduling, patient education, etc.);
- Agreement by the patient that it is the role of the practitioner to determine whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter;
- Details on security measures taken with the use of telemedicine services, such as encrypting date of service, password protected screen savers, encrypting data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures;
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a third party.

Medical Records:

The medical record should include, if applicable, copies of all patient-related electronic communications, including patient-practitioner communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine services. Informed consents obtained in

connection with an encounter involving telemedicine services should also be filed in the medical record. The patient record established during the use of telemedicine services must be accessible to both the practitioner and the patient, and consistent with all established laws and regulations governing patient healthcare records.

Privacy and Security of Patient Records and Exchange of Information:

Written policies and procedures should be maintained for documentation, maintenance, and transmission of the records of encounters using telemedicine services. Such policies and procedures should address (1) privacy, (2) health-care personnel (in addition to the practitioner addressee) who will process messages, (3) hours of operation, (4) types of transactions that will be permitted electronically, (5) required patient information to be included in the communication, such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.

Section Four: Prescribing.

Prescribing controlled substances requires the establishment of a bona fide practitioner-patient relationship in accordance with § 54.1-3303 (A) of the Code of Virginia. Prescribing ~~medications~~ controlled substances, in-person or via telemedicine services, is at the professional discretion of the prescribing practitioner. The indication, appropriateness, and safety considerations for each prescription provided via telemedicine services must be evaluated by the practitioner in accordance with applicable law and current standards of practice and consequently carries the same professional accountability as prescriptions delivered during an in-person encounter. Where such measures are upheld, and the appropriate clinical consideration is carried out and documented, the practitioner may exercise their judgment and prescribe ~~medications~~ controlled substances as part of telemedicine encounters in accordance with applicable state and federal law.

Prescriptions must comply with the requirements set out in Virginia Code §§ 54.1-3408.01 and 54.1-3303(A). Prescribing controlled substances in Schedule II through V via telemedicine also requires compliance with federal rules for the practice of telemedicine. Additionally, Practitioners issuing prescriptions as part of telemedicine services should include direct contact for the prescriber or the prescriber's agent on the prescription. This direct contact information ensures ease of access by pharmacists to clarify prescription orders, and further facilitates the prescriber-patient-pharmacist relationship.

For the purpose of prescribing Schedule VI controlled substances, "telemedicine services" is defined as it is in § 38.2-3418.16 of the Code of Virginia. Under that definition, "telemedicine services," as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient or consulting with other health care providers regarding a patient's diagnosis or treatment. "Telemedicine services" does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire.

Section Five: Guidance Document Limitations.

Nothing in this document shall be construed to limit the authority of the Board to investigate, discipline, or regulate its licensees pursuant to applicable Virginia statutes and regulations. Additionally, nothing in this document shall be construed to limit the Board's ability to review the delivery or use of telemedicine services by its licensees for adherence to the standard of care and compliance with the requirements set forth in the laws and regulations of the Commonwealth of Virginia. Furthermore, this document does not limit the Board's ability to determine that certain situations fail to meet the standard of care or standards set forth in laws and regulations despite technical adherence to the guidance produced herein.

Statutory references:

§ 54.1-3303. Prescriptions to be issued and drugs to be dispensed for medical or therapeutic purposes only.

A. A prescription for a controlled substance may be issued only by a practitioner of medicine, osteopathy, podiatry, dentistry or veterinary medicine who is authorized to prescribe controlled substances, or by a licensed nurse practitioner pursuant to § 54.1-2957.01, a licensed physician assistant pursuant to § 54.1-2952.1, or a TPA-certified optometrist pursuant to Article 5 (§ 54.1-3222 et seq.) of Chapter 32. The prescription shall be issued for a medicinal or therapeutic purpose and may be issued only to persons or animals with whom the practitioner has a bona fide practitioner-patient relationship.

For purposes of this section, a bona fide practitioner-patient-pharmacist relationship is one in which a practitioner prescribes, and a pharmacist dispenses, controlled substances in good faith to his patient for a medicinal or therapeutic purpose within the course of his professional practice. In addition, a bona fide practitioner-patient relationship means that the practitioner shall (i) ensure that a medical or drug history is obtained; (ii) provide information to the patient about the benefits and risks of the drug being prescribed; (iii) perform or have performed an appropriate examination of the patient, either physically or by the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically; except for medical emergencies, the examination of the patient shall have been performed by the practitioner himself, within the group in which he practices, or by a consulting practitioner prior to issuing a prescription; and (iv) initiate additional interventions and follow-up care, if necessary, especially if a prescribed drug may have serious side effects.

For the purpose of prescribing a Schedule VI controlled substance to a patient via telemedicine services as defined in § 38.2-3418.16, a prescriber may establish a bona fide practitioner-patient relationship by an examination through face-to-face interactive, two-way, real-time communications services or store-and-forward technologies when all of the following conditions are met: (a) the patient has provided a medical history that is available for review by the prescriber; (b) the prescriber obtains an updated medical history at the time of prescribing; (c) the prescriber makes a diagnosis at the time of prescribing; (d) the prescriber conforms to the standard of care expected of in-person care as appropriate to the patient's age and presenting condition, including when the standard of care requires the use of diagnostic testing and performance of a physical examination, which may be carried out through the use of peripheral devices appropriate to the patient's condition; (e) the prescriber is actively licensed in the Commonwealth and authorized to prescribe; (f) if the patient is a member or enrollee of a health plan or

carrier, the prescriber has been credentialed by the health plan or carrier as a participating provider and the diagnosing and prescribing meets the qualifications for reimbursement by the health plan or carrier pursuant to § 38.2-3418.16; and (g) upon request, the prescriber provides patient records in a timely manner in accordance with the provisions of § 32.1-127.1:03 and all other state and federal laws and regulations. Nothing in this paragraph shall permit a prescriber to establish a bona fide practitioner-patient relationship for the purpose of prescribing a Schedule VI controlled substance when the standard of care dictates that an in-person physical examination is necessary for diagnosis. Nothing in this paragraph shall apply to: (1) a prescriber providing on-call coverage per an agreement with another prescriber or his prescriber's professional entity or employer; (2) a prescriber consulting with another prescriber regarding a patient's care; or (3) orders of prescribers for hospital out-patients or in-patients.

Any practitioner who prescribes any controlled substance with the knowledge that the controlled substance will be used otherwise than medicinally or for therapeutic purposes shall be subject to the criminal penalties provided in § 18.2-248 for violations of the provisions of law relating to the distribution or possession of controlled substances.

§ 54.1-3408.01. Requirements for prescriptions.

A. The written prescription referred to in § 54.1-3408 shall be written with ink or individually typed or printed. The prescription shall contain the name, address, and telephone number of the prescriber. A prescription for a controlled substance other than one controlled in Schedule VI shall also contain the federal controlled substances registration number assigned to the prescriber. The prescriber's information shall be either preprinted upon the prescription blank, electronically printed, typewritten, rubber stamped, or printed by hand.

The written prescription shall contain the first and last name of the patient for whom the drug is prescribed. The address of the patient shall either be placed upon the written prescription by the prescriber or his agent, or by the dispenser of the prescription. If not otherwise prohibited by law, the dispenser may record the address of the patient in an electronic prescription dispensing record for that patient in lieu of recording it on the prescription. Each written prescription shall be dated as of, and signed by the prescriber on, the day when issued. The prescription may be prepared by an agent for the prescriber's signature.

This section shall not prohibit a prescriber from using preprinted prescriptions for drugs classified in Schedule VI if all requirements concerning dates, signatures, and other information specified above are otherwise fulfilled.

No written prescription order form shall include more than one prescription. However, this provision shall not apply (i) to prescriptions written as chart orders for patients in hospitals and long-term-care facilities, patients receiving home infusion services or hospice patients, or (ii) to a prescription ordered through a pharmacy operated by or for the Department of Corrections or the Department of Juvenile Justice, the central pharmacy of the Department of Health, or the central outpatient pharmacy operated by the Department of Behavioral Health and Developmental Services; or (iii) to prescriptions written for patients residing in adult and juvenile detention centers, local or regional jails, or work release centers operated by the Department of Corrections.

B. Prescribers' orders, whether written as chart orders or prescriptions, for Schedules II, III, IV, and V controlled drugs to be administered to (i) patients or residents of long-term care facilities served by a Virginia pharmacy from a remote location or (ii) patients receiving parenteral, intravenous,

intramuscular, subcutaneous or intraspinal infusion therapy and served by a home infusion pharmacy from a remote location, may be transmitted to that remote pharmacy by an electronic communications device over telephone lines which send the exact image to the receiver in hard copy form, and such facsimile copy shall be treated as a valid original prescription order. If the order is for a radiopharmaceutical, a physician authorized by state or federal law to possess and administer medical radioactive materials may authorize a nuclear medicine technologist to transmit a prescriber's verbal or written orders for radiopharmaceuticals.

C. The oral prescription referred to in § 54.1-3408 shall be transmitted to the pharmacy of the patient's choice by the prescriber or his authorized agent. For the purposes of this section, an authorized agent of the prescriber shall be an employee of the prescriber who is under his immediate and personal supervision, or if not an employee, an individual who holds a valid license allowing the administration or dispensing of drugs and who is specifically directed by the prescriber.

Agenda Item: NOIRA for supervision and direction of laser hair removal

Included in the agenda package:

A copy of HB2119

Staff note:

Since the statutory language requires laser hair removal by a *properly trained person under the direction and supervision of a licensed doctor of medicine or osteopathic medicine or a physician assistant*, regulations for doctors of medicine and osteopathy, physician assistants and nurse practitioners will need to be amended to define “direction and supervision” in this context.

Action:

Recommendation on a NOIRA to implement HB2119 in 18VAC85-20, 18VAC85-50 and 18VAC90-30.

VIRGINIA ACTS OF ASSEMBLY -- 2017 SESSION

CHAPTER 390

An Act to amend and reenact § 54.1-700 of the Code of Virginia and to amend the Code of Virginia by adding in Article 6 of Chapter 29 of Title 54.1 a section numbered 54.1-2973.1, relating to the practice of laser hair removal.

[H 2119]

Approved March 13, 2017

Be it enacted by the General Assembly of Virginia:

1. That § 54.1-700 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding in Article 6 of Chapter 29 of Title 54.1 a section numbered 54.1-2973.1 as follows:

§ 54.1-700. Definitions.

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

"Barber" means any person who shaves, shapes or trims the beard; cuts, singes, shampoos or dyes the hair or applies lotions thereto; applies, treats or massages the face, neck or scalp with oils, creams, lotions, cosmetics, antiseptics, powders, clays or other preparations in connection with shaving, cutting or trimming the hair or beard, and practices barbering for compensation and when such services are not performed for the treatment of disease.

"Barbering" means any one or any combination of the following acts, when done on the human body for compensation and not for the treatment of disease, shaving, shaping and trimming the beard; cutting, singeing, shampooing or dyeing the hair or applying lotions thereto; applications, treatment or massages of the face, neck or scalp with oils, creams, lotions, cosmetics, antiseptics, powders, clays, or other preparations in connection with shaving, cutting or trimming the hair or a beard. The term "barbering" shall not apply to the acts described hereinabove when performed by any person in his home if such service is not offered to the public.

"Barber instructor" means any person who has been certified by the Board as having completed an approved curriculum and who meets the competency standards of the Board as an instructor of barbering.

"Barbershop" means any establishment or place of business within which the practice of barbering is engaged in or carried on by one or more barbers.

"Board" means the Board for Barbers and Cosmetology.

"Body-piercer" means any person who for remuneration penetrates the skin of a person to make a hole, mark, or scar, generally permanent in nature.

"Body-piercing" means the act of penetrating the skin of a person to make a hole, mark, or scar, generally permanent in nature.

"Body-piercing salon" means any place in which a fee is charged for the act of penetrating the skin of a person to make a hole, mark, or scar, generally permanent in nature.

"Body-piercing school" means a place or establishment licensed by the Board to accept and train students in body-piercing.

"Cosmetologist" means any person who administers cosmetic treatments; manicures or pedicures the nails of any person; arranges, dresses, curls, waves, cleanses, cuts, shapes, singes, waxes, tweezes, shaves, bleaches, colors, relaxes, straightens, or performs similar work, upon human hair, or a wig or hairpiece, by any means, including hands or mechanical or electrical apparatus or appliances unless such acts as adjusting, combing, or brushing prestyled wigs or hairpieces do not alter the prestyled nature of the wig or hairpiece, and practices cosmetology for compensation.

"Cosmetology" includes, but is not limited to, the following practices: administering cosmetic treatments; manicuring or pedicuring the nails of any person; arranging, dressing, curling, waving, cleansing, cutting, shaping, singeing, waxing, tweezing, shaving, bleaching, coloring, relaxing, straightening, or similar work, upon human hair, or a wig or hairpiece, by any means, including hands or mechanical or electrical apparatus or appliances, but shall not include hair braiding or such acts as adjusting, combing, or brushing prestyled wigs or hairpieces when such acts do not alter the prestyled nature of the wig or hairpiece.

"Cosmetology instructor" means a person who has been certified by the Board as having completed an approved curriculum and who meets the competency standards of the Board as an instructor of cosmetology.

"Cosmetology salon" means any commercial establishment, residence, vehicle or other establishment, place or event wherein cosmetology is offered or practiced on a regular basis for compensation and may include the training of apprentices under regulations of the Board.

"Esthetician" means a person who engages in the practice of esthetics for compensation.

"Esthetics" includes, but is not limited to, the following practices of administering cosmetic treatments to enhance or improve the appearance of the skin: cleansing, toning, performing effleurage or other related movements, stimulating, exfoliating, or performing any other similar procedure on the skin of the human body or scalp by means of cosmetic preparations, treatments, or any nonlaser device, *whether by electrical, mechanical, or manual means*, for care of the skin; applying make-up or eyelashes to any person, tinting or perming eyelashes and eyebrows, and lightening hair on the body except the scalp; and removing unwanted hair from the body of any person by the use of *any nonlaser device, by tweezing, or by use of chemical, or mechanical means*. However, "esthetics" is not a healing art and shall not include any practice, activity, or treatment that constitutes the practice of medicine, osteopathic medicine, or chiropractic. The terms "healing arts," "practice of medicine," "practice of osteopathic medicine," and "practice of chiropractic" shall mean the same as those terms are defined in § 54.1-2900.

"Esthetics instructor" means a licensed esthetician who has been certified by the Board as having completed an approved curriculum and who meets the competency standards of the Board as an instructor of esthetics.

"Esthetics spa" means any commercial establishment, residence, vehicle, or other establishment, place, or event wherein esthetics is offered or practiced on a regular basis for compensation under regulations of the Board.

"Master esthetician" means a licensed esthetician who, in addition to the practice of esthetics, offers to the public for compensation, without the use of laser technology, lymphatic drainage, chemical exfoliation, or microdermabrasion, and who has met such additional requirements as determined by the Board to practice lymphatic drainage, chemical exfoliation with products other than Schedules II through VI controlled substances as defined in the Drug Control Act (§ 54.1-3400 et seq.), and microdermabrasion of the epidermis.

"Nail care" means manicuring or pedicuring natural nails or performing artificial nail services.

"Nail salon" means any commercial establishment, residence, vehicle or other establishment, place or event wherein nail care is offered or practiced on a regular basis for compensation and may include the training of apprentices under regulations of the Board.

"Nail school" means a place or establishment licensed by the board to accept and train students in nail care.

"Nail technician" means any person who for compensation manicures or pedicures natural nails, or who performs artificial nail services for compensation, or any combination thereof.

"Nail technician instructor" means a licensed nail technician who has been certified by the Board as having completed an approved curriculum and who meets the competency standards of the Board as an instructor of nail care.

"Physical (wax) depilatory" means the wax depilatory product or substance used to remove superfluous hair.

"School of cosmetology" means a place or establishment licensed by the Board to accept and train students and which offers a cosmetology curriculum approved by the Board.

"School of esthetics" means a place or establishment licensed by the Board to accept and train students and which offers an esthetics curriculum approved by the Board.

"Tattoo parlor" means any place in which tattooing is offered or practiced.

"Tattoo school" means a place or establishment licensed by the Board to accept and train students in tattooing.

"Tattooer" means any person who for remuneration practices tattooing.

"Tattooing" means the placing of designs, letters, scrolls, figures, symbols or any other marks upon or under the skin of any person with ink or any other substance, resulting in the permanent coloration of the skin, including permanent make-up or permanent jewelry, by the aid of needles or any other instrument designed to touch or puncture the skin.

"Wax technician" means any person licensed by the Board who removes hair from the hair follicle using a physical (wax) depilatory or by tweezing.

"Wax technician instructor" means a licensed wax technician who has been certified by the Board as having completed an approved curriculum and who meets the competency standards of the Board as an instructor of waxing.

"Waxing" means the temporary removal of superfluous hair from the hair follicle on any area of the human body through the use of a physical (wax) depilatory or by tweezing.

"Waxing salon" means any commercial establishment, residence, vehicle or other establishment, place or event wherein waxing is offered or practiced on a regular basis for compensation and may include the training of apprentices under regulations of the Board.

"Waxing school" means a place or establishment licensed by the Board to accept and train students in waxing.

§ 54.1-2973.1. Practice of laser hair removal.

The practice of laser hair removal shall be performed by a properly trained person licensed to practice medicine or osteopathic medicine or a physician assistant as authorized pursuant to § 54.1-2952 or a nurse practitioner as authorized pursuant to § 54.1-2957 or by a properly trained

person under the direction and supervision of a licensed doctor of medicine or osteopathic medicine or a physician assistant as authorized pursuant to § 54.1-2952 or a nurse practitioner as authorized pursuant to § 54.1-2957 who may delegate such practice in accordance with subdivision A 6 of § 54.1-2901.



Chronic Pain Case Study

Virginia Action Coalition/Access to Care Workgroup:

Phyllis Whitehead, PhD, APRN/CNS

Amanda Wilkins, CNM, MSN

Katherine Morris, RN, MSN, CPNP, CSPI

Cathy A. Harrison, DNAP, MSN, CRNA

Megen Hebdon, DNP, RN, FNP-c

Objectives

- Discuss the chronic pain and opioid epidemic
- Review the CDC recommendations for managing chronic pain
- Identify non-medication strategies to manage chronic pain

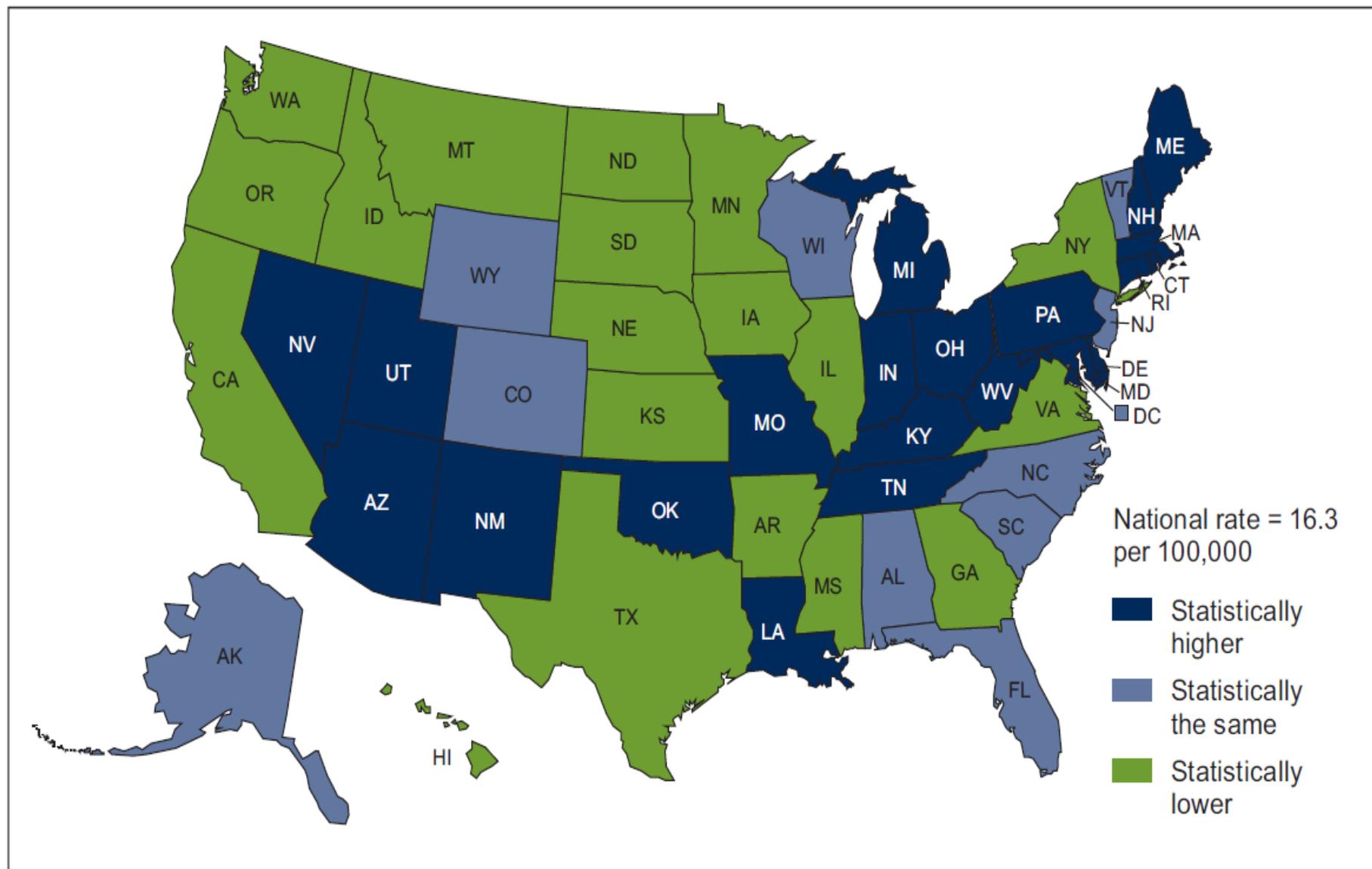
Background

- 20% of patients presenting to physician offices with non-cancer pain symptoms or pain-related diagnoses (including acute and chronic pain) receive an opioid prescription.
- 259 million prescriptions for opioid pain medication
- 7.3% from 2007 to 2012
- Opioid prescribing rates increased more for family practice, general practice, and internal medicine compared with other specialties

Background

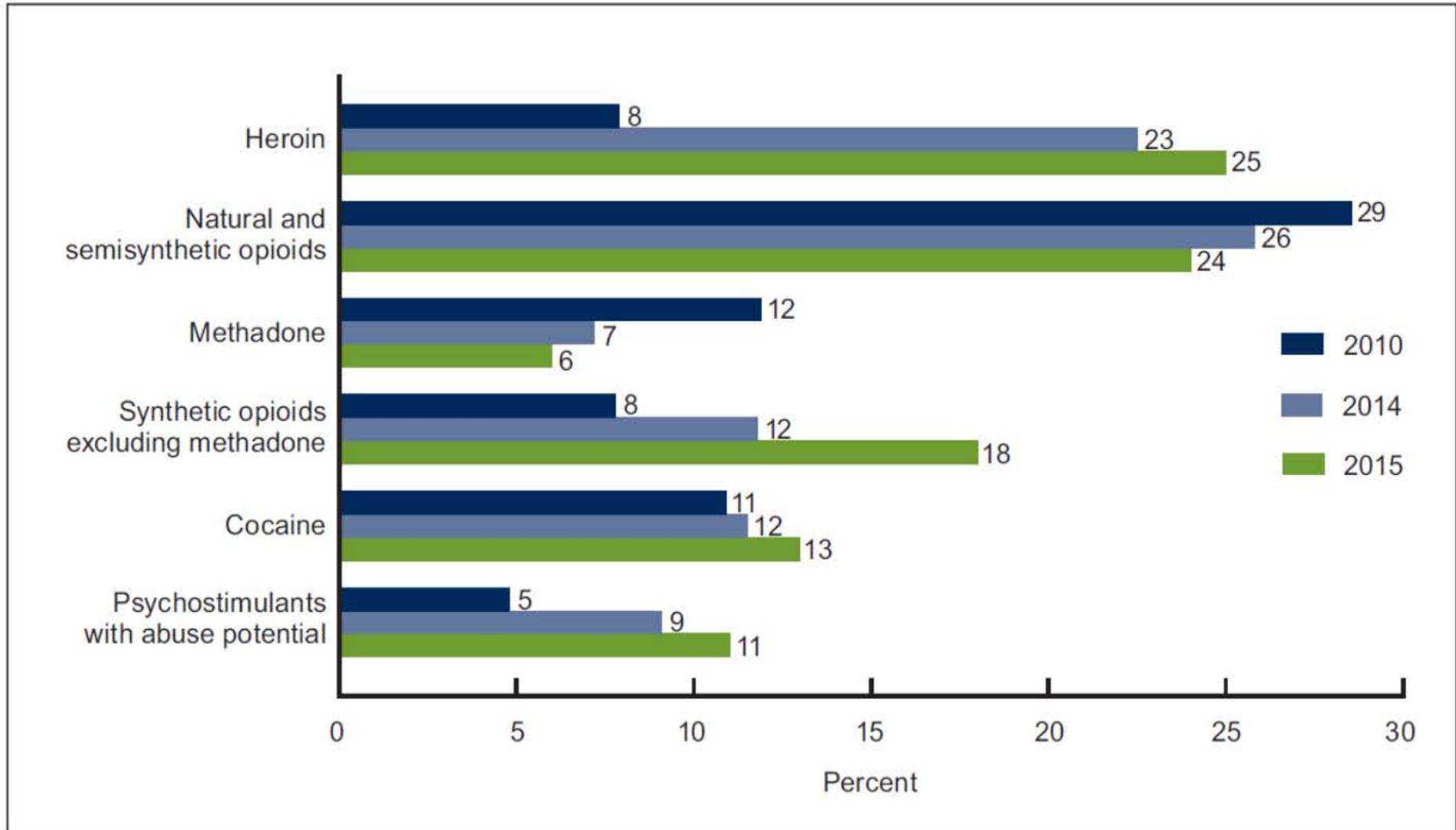
- Opioids have serious risks, including overdose and opioid use disorder.
- From 1999 to 2014, > 165,000 persons died from opioid overdose in U.S.
- >420,000 emergency department visits
- 1.9 million abused or dependent

Figure 4. Age-adjusted drug overdose death rates, by state: United States, 2015



NOTES: Deaths are classified using the *International Classification of Diseases, Tenth Revision*. Drug overdose deaths are identified using underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. Access data table for Figure 4 at: https://www.cdc.gov/nchs/data/databriefs/db273_table.pdf#4. SOURCE: NCHS, National Vital Statistics System, Mortality.

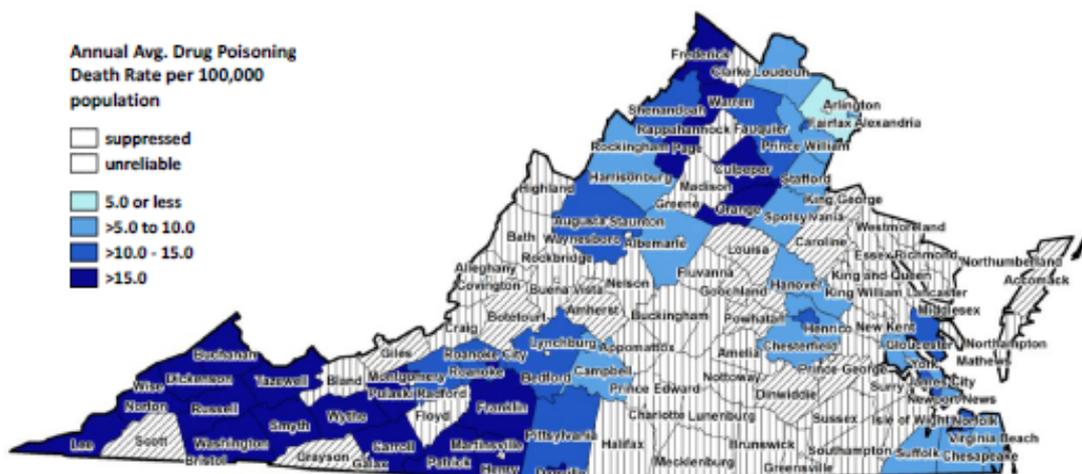
Figure 5. Percentage of drug overdose deaths involving selected drug categories: United States, 2010, 2014, and 2015



NOTES: Deaths are classified using the *International Classification of Diseases, Tenth Revision*. Drug overdose deaths are identified using underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. The total number of drug overdose deaths was 38,329 in 2010; 47,055 in 2014; and 52,404 in 2015. Drug overdose deaths involving selected drug categories are identified by specific multiple-cause-of-death codes: heroin, T40.1; natural and semisynthetic opioids, T40.2; methadone, T40.3; synthetic opioids excluding methadone, T40.4; cocaine, T40.5; and psychostimulants with abuse potential, T43.6. Categories are not mutually exclusive because deaths may involve more than one drug. The percentage of drug overdose deaths lacking information on the specific drugs involved varied by year: 25% in 2010, 19% in 2014, and 17% in 2015. Access data table for Figure 5 at: https://www.cdc.gov/nchs/data/databriefs/db273_table.pdf#5. SOURCE: NCHS, National Vital Statistics System Mortality.

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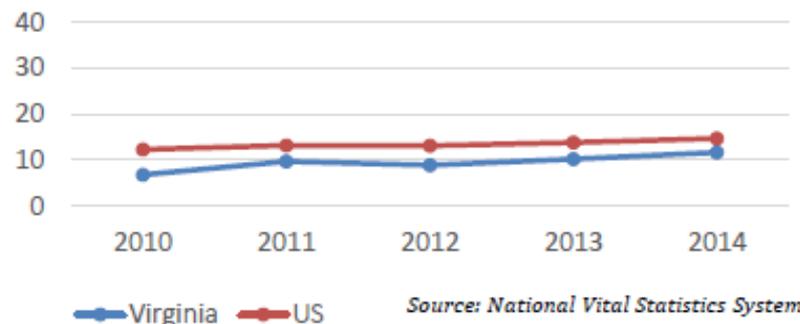
Drug Poisoning Death Rate per 100,000, by County, 2010-2014



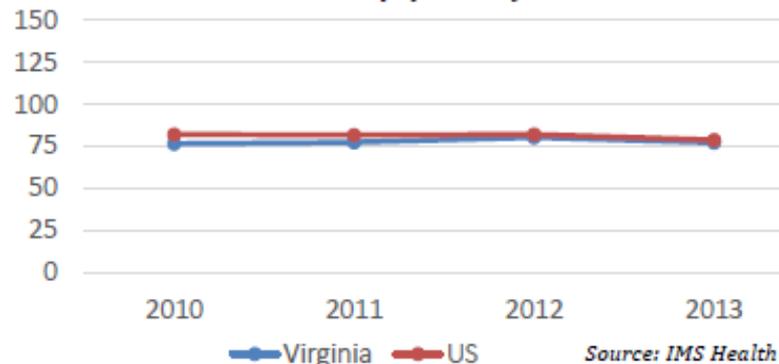
Source: CDC NVSS Multiple Cause of Death File, 2010-2014

Age-Adjusted Drug Poisoning Death Rate (2014): **11.7 per 100K population**
 (Avg. National Rate: 14.7)
 National Rank in Drug Poisoning Death Rate (2014): **37th** (tied w/ KS)

Drug Poisoning Death Rate by State and National (age-adjusted per 100,000 population)



Annual rate of opioid pain reliever prescriptions dispensed by retail pharmacies (per 100 population)

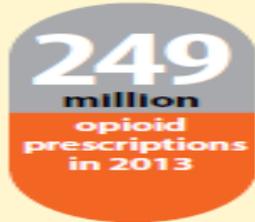


Under the President's budget proposal, Virginia would be eligible for up to **\$17 million dollars** over 2 years to expand access to treatment for opioid use disorders.

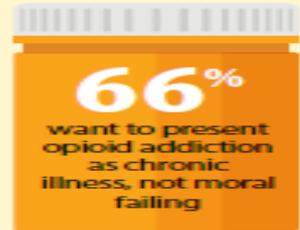
*The final funding amount will depend on Congressional action and the strength of the State's application and plan to combat the epidemic.

Healthcare Professionals' Attitudes Toward OPIOIDS

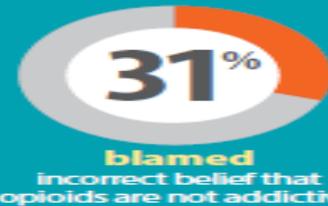
OPIOID ADDICTION BY THE NUMBERS



Clinicians need better tools to fight the OPIOID EPIDEMIC



Physicians and other clinicians were surveyed about the OPIOID EPIDEMIC



5 QUESTIONS FOR PROVIDERS

- **1** Is prescribing an opioid appropriate?
- **2** Have I considered alternate treatments?
- **3** How will this patient react to the opioid dosage?
- **4** Am I carefully monitoring high-risk patients?
- **5** What have I done to reduce long-term opioid use?

Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥ 3 months, excluding cancer, palliative, and end-of-life care

CHECKLIST

When CONSIDERING long-term opioid therapy

- Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- Check that non-opioid therapies tried and optimized.
- Discuss benefits and risks (eg, addiction, overdose) with patient.
- Evaluate risk of harm or misuse:
 - Discuss risk factors with patient.
 - Check prescription drug monitoring program (PDMP) data.
 - Check urine drug screen.
- Set criteria for stopping or continuing opioids.
- Assess baseline pain and function (eg, PEG scale).
- Schedule initial reassessment within 1–4 weeks.
- Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If RENEWING without patient visit

- Check that return visit is scheduled ≤ 3 months from last visit.

When REASSESSING at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- Assess pain and function (eg, PEG); compare results to baseline.
- Evaluate risk of harm or misuse:
 - Observe patient for signs of over-sedation or overdose risk.
 - If yes: Taper dose.
 - Check PDMP.
 - Check for opioid use disorder if indicated (eg, difficulty controlling use).
 - If yes: Refer for treatment.
- Check that non-opioid therapies optimized.
- Determine whether to continue, adjust, taper, or stop opioids.
- Calculate opioid dosage morphine milligram equivalent (MME).
 - If ≥ 50 MME/day total (≥ 50 mg hydrocodone; ≥ 33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
 - Avoid ≥ 90 MME/day total (≥ 90 mg hydrocodone; ≥ 60 mg oxycodone), or carefully justify; consider specialist referral.
- Schedule reassessment at regular intervals (≤ 3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

- *Benefits of long-term opioid therapy for chronic pain not well supported by evidence.*
- *Short-term benefits small to moderate for pain; inconsistent for function.*
- *Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.*

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (PDMP): Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores (30% improvement from baseline is clinically meaningful)

Q1: *What number from 0–10 best describes your pain in the past week?*

0 = “no pain”, 10 = “worst you can imagine”

Q2: *What number from 0–10 describes how, during the past week, pain has interfered with your enjoyment of life?*

0 = “not at all”, 10 = “complete interference”

Q3: *What number from 0–10 describes how, during the past week, pain has interfered with your general activity?*

0 = “not at all”, 10 = “complete interference”



U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

TO LEARN MORE

www.cdc.gov/drugoverdose/prescribing/guideline.html

CDC Chronic Pain Opioid Guidelines

- Provide recommendations for the prescribing of opioid pain medication for patients 18 and older in primary care settings.
- Chronic pain (pain lasting longer than 3 months or past the time of normal tissue healing)
 - Outside of active cancer treatment, palliative care, and end-of-life care.

<http://www.cdc.gov/drugoverdose/prescribing/guideline.html>

12 Recommendations

- Nonpharmacologic therapy and non-opioid pharmacologic therapy preferred
- Before starting opioids, establish treatment goals with **ALL** patients based on improved functionality
- Discuss known risks and realistic benefits
- Prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids
- Prescribe the lowest effective dosage
 - Should use caution when considering increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day
 - Should avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to ≥ 90 MME/day

Recommendations

- For acute pain, prescribe the lowest effective dose of immediate-release opioids
 - Prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids.
 - Three days or less will often be sufficient; more than seven days will rarely be needed
- Evaluate benefits and harms within 1- 4 weeks of starting opioids for chronic pain or of dose escalation.
 - Evaluate benefits and harms of continued therapy with patients every 3 months or more frequently.
 - If benefits do not outweigh harms of continued opioids, should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids

Recommendations

- Before starting and periodically during continuation of opioids, should evaluate risk factors for opioid-related harms.
 - Should incorporate into the management plan strategies to mitigate risk
 - Consider offering naloxone with increase risk for opioid overdose
 - History of overdose
 - History of substance use disorder
 - Higher opioid dosages (≥ 50 MME/day)
 - Or concurrent benzodiazepine use, are present

Recommendations

- Should review history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data (Q3 months) to determine:
 - Whether patient is receiving opioid dosages or dangerous combinations that put at risk for overdose
- Should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

Recommendations

- Should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible
- Should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone along with behavioral therapies) for patients with opioid use disorder.

***Note: Clinicians should consider the circumstances and unique needs of each patient when providing care.**

Cesarean Section Pain Management Case Study



Amanda Wilkins, CNM, MSN
February 12, 2017

Case Presentation

Mary is a 28 year old G2P1 who is 39 weeks pregnant with no pregnancy complications. Her last baby was born via C-section for breech presentation. Mary desires a repeat C-section with this baby.

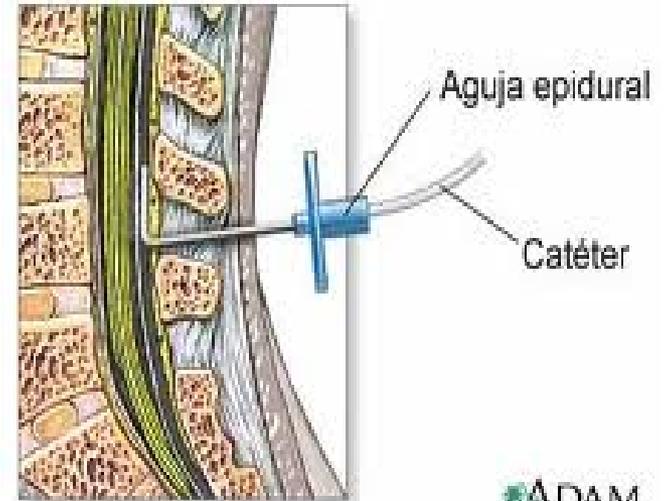
What options are available for pain management for this procedure?

What options are available for post-procedure pain management?



Pain Management During the Procedure

- Epidural/Spinal (Regional Anesthesia)
- General Anesthesia (Put completely to sleep)



Regional Anesthesia (Epidural/Spinal)

- Typically Morphine, but can also be Fentanyl, Meperidine, Nalbuphine or Buprenorphine (Verstraete & Van De Velde, 2012, p. 150-151)
- Intrathecal Morphine- “Gold Standard”- Easy to administer, low side effects, minimal to no effects on the baby (including with breast feeding) and very effective in controlling pain (Verstraete & Van De Velde, 2012, p. 150)
- Preferred method of pain control during cesarean if no maternal or fetal contraindications (Hawkins & Bucklin, 2012, p. 383)



General Anesthesia

- Consists of induction (medications to make the patient unconscious), muscle relaxants, intubation, reversal and extubation (Hawkins & Bucklin, 2012, p. 381-383)
- Used for about 10% of Cesarean deliveries (Hawkins & Bucklin, 2012, p. 379)
- Typically used in emergencies and if there is no time to place an epidural/spinal



Post-procedure Pain Management

- Duramorph
- PCA
- Ketorolac and Ibuprofen
- Oral opioids
- Gabapentin



Duramorph

- Morphine- added to the local anesthetic solution and placed intrathecally
- Can be given in a single dose at the time of c-section and can last up to 24 hours
- Side effects: Itching, nausea, headache and respiratory depression (rare)
- Provides much better pain relief than IM or IV opioids (Hawkins & Bucklin, 2012, p. 384)



PCA

- Patient Controlled Analgesia
- Typically used if the patient underwent general anesthesia or neuraxial opioids provide inadequate pain control
- Medicine in the PCA is usually Morphine, hydromorphone (Dilaudid) or Fentanyl
- Patient gives herself a bolus of medication, thus controlling her own pain (Hawkins & Bucklin, 2012, p. 384)



Ketorolac & Ibuprofen

- Non- opioid
- Very effective in managing post-surgical pain
- Reduces the use of PCA opioids (Hawkins & Bucklin, 2012, p. 384)
- A study done by Lowder, Shackelford, Holbert & Beste, 2003, found that the use of post-op opioids is significantly reduced in patients who had gotten Ketorolac after their c-section. The placebo group used nearly 50% more opioids than the study group.
- Ketorolac is IV and Ibuprofen is oral, typically use IV for 24 hours then transition to orals



Oral Opioids

- Commonly used to help manage pain after a c-section
- Common medications include Percocet, Lortab and Vicodin
- Benefits: Ease of administration, well tolerated, cost effective, avoidance of IV-PCA associated complications and effective in managing pain (Verstraete & Van De Velde, 2012, p. 157)



Gabapentin

- Non-opioid that can also help in managing pain from c-section
- In their study, Moore, Costello, Wieczorek, Shah, Taddio & Carvalho, 2011, found that a single dose of 600 mg of Gabapentin given 1 hour prior to c-section significantly improved pain scores in the first 48 hours postpartum and increased patient satisfaction
- May cause increased maternal sedation but does not adversely impact the baby



Nitrous Oxide (N₂O)

- Nitrous Oxide has recently been introduced as an option for analgesia during labor in several area medical centers.
- Dentists have used it for many years to provide analgesia and alleviate stress/fears during dental procedures.

Pain Control Options for Patients Undergoing Dental Procedures

- The Virginia Board of Dentistry has recently developed guidelines similar to the Boards of Medicine and Nursing to limit the use of opioid medications in the treatment of pain associated with surgical and non-surgical dental procedures.
- Two dental practices in Richmond have adopted the practice of administering Non-Steroidal Anti-inflammatory Drugs (NSAIDs) pre and post procedure.

Dental Case Studies

- David is a 47 year old male who presents with a diagnosis of severe periodontal disease. His treatment plan includes a full mouth debridement with osseous in all four quadrants and extractions of third molars. He has decided to receive the care under moderate to deep sedation provided by a Certified Registered Nurse Anesthetist (CRNA). The procedure and anesthetic were uneventful and prior to the end of the procedure, David receives 30 mg of Ketorolac IV. Per the post procedure instructions, he is to take 500 mg of Tylenol once he arrives home and to follow four hours later with 800 mg of Ibuprophen. Alternating the two every four hours.

Dental Case Study

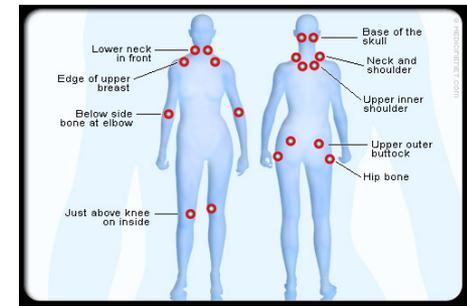
- Susan is a 42 year old female in good physical health, but due to her fear of dentists, has neglected her oral health for many years. Her treatment plan includes multiple restorations, crown preparations and a root canal. She has elected to have her dental care under moderate to deep sedation provided by a CRNA. She was instructed to take 500 mg Tylenol the morning of the procedure and received 30 mg of Ketorolac at the end. The same post procedure administration of NSAIDs was prescribed.

Non-Steroidal Anti-inflammatory Drugs For Pain Control

- The benefits of using NSAIDs for patients undergoing dental procedures include:
- No side effects. opioids can cause dizziness, nausea, light headiness and constipation just to name a few.
- Non Addictive
- Provide analgesia and reduce swelling as a result of their anti-inflammatory properties.

Fibromyalgia

- Characterized by chronic, wide-spread pain
- Diagnosed based on history and physical exam
- Treatment:
 - Most important: Exercise
 - Other behavioral change: weight loss, sleep hygiene, mindfulness, and relaxation techniques
 - Often occurs in combination with depression and anxiety
 - Approved medications: Cymbalta, Savella, Lyrica
 - Opioids are not recommended
 - Best functional outcomes when individuals combine exercise, behavior change, and treatment of depression and anxiety, in addition to medications

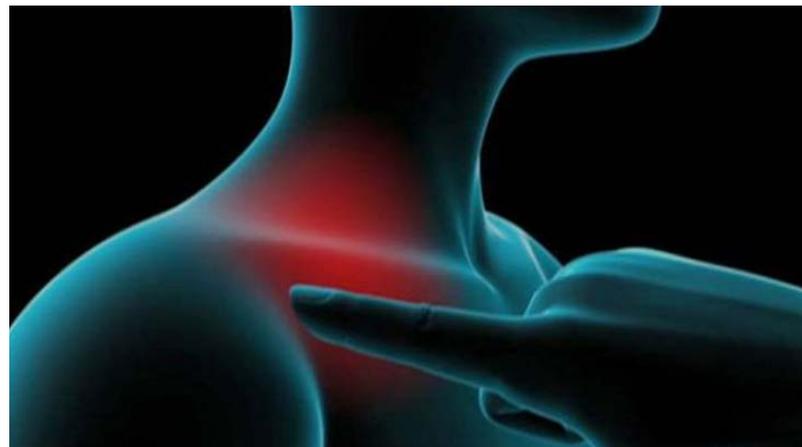


Fibromyalgia Case

- Judy is a 45 year-old woman who has noted muscle pain over the past 6 months. She has seen her provider several times to figure out where her symptoms are coming from.

Fibromyalgia Case

- Her pain is not located in the joints, and she often notes tenderness to the touch. She has a long-standing history of depression and she has periods of insomnia when her stress levels are high.



Fibromyalgia Case

- She has 3 children, she works full time as a school teacher, and she is actively engaged in her local church



Fibromyalgia Case

- Her provider ultimately diagnoses her with fibromyalgia.
- Judy is currently taking Prozac for her depression and would like to avoid other medications if she can.



Fibromyalgia Case

- After discussing treatment options with her provider, she decides to focus on the following:
 - Daily exercise
 - Sleep hygiene (using her bed for sleep and intimacy, avoiding screens immediately before bed, and having a set bedtime)
 - Mindfulness
 - Follow-up with her provider every 2 weeks by phone or appointment until her symptoms are under control.

Back Pain



- Many causes for chronic back pain: arthritis, injuries, inherited conditions
- Red flags (seek immediate evaluation): recent infection, fever, weight loss, history of cancer, bowel or bladder changes, numbness, and/or weakness
- If no red flags: initial x-ray or other imaging is often not required

Back Pain

- Start with conservative management: limit lifting, stretches/exercises, physical therapy, Tylenol or anti-inflammatories (Advil/Aleve), and short-term muscle relaxants
- Many cases of back pain resolve after one month of conservative management
- Long term outcomes (pain, function, opioid use disorders) are generally better with conservative management
- Referral to a specialist and/or an MRI is often recommended following a month of conservative management

Back Pain Case

- Joseph is a 38 year-old man who notes back pain following a weekend of camping and boating. The pain starts in his lower back and radiates all the way down his left leg.



Back Pain Case

- He does not have a fever, changes in bowel or bladder function, or loss of function in his leg. Sometimes he notes a burning/tingling pain in his leg.



Back Pain Case

- He goes into an urgent care after 2 days with the pain.
- He is diagnosed with lumbar radiculopathy
- He is started on a few days of Flexeril, Aleve twice daily, use of ice/heat as needed, and a referral to physical therapy.

Back Pain Case

- He follows up with his primary care provider after one month. His back pain has all but resolved, but he continues to have the leg symptoms that interfere with his work as a car mechanic.



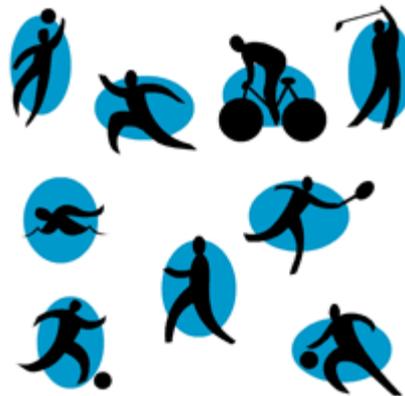
Back Pain Case

- An MRI is ordered and the findings suggest a disc herniation that is pressing on the spinal nerve at L5.
- He is referred to a spinal specialist who recommends starting with a lumbar epidural steroid injection.
- Joseph agrees to this and receives relief from this procedure.



Back Pain Case

- Knowing he could have either complete resolution of his symptoms or a flare-up at some point, Joseph decides to start a regular exercise regimen, lose weight, and do his back exercises on a daily basis.



Functional Goals

- The goal for pain management is not freedom from pain
- The goal for pain management should focus primarily on functional goals:
 - Work
 - Sleep
 - Leisure
- Functional goals should be established as a team with the patient, family, and health care provider.

Functional Goals

STUDY ID # _____ DO NOT WRITE ABOVE THIS LINE HOSPITAL # _____

Brief Pain Inventory (Short Form)

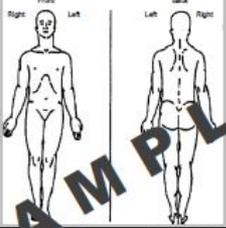
Date: ____/____/____ Time: _____

Name: _____ Last _____ First _____ Middle Initial _____

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes 2. No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by circling the one number that best describes your pain at its worst in the _____ hours.

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain as bad as you can imagine

4. Please rate your pain by circling the one number that best describes your pain at its least in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain as bad as you can imagine

5. Please rate your pain by circling the one number that best describes your pain on the average.

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain as bad as you can imagine

6. Please rate your pain by circling the one number that tells how much pain you have right now.

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain as bad as you can imagine

Page 1 of 2

STUDY ID # _____ DO NOT WRITE ABOVE THIS LINE HOSPITAL # _____

Date: ____/____/____ Time: _____

Name: _____ Last _____ First _____ Middle Initial _____

7. What treatments or medications are you receiving for your pain?

8. In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
No Relief Complete Relief

9. Circle the one number that describes how, during the past 24 hours, pain has interfered with you:

A. General Activity

0 1 2 3 4 5 6 7 8 9 10
Does not Completely Interfere Interferes

B. Mood

0 1 2 3 4 5 6 7 8 9 10
Does not Completely Interfere Interferes

C. Walking Ability

0 1 2 3 4 5 6 7 8 9 10
Does not Completely Interfere Interferes

D. Normal Work (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10
Does not Completely Interfere Interferes

E. Relations with other people

0 1 2 3 4 5 6 7 8 9 10
Does not Completely Interfere Interferes

F. Sleep

0 1 2 3 4 5 6 7 8 9 10
Does not Completely Interfere Interferes

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10
Does not Completely Interfere Interferes

Page 2 of 2

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Pain Research Group
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OTC Narcan Administration

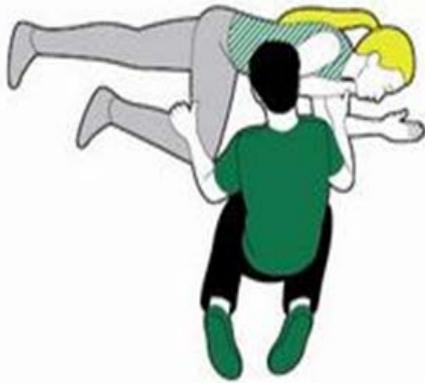
- Narcan (Naloxone) is a pure opioid antagonist that reverses coma and respiratory depression.
- It is safe to use in an unknown overdose situation and can be used to diagnose an opioid overdose.
- EMT's have been routinely administering Narcan to patients with suspected opioid overdose who present with respiratory difficulty, loss of consciousness or altered mental status, hypotension and bradycardia.
- Families are now being taught to administer Narcan nasal spray to family members who are abusing drugs.
- OTC administration is saving lives before emergency services arrive in homes in Virginia.

Virginia's Revive! Program

- Narcan training for health professionals, families and friends
- Physicians write a standing order for a pharmacist to dispense intranasal Narcan to a family member
- Cautions:
 - Keep Narcan at room temperature
 - Do not keep Narcan in an automobile
 - Check the expiration date

Opioid Overdose

- If you suspect an opioid overdose check the person for responsiveness, place the person in recovery position then call 911



- Begin rescue breathing if the person is not breathing



HOW TO ADMINISTER NARCAN

- Remove both of the yellow caps
- Remove red cap
- Grip the clear plastic wings and screw them onto the syringe
- Screw the capsule of Narcan into the barrel of syringe
- Insert the white cone into a nostril then give a short, vigorous push on the end of the capsule to spray the Narcan into the person's nose
- Spray one half of the capsule into each nostril



Side Effects of Narcan

- Patients usually respond within 3-4 minutes
- They awaken suddenly, are confused and may fight you
- Vomiting may occur
- Remain calm and speak quietly to the patient
- Narcan's duration of effect is 60 minutes and may need to be repeated

Urine Drug Screening

- Urine drug testing always detects the opiates Morphine, Heroin, Codeine and Paregoric.
- A urine drug screen may be positive for Hydrocodone, Hydromorphone , and Oxycodone.
- UDS does not detect Methadone, Tramadol, Fentanyl, Imodium, Lomotil and Demerol as opiates.
- Heroin and Morphine can be detected in urine for 2 to 4 days

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