Advisory Board on Physician Assistants

Virginia Board of Medicine

May 23, 2019
1:00 p.m.

Advisory Board on Physician Assistants

Board of Medicine
Thursday, May 23, 2019 @ 1:00 p.m.
9960 Mayland Drive, Suite 201, Henrico, VA
Training Room 2

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

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

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

Training Room 2

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Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

DRAFT UNAPPROVED

ADVISORY BOARD ON PHYSICIAN ASSISTANTS

Board of Medicine
Thursday October 4, 2018, 1:00 PM
9960 Mayland Drive, Suite 201
Richmond, VA - Training Room 2

The Advisory Board on Physician Assistants met Thursday, October 4, 2018 at 1:00 p.m. at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Richmond, Virginia.

MEMBERS PRESENT:	Portia Tomlinson, PA-C, Chair Rachel Carlson, PA-C, Vice-Chair Frazier W. Frantz, MD Thomas Parish, PA-C Tracey Dunn, Citizen Member
MEMBERS ABSENT:	None
STAFF PRESENT:	William L. Harp, MD, Executive Director Colanthia Morton Opher, Deputy for Administration Elaine Yeatts, DHP Senior Policy Analyst ShaRon Clanton, Licensing Specialist Jennifer Deschenes, Deputy for Discipline
GUESTS PRESENT:	Rose Rutherford, VAPA Robert Glasgow, PA-C, VAPA W. Scott Johnson, JD, MSV Michael Goodman, JD, Goodman Allen

Call to Order-Portia Tomlinson, PA-C Chair

Ms. Tomlinson called the meeting to order.

Emergency Egress Procedures-Alan Heaberlin

Dr. Harp provided the emergency egress instructions.

Roll Call

Roll was called, and a quorum was declared.

Approval of Minutes 1-2

Ms. Carlson moved to adopt the minutes of February 1, 2018 as written. The motion was seconded and carried.

Adoption of Agenda

Mr. Parish added an amendment to the agenda; the amended agenda was approved.

Public Comment on Agenda Items

None

NEW BUSINESS

1. **Periodic review of regulations-Elaine Yeatts**

   Mrs. Yeatts reviewed the regulations with the Advisory Board. The members recommended the following changes be presented to the Board on October 18, 2018.

   18VAC85-50-10. Definitions. Add "Supervision" means the supervising physician *licensed in the Commonwealth* has on going, regular communication with the physician assistant on the care and treatment of patients, is easily available, and can be physically present or accessible for consultation with the physician assistant with one hour."

   18VAC85-50-115. Responsibilities of the physician assistant. B. In the second sentence, strike who has registered with the board.

   18VAC85-50-130. Qualifications for approval of prescriptive authority.
   Change in 2. Maintain a practice agreement acceptable to the board prescribed in accordance with 18BAC85-50-101. Strike out following sentence and number 3. Change number 4 to number 3.
   18VAC85-50-140. Approved drugs and devices. B. End first sentence at practice agreement, and strike remaining portion of sentence to read: "The physician assistant may prescribe only those categories of drugs and devices included in the practice agreement."

2. **Virginia's Licensed Physician Assistant Workforce**

   Dr. Carter gave a brief description and overall review of the workforce report.

3. **Request for Advisory Opinion or Guidance re PA** Supervision

   Ms. Deschenes spoke on the letter dated July 31, 2018 from Mike Goodman, JD.

4. **Board member badges**

   Dr. Harp briefed the Advisory on the decision to no longer issue badges to Board members. Mr. Parrish turned his badge in to Mrs. Morton Opher.

5. 2019 Meeting Calendar

Members requested a change in date for the meeting scheduled May 23, 2019.

6. Election of Officers

Mr. Parrish moved that Ms. Tomlinson remain Chair. Ms. Dunn moved that Mr. Parrish serve as Vice Chair. The motion was seconded and carried.

Announcements

None

Adjournment

Meeting adjourned at 2:51 p.m.

Next meeting date:

January 24, 2019 @ 1:00 p.m.

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Portia Tomlinson, PA-C, Chair

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William L. Harp, M.D., Executive Director

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ShaRon Clanton, Licensing Specialist

Board of Medicine
Report of the 2019 General Assembly

HB 1952 Patient care teams; podiatrists and physician assistants.

Chief patron: Campbell, J.L.

Summary as passed House:

Patient care team podiatrist definition; physician assistant supervision requirements. Establishes the role of "patient care team podiatrist" as a provider of management and leadership to physician assistants in the care of patients as part of a patient care team. The bill modifies the supervision requirements for physician assistants by establishing a patient care team model. The bill directs the Board of Medicine to adopt emergency regulations to implement the provisions of the bill and is identical to SB 1209.

02/22/19 Governor: Acts of Assembly Chapter text (CHAP0137)

HB 1970 Telemedicine services; payment and coverage of services.

Chief patron: Kilgore

Summary as passed:

Telemedicine services; coverage. Requires insurers, corporations, or health maintenance organizations to cover medically necessary remote patient monitoring services as part of their coverage of telemedicine services to the full extent that these services are available. The bill defines remote patient monitoring services as the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload. The bill requires the Board of Medical Assistance Services to include in the state plan for medical assistance services a provision for the payment of medical assistance for medically necessary health care services provided through telemedicine services. This bill is identical to SB 1221.

03/05/19 Governor: Acts of Assembly Chapter text (CHAP0211)

HB 1971 Health professions and facilities; adverse action in another jurisdiction.

Chief patron: Stolle

Summary as introduced:

Health professions and facilities; adverse action in another jurisdiction. Provides that the mandatory suspension of a license, certificate, or registration of a health professional by the Director of the Department of Health Professions is not required when the license, certificate, or registration of a health professional is revoked, suspended, or surrendered in another jurisdiction based on disciplinary action or mandatory suspension in the Commonwealth. The bill extends the time by which the Board of Pharmacy (Board) is required to hold a hearing after receiving an application for reinstatement from a nonresident pharmacy whose registration has been suspended by the Board based on revocation or suspension in another jurisdiction from not later than its next regular meeting after the expiration of 30 days from receipt of the reinstatement application to not later than its next regular meeting after the expiration of 60 days from receipt of the reinstatement application.

02/22/19 Governor: Acts of Assembly Chapter text (CHAP0138)

HB 2169 Physician assistants; licensure by endorsement.

Chief patron: Thomas

Summary as passed:

Physician assistants; licensure by endorsement. Authorizes the Board of Medicine to issue a license by endorsement to an applicant for licensure as a physician assistant who (i) is the spouse of an active duty member of the Armed Forces of the United States or the Commonwealth, (ii) holds current certification from the National Commission on Certification of Physician Assistants, and (iii) holds a license as a physician assistant that is in good standing, or that is eligible for reinstatement if lapsed, under the laws of another state.

03/12/19 Governor: Acts of Assembly Chapter text (CHAP0338)

HB 2184 Volunteer license, special; issuance for limited practice.

Chief patron: Kilgore

Summary as passed:

Volunteer dentists and dental hygienists. Removes certain requirements for dentists and dental hygienists volunteering to provide free health care for up to three consecutive days to an underserved area of the Commonwealth under the auspices of a publicly supported nonprofit organization that sponsors the provision of health care to populations of underserved people.

03/08/19 Governor: Acts of Assembly Chapter text (CHAP0290)

HB 2228 Nursing and Psychology, Boards of; health regulatory boards, staggered terms.

Chief patron: Bagby

Summary as introduced:

Composition of the Boards of Nursing and Psychology; health regulatory boards; staggered terms. Alters the composition of the Board of Nursing and replaces the requirement that the Board of Nursing meet each January with the requirement that it meet at least annually. The bill also removes specific officer titles from the requirement that the Board of Nursing elect officers from its membership. The bill replaces the requirement that a member of the Board of Psychology be licensed as an applied psychologist with the requirement that that position be filled by a member who is licensed in any category of psychology. The bill also provides a mechanism for evenly staggering the terms of members of the following health regulatory boards, without affecting the terms of current members: Board of Nursing, Board of Psychology, Board of Dentistry, Board of Long-Term Care Administrators, Board of Medicine, Board of Veterinary Medicine, Board of Audiology and Speech-Language Pathology, Board of Pharmacy, and Board of Counseling.

02/27/19 Governor: Acts of Assembly Chapter text (CHAP0169)

HB 2457 Medicine, osteopathy, podiatry, or chiropractic, practitioners of; inactive license, charity care.

Chief patron: Landes

Summary as passed:

Practitioners of medicine, osteopathy, podiatry, or chiropractic; retiree license. Provides that the Board of Medicine may issue a retiree license to any doctor of medicine, osteopathy, podiatry, or chiropractic who holds an active, unrestricted license to practice in the Commonwealth upon receipt of a request and submission of the required fee. The bill provides that a person to whom a retiree license has been issued shall not be required to meet continuing competency requirements for the first biennial renewal of such license. The bill also provides that a person to whom a retiree license has been issued shall only engage in the practice of medicine, osteopathy, podiatry, or chiropractic for the purpose of providing charity care or health care services to patients in their residence for whom travel is a barrier to receiving health care.

03/14/19 Governor: Acts of Assembly Chapter text (CHAP0379)

HB 2557 Drug Control Act; classifies gabapentin as a Schedule V controlled substance.

Chief patron: Pillion

Summary as passed:

Drug Control Act; Schedule V; gabapentin. Classifies gabapentin as a Schedule V controlled substance. Current law lists gabapentin as a drug of concern. The bill also removes the list of drugs of concern from the Code of Virginia and provides that any wholesale drug distributor licensed and regulated by the Board of Pharmacy and registered with and regulated by the U.S. Drug Enforcement Administration shall have until July 1, 2020, or within six months of final approval of compliance from the Board of Pharmacy and the U.S. Drug Enforcement Administration, whichever is earlier, to comply with storage requirements for Schedule V controlled substances containing gabapentin.

03/05/19 Governor: Acts of Assembly Chapter text (CHAP0214)

HB 2559 Electronic transmission of certain prescriptions; exceptions.

Chief patron: Pillion

Summary as passed House:

Electronic transmission of certain prescriptions; exceptions. Provides certain exceptions, effective July 1, 2020, to the requirement that any prescription for a controlled substance that contains an opioid be issued as an electronic prescription. The bill requires the licensing health regulatory board of a prescriber to grant such prescriber a waiver of the electronic prescription requirement for a period not to exceed one year due to demonstrated economic hardship, technological limitations that are not reasonably within the control of the prescriber, or other exceptional circumstances demonstrated by the prescriber. The bill provides that a dispenser is not required to verify whether one of the exceptions applies when he receives a non-electronic prescription for a controlled substance containing an opioid. The bill requires the Boards of Medicine, Nursing, Dentistry, and Optometry to promulgate regulations to implement the prescriber waivers. Finally, the bill requires the Secretary of Health and Human Resources to convene a work group to identify successes and challenges of the electronic prescription requirement and offer possible recommendations for increasing the electronic prescribing of controlled substances that contain an opioid and to report to the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health by November 1, 2022.

03/21/19 Governor: Acts of Assembly Chapter text (CHAP0664)

HB 2731 Lyme disease; disclosure of information to patients.

Chief patron: Edmunds

Summary as passed House:

Lyme disease; disclosure of information to patients. Requires every laboratory reporting the results of a test for Lyme disease ordered by a health care provider in an office-based setting to include, together with the results of such test provided to the health care provider, a notice stating that the results of Lyme disease tests may vary and may produce results that are inaccurate and that a patient may not be able to rely on a positive or negative result from such test. Such notice shall also include a statement that health care providers are encouraged to discuss Lyme disease test results with the patient for whom the test was ordered. The bill also provides that a laboratory that complies with the provisions of the bill shall be immune from civil liability absent gross negligence or willful misconduct.

03/18/19 Governor: Acts of Assembly Chapter text (CHAP0435)

SB 1004 Elective procedure, test, or service; estimate of payment amount.

Chief patron: Chase

Summary as passed:

Advance estimate of patient payment amount for elective medical procedure, test, or service; notice of right to request. Provides that every hospital currently required to provide an estimate of the payment amount for an elective procedure, test, or service for which a patient may be responsible shall also be required to provide each patient with written information regarding his right to request such estimate, to post written information regarding a patient's right to request such estimate conspicuously in public areas of the hospital, and to make such information available on the hospital's website.

03/21/19 Governor: Acts of Assembly Chapter text (CHAP0671)

SB 1106 Physical therapists & physical therapist assistants; licensure, Physical Therapy Licensure Compact.

Chief patron: Peake

Summary as introduced:

Licensure of physical therapists and physical therapist assistants; Physical Therapy Licensure Compact. Authorizes Virginia to become a signatory to the Physical Therapy Licensure Compact. The Compact permits eligible licensed physical therapists and physical therapist assistants to practice in Compact member states, provided they are licensed in at least one member state. In addition, the bill requires each applicant for licensure in the Commonwealth as a physical therapist or physical therapist assistant to submit fingerprints and provide personal descriptive information in order for the Board to receive a state and federal criminal history record report for each applicant. The bill has a delayed effective date of January 1, 2020, and directs the Board of Physical Therapy to adopt emergency regulations to implement the provisions of the bill.

03/08/19 Governor: Acts of Assembly Chapter text (CHAP0300)

SB 1167 Medicaid recipients; treatment involving opioids or opioid replacements, payment.

Chief patron: Chafin

Summary as passed:

Medicaid recipients; treatment involving opioids or opioid replacements; payment. Prohibits health care providers licensed by the Board of Medicine from requesting or requiring a patient who is a recipient of medical assistance services pursuant to the state plan for medical assistance to pay out-of-pocket costs associated with the provision of service involving (i) the prescription of an opioid for the management of pain or (ii) the prescription of buprenorphine-containing products, methadone, or other opioid replacements approved for the treatment of opioid addiction by the U.S. Food and Drug Administration for medication-assisted treatment of opioid addiction. The bill requires providers who do not accept payment from the Department of Medical Assistance Services (DMAS) who provide such services to patients participating in the Commonwealth's program of medical assistance services to provide written notice to such patient that (a) the Commonwealth's program of medical assistance services covers such health care services and DMAS will pay for such health care services if such health care services meet DMAS's medical necessity criteria and (b) the provider does not participate in the Commonwealth's program of medical assistance and will not accept payment from DMAS for such health care services. Such notice and the patient's acknowledgement of such notice shall be documented in the patient's medical record. This bill is identical to HB 2558.

03/18/19 Governor: Acts of Assembly Chapter text (CHAP0444)

SB 1439 Death certificates; medical certification, electronic filing.

Chief patron: McClellan

Summary as passed:

Death certificates; medical certification; electronic filing. Requires the completed medical certification portion of a death certificate to be filed electronically with the State Registrar of Vital Records through the Electronic Death Registration System and provides that, except for under certain circumstances, failure to file a medical certification of death electronically through the Electronic Death Registration System shall constitute grounds for disciplinary action by the Board of Medicine. The bill includes a delayed effective date of January 1, 2020, and a phased-in requirement for registration with the Electronic Death Registration System and electronic filing of medical certifications of death for various categories of health care providers. The bill directs the Department of Health to work with stakeholders to educate and encourage physicians, physician assistants, and nurse practitioners to timely register with and utilize the Electronic Death Registration System.

03/05/19 Governor: Acts of Assembly Chapter text (CHAP0224)

SB 1547 Music therapists; Board of Health Professions to evaluate regulation.

Chief patron: Vogel

Summary as passed:

Music therapy. Directs the Board of Health Professions to evaluate whether music therapists and the practice of music therapy should be regulated and the degree of regulation to be imposed. The bill requires the Board to report the results of its evaluation to the Chairmen of the Senate Committee on Education and Health and the House Committee on Health, Welfare and Institutions by November 1, 2019.

03/21/19 Governor: Acts of Assembly Chapter text (CHAP0680)

SB 1557 Pharmacy, Board of; cannabidiol oil and tetrahydrocannabinol oil, regulation of pharmaceutical.

Chief patron: Dunnavant

Summary as passed:

Board of Pharmacy; cannabidiol oil and tetrahydrocannabinol oil; regulation of pharmaceutical processors. Authorizes licensed physician assistants and licensed nurse practitioners to issue a written

certification for use of cannabidiol oil and THC-A oil. The bill requires the Board to promulgate regulations establishing dosage limitations, which shall require that each dispensed dose of cannabidiol oil or THC-A oil not exceed 10 milligrams of tetrahydrocannabinol. The bill requires the Secretary of Health and Human Resources and the Secretary of Agriculture and Forestry to convene a work group to review and recommend an appropriate structure for an oversight organization in Virginia and report its findings and recommendations to the Chairmen of the Senate Committees on Agriculture, Conservation and Natural Resources and Education and Health and the House Committees on Agriculture, Chesapeake and Natural Resources and Health, Welfare and Institutions by November 1, 2019.

03/21/19 Governor: Acts of Assembly Chapter text (CHAP0681)

SB 1760 Diagnostic X-ray machines; operation of machine.

Chief patron: DeSteph

Summary as introduced:

Diagnostic X-ray machines; operation. Provides that no person who has been trained and certified in the operation of a diagnostic X-ray machine by the manufacturer of such machine is required to obtain any other training, certification, or licensure or be under the supervision of a person who has obtained training, certification, or licensure to operate such a diagnostic X-ray machine, provided that (i) such diagnostic X-ray machine (a) is registered and certified by the Department of Health, (b) is being operated to conduct a body composition scan, and (c) is not operated to determine bone density or in the diagnosis or treatment of a patient and (ii) the subject of the body composition scan is notified of the risks associated with exposure to radiation emitted by the diagnostic X-ray machine.

01/31/19 Senate: Passed by indefinitely in Education and Health with letter (15-Y 0-N)

SB 1778 Counseling minors; certain health regulatory boards to promulgate regulations.

Chief patron: Newman

Summary as introduced:

Health regulatory boards; conversion therapy. Directs the Board of Counseling, the Board of Medicine, the Board of Nursing, the Board of Psychology, and the Board of Social Work to each promulgate regulations prohibiting the use of electroshock therapy, aversion therapy, or other physical treatments in the practice of conversion therapy with any person under 18 years of age.

02/06/19 Senate: Left in Education and Health

Board of Medicine
Regulatory/Policy Actions – 2019 General Assembly

EMERGENCY REGULATIONS:

Legislative source	Mandate	Promulgating agency	Board adoption date	Effective date Within 280 days of enactment
HB1952	Patient care team – PAs	Medicine	6/13/19 or 8/2/19 (signed 2/22)	**11/25/19**
HB2559	Waiver for electronic prescribing	Medicine	6/13/19 or 8/2/19 (signed 3/21)	**12/24/19**

APA REGULATORY ACTIONS

Legislative source	Mandate	Promulgating agency	Adoption date	Effective date
HB2457	Retiree license	Medicine	NOIRA – 6/13/19	?

NON-REGULATORY ACTIONS

Legislative source	Affected agency	Action needed	Due date
HB1970	Department	Review of telehealth; practice by adjacent physicians	11/1/19
HB2169	Medicine	Review/revision of application content & process to identify & expedite military spouse apps	7/1/19
SB1557	Medicine/Pharmacy/Department	Inclusion of NPs and PAs for registration to issue certifications Participation in workgroup to study oversight organization	7/1/19
SB1760 (not passed)	Department (Medicine)	Study of Xrays in spas – VDH	11/1/19
HJ682 (not passed)	Department	Study of foreign-trained physicians to provide services in rural areas	11/1/19

Future Policy Actions:

HB793 (2018) - (2) the Department of Health Professions, by **November 1, 2020**, to report to the General Assembly a process by which nurse practitioners who practice without a practice agreement may be included in the online Practitioner Profile maintained by the Department of Health Professions; and (3) the Boards of Medicine and Nursing to report information related to the practice of nurse practitioners without a practice agreement that includes certain data, complaints and disciplinary actions, and recommended modifications to the provisions of this bill to the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health and the Chairman of the Joint Commission on Health Care by **November 1, 2021**.

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

VIRGINIA ACTS OF ASSEMBLY -- 2019 SESSION

CHAPTER 137

An Act to amend and reenact §§ 54.1-2900, 54.1-2951.1 through 54.1-2952.1, 54.1-2953, and 54.1-2957 of the Code of Virginia, relating to patient care teams; podiatrists and physician assistants.

[H 1952]

Approved February 22, 2019

Be it enacted by the General Assembly of Virginia:

1. That §§ 54.1-2900, 54.1-2951.1 through 54.1-2952.1, 54.1-2953, and 54.1-2957 of the Code of Virginia are amended and reenacted as follows:

§ 54.1-2900. Definitions.

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

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

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

"Board" means the Board of Medicine.

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

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

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

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

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

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

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

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

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

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

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

"Patient care team physician" means a physician who is actively licensed to practice medicine in the Commonwealth, who regularly practices medicine in the Commonwealth, and who provides management

and leadership in the care of patients as part of a patient care team.

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

"Physician assistant" means ~~an individual~~ *a health care professional* who has met the requirements of the Board for licensure ~~and who works under the supervision of a licensed doctor of medicine, osteopathy, or podiatry~~ *as a physician assistant.*

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

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

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

"Practice of chiropractic" means the adjustment of the 24 movable vertebrae of the spinal column, and assisting nature for the purpose of normalizing the transmission of nerve energy, but does not include the use of surgery, obstetrics, osteopathy or the administration or prescribing of any drugs, medicines, serums or vaccines. "Practice of chiropractic" shall include performing the physical examination of an applicant for a commercial driver's license or commercial learner's permit pursuant to § 46.2-341.12 if the practitioner has (i) applied for and received certification as a medical examiner pursuant to 49 C.F.R. Part 390, Subpart D and (ii) registered with the National Registry of Certified Medical Examiners.

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

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

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

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

or ambulatory surgery center at which the podiatrist has privileges, as described in § 54.1-2939. The Board of Medicine shall determine whether a specific type of treatment of the foot and ankle is within the scope of practice of podiatry.

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

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

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

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

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

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

"Respiratory care" means the practice of the allied health profession responsible for the direct and indirect services, including inhalation therapy and respiratory therapy, in the treatment, management, diagnostic testing, control, and care of patients with deficiencies and abnormalities associated with the cardiopulmonary system under qualified medical direction.

§ 54.1-2951.1. Requirements for licensure and practice as a physician assistant.

A. The Board shall promulgate regulations establishing requirements for licensure as a physician assistant that shall include the following:

1. Successful completion of a physician assistant program or surgical physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant;

2. Passage of the certifying examination administered by the National Commission on Certification of Physician Assistants; and

3. Documentation that the applicant for licensure has not had his license or certification as a physician assistant suspended or revoked and is not the subject of any disciplinary proceedings in another jurisdiction.

B. ~~Prior to initiating~~ *Every physician assistant shall* practice ~~with a supervising physician, the physician assistant shall enter into a written or electronic practice agreement~~ *as part of a patient care*

team and shall enter into a written or electronic practice agreement with at least one ~~supervising physician~~ *patient care team physician* or *patient care team* podiatrist.

C. A practice agreement shall include ~~delegated activities~~ *acts* pursuant to § 54.1-2952, provisions for the periodic review of patient charts or electronic health records, guidelines for ~~availability and ongoing communications~~ *collaboration and consultation* among the parties to the agreement and the patient, periodic joint evaluation of the services delivered, and provisions for appropriate physician input in complex clinical cases, in patient emergencies, and for referrals.

A practice agreement may include provisions for periodic site visits by ~~supervising licensees who supervise and direct assistants who provide services~~ *a patient care team physician or patient care team podiatrist who is part of the patient care team* at a location other than where the licensee regularly practices. Such visits shall be in the manner and at the frequency as determined by ~~the supervising~~ *a patient care team* physician or *patient care team* podiatrist *who is part of the patient care team.*

D. Evidence of a practice agreement shall be maintained by the physician assistant and provided to the Board upon request. *The practice agreement may be maintained in writing or electronically, and may be a part of credentialing documents, practice protocols, or procedures.*

§ 54.1-2951.2. Issuance of a license.

The Board shall issue ~~the~~ *a* license to the physician assistant to practice ~~under the supervision of a licensed doctor of medicine, osteopathy, or podiatry,~~ *as part of a patient care team* in accordance with § 54.1-2951.1.

§ 54.1-2951.3. Restricted volunteer license for certain physician assistants.

A. The Board may issue a restricted volunteer license to a physician assistant who meets the qualifications for licensure for physician assistants. The Board may refuse issuance of licensure pursuant to § 54.1-2915.

B. A person holding a restricted volunteer license under this section shall:

1. Only practice in public health or community free clinics approved by the Board;

2. Only treat patients who have no insurance or who are not eligible for financial assistance for medical care; and

3. Not receive remuneration directly or indirectly for practicing as a physician assistant.

C. A physician assistant with a restricted volunteer license issued under this section shall only practice as a physician assistant and perform certain ~~delegated~~ acts which constitute the practice of medicine to the extent and in the manner authorized by the Board if:

1. A *patient care team* physician ~~who supervises physician assistants~~ *or patient care team podiatrist* is available *at all times to collaborate and consult with the physician assistant*; or

2. ~~The~~ *A patient care team* physician ~~supervising any physician assistant~~ *or patient care team podiatrist* periodically reviews the relevant patient records.

D. A restricted volunteer license granted pursuant to this section shall be issued to the physician assistant without charge, shall expire twelve months from the date of issuance, and may be renewed annually in accordance with regulations promulgated by the Board.

E. A physician assistant holding a restricted volunteer license issued pursuant to this section is subject to the provisions of this chapter and the regulations promulgated under this chapter unless otherwise provided for in this section.

§ 54.1-2952. Role of patient care team physician or patient care team podiatrist on patient care teams; services that may be performed by physician assistants; responsibility of licensee; employment of physician assistants.

A. A *patient care team* physician or ~~a~~ *patient care team* podiatrist licensed under this chapter may ~~supervise~~ *serve on a patient care team with* physician assistants and ~~delegate certain acts which constitute the~~ *shall provide collaboration and consultation to such physician assistants. No patient care team physician or patient care team podiatrist shall be allowed to collaborate or consult with more than six physician assistants on a patient care team at any one time.*

B. Physician assistants may practice ~~of~~ medicine to the extent and in the manner authorized by the Board. ~~The physician shall provide continuous supervision as required by this section; however, the requirement for physician supervision of physician assistants shall not be construed as requiring the physical presence of the supervising physician during all times and places of service delivery by physician assistants~~ *A patient care team physician or patient care team podiatrist shall be available at all times to collaborate and consult with physician assistants.* Each *patient care* team ~~of supervising physician and physician assistant~~ shall identify the relevant physician assistant's scope of practice~~, including the delegation of medical tasks as appropriate to the physician assistant's level of competence, the physician assistant's relationship with and access to the supervising physician,~~ and an evaluation process for the physician assistant's performance.

C. Physician assistants appointed as medical examiners pursuant to § 32.1-282 shall ~~be under the continuous supervision of~~ *only function as part of a patient care team that has* a licensed doctor of medicine or osteopathic medicine who has been appointed to serve as a medical examiner pursuant to § 32.1-282.

~~No licensee shall be allowed to supervise more than six physician assistants at any one time.~~

D. Any professional corporation or partnership of any licensee, any hospital and any commercial enterprise having medical facilities for its employees ~~which~~ *that* are supervised by one or more physicians or podiatrists may employ one or more physician assistants in accordance with the provisions of this section.

Activities shall be ~~delegated~~ *performed* in a manner consistent with sound medical practice and the protection of the health and safety of the patient. Such activities shall be set forth in a practice ~~supervision~~ agreement between the physician assistant and the ~~supervising~~ *patient care team* physician or *patient care team* podiatrist and may include health care services ~~which~~ *that* are educational, diagnostic, therapeutic, *or* preventive, ~~or include~~ *including establishing a diagnosis, providing* treatment, ~~but shall not include the establishment of a final diagnosis or treatment plan for the patient unless set forth in the practice supervision agreement~~ *and performing procedures*. Prescribing or dispensing of drugs may be permitted as provided in § 54.1-2952.1. In addition, a ~~licensee is authorized to delegate and supervise~~ *physician assistant may perform* initial and ongoing evaluation and treatment of any patient in a hospital, including its emergency department, ~~when performed under the direction, supervision and control of the supervising licensee~~ *in accordance with the practice agreement, including tasks performed, relating to the provision of medical care in an emergency department*. ~~When practicing in a hospital, the physician assistant shall report any acute or significant finding or change in a patient's clinical status to the supervising physician as soon as circumstances require and shall record such finding in appropriate institutional records. The physician assistant shall transfer to a supervising physician the direction of care of a patient in an emergency department who has a life-threatening injury or illness. Prior to the patient's discharge, the services rendered to each patient by a physician assistant in a hospital's emergency department shall be reviewed in accordance with the practice agreement and the policies and procedures of the health care institution. A physician assistant who is employed to practice in an emergency department shall be under the supervision of a physician present within the facility.~~

~~Further, unless otherwise prohibited by federal law or by hospital bylaws, rules, or policies, nothing in this section shall prohibit any physician assistant who is not employed by the emergency physician or his professional entity from practicing in a hospital emergency department, within the scope of his practice, while under continuous physician supervision as required by this section, whether or not the supervising physician is physically present in the facility.~~ The ~~supervising~~ *patient care team* physician who ~~authorizes such practice by his~~ *collaborates and consults with a* physician assistant shall ~~(i)~~ retain exclusive ~~supervisory~~ control of and responsibility for the physician assistant ~~and (ii)~~. *The patient care team physician or the on-duty emergency department physician shall* be available at all times for *collaboration and* consultation with both the physician assistant and the emergency department physician. ~~Prior to the patient's discharge from the emergency department, the physician assistant shall communicate the proposed disposition plan for any patient under his care to both his supervising physician and the emergency department physician.~~ No person shall have ~~control of or supervisory~~ responsibility for any physician assistant who is not employed by the person or the person's business entity.

~~B.~~ *E.* No physician assistant shall perform any ~~delegated~~ acts ~~except at the direction of the licensee and under his supervision and control~~ *beyond those set forth in the practice agreement or authorized as part of the patient care team*. No physician assistant practicing in a hospital shall render care to a patient unless the physician responsible for that patient has signed the practice agreement, pursuant to regulations of the Board, to act as ~~supervising~~ *a* physician *on a patient care team* for that physician assistant. Every licensee, professional corporation or partnership of licensees, hospital, or commercial enterprise that employs a physician assistant shall be fully responsible for the acts of the physician assistant in the care and treatment of human beings.

~~C.~~ *F.* Notwithstanding the provisions of § 54.1-2956.8:1, a licensed physician assistant who (i) is working ~~under the supervision of a licensed doctor of medicine or osteopathy specializing~~ in the field of radiology *as part of a patient care team*, (ii) has been trained in the proper use of equipment for the purpose of performing radiologic technology procedures consistent with Board regulations, and (iii) has successfully completed the exam administered by the American Registry of Radiologic Technologists for physician assistants for the purpose of performing radiologic technology procedures may use fluoroscopy for guidance of diagnostic and therapeutic procedures.

§ 54.1-2952.1. Prescription of certain controlled substances and devices by licensed physician assistants.

A. In accordance with the provisions of this section and pursuant to the requirements of Chapter 33 (§ 54.1-3300 et seq.), a licensed physician assistant shall have the authority to prescribe controlled substances and devices as set forth in Chapter 34 (§ 54.1-3400 et seq.), provided that the physician assistant has entered into and is, at the time of writing a prescription, a party to a practice agreement with a licensed *patient care team* physician or *patient care team* podiatrist that provides for ~~the direction and supervision by such licensee of~~ *collaboration and consultation regarding* the prescriptive practices of the physician assistant. Such practice agreements shall include *a statement of* the controlled substances the physician assistant is or is not authorized to prescribe and may restrict such prescriptive

authority as deemed appropriate by the *patient care team* physician or *patient care team* podiatrist ~~providing direction and supervision~~.

B. It shall be unlawful for the physician assistant to prescribe controlled substances or devices pursuant to this section unless such prescription is authorized by the practice agreement ~~between the licensee and the assistant~~ *and the requirements in this section.*

C. The Board of Medicine, in consultation with the Board of Pharmacy, shall promulgate such regulations governing the prescriptive authority of physician assistants as are deemed reasonable and necessary to ensure an appropriate standard of care for patients.

The regulations promulgated pursuant to this section shall include, at a minimum, (i) such requirements as may be necessary to ensure continued physician assistant competency ~~that~~, *which* may include continuing education, testing, and~~/or~~ any other requirement~~,~~ and shall address the need to promote ethical practice, an appropriate standard of care, patient safety, the use of new pharmaceuticals, and appropriate communication with patients~~;~~, and (ii) a requirement that the physician assistant disclose to his patients ~~the~~ *his* name, address, and telephone number ~~of the supervising licensee~~ and that he is a physician assistant. ~~A separate office for the physician assistant shall not be established~~ *If a patient or his representative requests to speak with the patient care team physician or patient care team podiatrist, the physician assistant shall arrange for communication between the parties or provide the necessary information.*

D. This section shall not prohibit a licensed physician assistant from administering controlled substances in compliance with the definition of "administer" in § 54.1-3401 or from receiving and dispensing manufacturers' professional samples of controlled substances in compliance with the provisions of this section.

§ 54.1-2953. Renewal, revocation, suspension, and refusal.

The Board may revoke, suspend, or refuse to renew ~~an approval~~ *a license to practice as a physician assistant* for any of the following:

1. Any ~~reason stated in this chapter for revocation or suspension of the license of a practitioner~~ *action by a physician assistant constituting unprofessional conduct pursuant to § 54.1-2915*;

2. ~~Failure of the supervising licensee to supervise the physician assistant or failure of the employer to provide a licensee to supervise the~~ *Practice by a* physician assistant *other than as part of a patient care team, including practice without entering into a practice agreement with at least one patient care team physician or patient care team podiatrist*;

3. ~~The physician assistant's engaging in acts beyond the scope of authority as approved by the Board~~ *Failure of the physician assistant to practice in accordance with the requirements of his practice agreement*;

4. Negligence or incompetence on the part of the physician assistant or ~~the supervising licensee in his use of the physician assistant~~ *other member of the patient care team under his supervision*;

5. ~~Violating~~ *Violation of* or ~~cooperating with others~~ *cooperation* in ~~violating~~ *the violation of* any provision of this chapter or the regulations of the Board; or

6. ~~A change in the Board's requirements for approval with which the~~ *Failure to comply with any regulation of the Board required for licensure of a* physician assistant ~~or the licensee does not comply~~.

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

A. As used in this section:

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

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

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

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

C. Every nurse practitioner other than a nurse practitioner licensed by the Boards of Medicine and Nursing as a certified nurse midwife or a certified registered nurse anesthetist or a nurse practitioner who meets the requirements of subsection I shall maintain appropriate collaboration and consultation, as evidenced in a written or electronic practice agreement, with at least one patient care team physician. A nurse practitioner who meets the requirements of subsection I may practice without a written or electronic practice agreement. A nurse practitioner who is licensed by the Boards of Medicine and

Nursing as a certified nurse midwife shall practice pursuant to subsection H. A nurse practitioner who is a certified registered nurse anesthetists shall practice under the supervision of a licensed doctor of medicine, osteopathy, podiatry, or dentistry. A nurse practitioner who is appointed as a medical examiner pursuant to § 32.1-282 shall practice in collaboration with a licensed doctor of medicine or osteopathic medicine who has been appointed to serve as a medical examiner pursuant to § 32.1-282. Collaboration and consultation among nurse practitioners and patient care team physicians may be provided through telemedicine as described in § 38.2-3418.16.

Physicians on patient care teams may require that a nurse practitioner be covered by a professional liability insurance policy with limits equal to the current limitation on damages set forth in § 8.01-581.15.

Service on a patient care team by a patient care team member shall not, by the existence of such service alone, establish or create liability for the actions or inactions of other team members.

D. The Boards of Medicine and Nursing shall jointly promulgate regulations specifying collaboration and consultation among physicians and nurse practitioners working as part of patient care teams that shall include the development of, and periodic review and revision of, a written or electronic practice agreement; guidelines for availability and ongoing communications that define consultation among the collaborating parties and the patient; and periodic joint evaluation of the services delivered. Practice agreements shall include provisions for (i) periodic review of health records, which may include visits to the site where health care is delivered, in the manner and at the frequency determined by the nurse practitioner and the patient care team physician and (ii) input from appropriate health care providers in complex clinical cases and patient emergencies and for referrals. Evidence of a practice agreement shall be maintained by a nurse practitioner and provided to the Boards upon request. For nurse practitioners providing care to patients within a hospital or health care system, the practice agreement may be included as part of documents delineating the nurse practitioner's clinical privileges or the electronic or written delineation of duties and responsibilities in collaboration and consultation with a patient care team physician.

E. The Boards of Medicine and Nursing may issue a license by endorsement to an applicant to practice as a nurse practitioner if the applicant has been licensed as a nurse practitioner under the laws of another state and, pursuant to regulations of the Boards, the applicant meets the qualifications for licensure required of nurse practitioners in the Commonwealth. A nurse practitioner to whom a license is issued by endorsement may practice without a practice agreement with a patient care team physician pursuant to subsection I if such application provides an attestation to the Boards that the applicant has completed the equivalent of at least five years of full-time clinical experience, as determined by the Boards, in accordance with the laws of the state in which the nurse practitioner was licensed.

F. Pending the outcome of the next National Specialty Examination, the Boards may jointly grant temporary licensure to nurse practitioners.

G. In the event a physician who is serving as a patient care team physician dies, becomes disabled, retires from active practice, surrenders his license or has it suspended or revoked by the Board, or relocates his practice such that he is no longer able to serve, and a nurse practitioner is unable to enter into a new practice agreement with another patient care team physician, the nurse practitioner may continue to practice upon notification to the designee or his alternate of the Boards and receipt of such notification. Such nurse practitioner may continue to treat patients without a patient care team physician for an initial period not to exceed 60 days, provided the nurse practitioner continues to prescribe only those drugs previously authorized by the practice agreement with such physician and to have access to appropriate input from appropriate health care providers in complex clinical cases and patient emergencies and for referrals. The designee or his alternate of the Boards shall grant permission for the nurse practitioner to continue practice under this subsection for another 60 days, provided the nurse practitioner provides evidence of efforts made to secure another patient care team physician and of access to physician input.

H. Nurse practitioners licensed by the Boards of Medicine and Nursing in the category of certified nurse midwife shall practice in consultation with a licensed physician in accordance with a practice agreement between the nurse practitioner and the licensed physician. Such practice agreement shall address the availability of the physician for routine and urgent consultation on patient care. Evidence of a practice agreement shall be maintained by a nurse practitioner and provided to the Boards upon request. The Boards shall jointly promulgate regulations, consistent with the Standards for the Practice of Midwifery set by the American College of Nurse-Midwives, governing such practice.

I. A nurse practitioner, other than a nurse practitioner licensed by the Boards of Medicine and Nursing in the category of certified nurse midwife or certified registered nurse anesthetist, who has completed the equivalent of at least five years of full-time clinical experience as a licensed nurse practitioner, as determined by the Boards, may practice in the practice category in which he is certified and licensed without a written or electronic practice agreement upon receipt by the nurse practitioner of an attestation from the patient care team physician stating (i) that the patient care team physician has served as a patient care team physician on a patient care team with the nurse practitioner pursuant to a practice agreement meeting the requirements of this section and § 54.1-2957.01; (ii) that while a party to

such practice agreement, the patient care team physician routinely practiced with a patient population and in a practice area included within the category for which the nurse practitioner was certified and licensed; and (iii) the period of time for which the patient care team physician practiced with the nurse practitioner under such a practice agreement. A copy of such attestation shall be submitted to the Boards together with a fee established by the Boards. Upon receipt of such attestation and verification that a nurse practitioner satisfies the requirements of this subsection, the Boards shall issue to the nurse practitioner a new license that includes a designation indicating that the nurse practitioner is authorized to practice without a practice agreement. In the event that a nurse practitioner is unable to obtain the attestation required by this subsection, the Boards may accept other evidence demonstrating that the applicant has met the requirements of this subsection in accordance with regulations adopted by the Boards.

A nurse practitioner authorized to practice without a practice agreement pursuant to this subsection shall (a) only practice within the scope of his clinical and professional training and limits of his knowledge and experience and consistent with the applicable standards of care, (b) consult and collaborate with other health care providers based on the clinical conditions of the patient to whom health care is provided, and (c) establish a plan for referral of complex medical cases and emergencies to physicians or other appropriate health care providers.

A nurse practitioner practicing without a practice agreement pursuant to this subsection shall obtain and maintain coverage by or shall be named insured on a professional liability insurance policy with limits equal to the current limitation on damages set forth in § 8.01-581.15.

2. That the Board of Medicine shall promulgate regulations to implement the provisions of this act to be effective within 280 days of its enactment.

VIRGINIA ACTS OF ASSEMBLY -- 2019 SESSION

CHAPTER 664

An Act to amend and reenact §§ 54.1-3408.02, as it shall become effective, and 54.1-3410 of the Code of Virginia, relating to electronic transmission of certain prescriptions; exceptions.

[H 2559]

Approved March 21, 2019

Be it enacted by the General Assembly of Virginia:

1. That §§ 54.1-3408.02, as it shall become effective, and 54.1-3410 of the Code of Virginia are amended and reenacted as follows:

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

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

B. Any prescription for a controlled substance that contains an ~~opiate~~ *opioid* shall be issued as an electronic prescription.

C. The requirements of subsection B shall not apply if:

1. The prescriber dispenses the controlled substance that contains an opioid directly to the patient or the patient's agent;

2. The prescription is for an individual who is residing in a hospital, assisted living facility, nursing home, or residential health care facility or is receiving services from a hospice provider or outpatient dialysis facility;

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

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

5. The prescription is issued by a licensed veterinarian for the treatment of an animal;

6. The FDA requires the prescription to contain elements that are not able to be included in an electronic prescription;

7. The prescription is for an opioid under a research protocol;

8. The prescription is issued in accordance with an executive order of the Governor of a declared emergency;

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

10. The prescriber has been issued a waiver pursuant to subsection D.

D. The licensing health regulatory board of a prescriber may grant such prescriber, in accordance with regulations adopted by such board, a waiver of the requirements of subsection B, for a period not to exceed one year, due to demonstrated economic hardship, technological limitations that are not reasonably within the control of the prescriber, or other exceptional circumstances demonstrated by the prescriber.

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

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

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

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

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

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

1. If the prescription is written, it shall be properly executed, dated and signed by the person prescribing on the day when issued and bear the full name and address of the patient for whom, or of the owner of the animal for which, the drug is dispensed, and the full name and address of the person prescribing. If the prescription is for an animal, it shall state the species of animal for which the drug is prescribed.

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

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

C. A drug controlled by Schedule VI may be refilled without authorization from the prescriber if, after reasonable effort has been made to contact him, the pharmacist ascertains that he is not available and the patient's health would be in imminent danger without the benefits of the drug. The refill shall be made in compliance with the provisions of § 54.1-3411.

If the written or oral prescription is for a Schedule VI drug or device and does not contain the address or registry number of the prescriber, or the address of the patient, the pharmacist need not reduce such information to writing if such information is readily retrievable within the pharmacy.

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

E. (Effective July 1, 2020) ~~No pharmacist shall dispense a controlled substance that contains an opiate unless the prescription for such controlled substance is issued as an electronic prescription.~~ *A dispenser who receives a non-electronic prescription for a controlled substance containing an opioid is not required to verify that one of the exceptions set forth in § 54.1-3408.02 applies and may dispense such controlled substance pursuant to such prescription and applicable law.*

2. That the Board of Medicine, the Board of Nursing, the Board of Dentistry, and the Board of Optometry shall promulgate regulations to implement the provisions of this act regarding prescriber waivers to be effective within 280 days of its enactment.

3. That the Secretary of Health and Human Resources shall convene a work group of interested stakeholders, including the Medical Society of Virginia, the Virginia Hospital and Healthcare Association, the Virginia Dental Association, the Virginia Association of Health Plans, and the Virginia Pharmacists Association, to evaluate the implementation of the electronic prescription requirement for controlled substances and shall report to the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health by November 1, 2022. The work group's report shall identify the successes and challenges of implementing the electronic prescription requirement and offer possible recommendations for increasing the electronic prescribing of controlled substances that contain an opioid.

VIRGINIA ACTS OF ASSEMBLY -- 2019 SESSION

CHAPTER 224

An Act to amend and reenact §§ 32.1-263 and 54.1-2915 of the Code of Virginia, relating to death certificates; medical certifications; electronic filing.

[S 1439]

Approved March 5, 2019

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-263 and 54.1-2915 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-263. Filing death certificates; medical certification; investigation by Office of the Chief Medical Examiner.

A. A death certificate, including, if known, the social security number or control number issued by the Department of Motor Vehicles pursuant to § 46.2-342 of the deceased, shall be filed for each death that occurs in the Commonwealth. Non-electronically filed death certificates shall be filed with the registrar of any district in the Commonwealth within three days after such death and prior to final disposition or removal of the body from the Commonwealth. Electronically filed death certificates shall be filed with the State Registrar of Vital Records through the Electronic Death Registration System within three days after such death and prior to final disposition or removal of the body from the Commonwealth. Any death certificate shall be registered by such registrar if it has been completed and filed in accordance with the following requirements:

1. If the place of death is unknown, but the dead body is found in the Commonwealth, the death shall be registered in the Commonwealth and the place where the dead body is found shall be shown as the place of death. If the date of death is unknown, it shall be determined by approximation, taking into consideration all relevant information, including information provided by the immediate family regarding the date and time that the deceased was last seen alive, if the individual died in his home; and

2. When death occurs in a moving conveyance, in the United States of America and the body is first removed from the conveyance in the Commonwealth, the death shall be registered in the Commonwealth and the place where it is first removed shall be considered the place of death. When a death occurs on a moving conveyance while in international waters or air space or in a foreign country or its air space and the body is first removed from the conveyance in the Commonwealth, the death shall be registered in the Commonwealth but the certificate shall show the actual place of death insofar as can be determined.

B. The licensed funeral director, funeral service licensee, office of the state anatomical program, or next of kin as defined in § 54.1-2800 who first assumes custody of a dead body shall complete the certificate of death. He shall obtain personal data of the deceased necessary to complete the certificate of death, including the social security number of the deceased or control number issued to the deceased by the Department of Motor Vehicles pursuant to § 46.2-342, from the best qualified person or source available and obtain the medical certification from the person responsible therefor.

If a licensed funeral director, funeral service licensee, or representative of the office of the state anatomical program completes the certificate of death, he shall file the certificate of death with the State Registrar of Vital Records electronically using the Electronic Death Registration System and in accordance with the requirements of subsection A. If a member of the next of kin of the deceased completes the certificate of death, he shall file the certificate of death in accordance with the requirements of subsection A but shall not be required to file the certificate of death electronically.

C. The medical certification shall be completed~~, signed in black or dark blue ink, and returned to the funeral director~~ *and filed electronically with the State Registrar of Vital Records using the Electronic Death Registration System* within 24 hours after death by the physician in charge of the patient's care for the illness or condition which resulted in death except when inquiry or investigation by the Office of the Chief Medical Examiner is required by § 32.1-283 or 32.1-285.1, or by the physician that pronounces death pursuant to § 54.1-2972. If the death occurred while under the care of a hospice provider, the medical certification shall be completed by the decedent's health care provider and filed electronically with the State Registrar of Vital Records using the Electronic Death Registration System for completion of the death certificate.

In the absence of such physician or with his approval, the certificate may be completed and ~~signed~~ *filed* by the following: (i) another physician employed or engaged by the same professional practice; (ii) a physician assistant supervised by such physician; (iii) a nurse practitioner practicing in accordance with the provisions of § 54.1-2957; (iv) the chief medical officer or medical director, or his designee, of the institution, hospice, or nursing home in which death occurred; (v) a physician specializing in the delivery of health care to hospitalized or emergency department patients who is employed by or engaged by the facility where the death occurred; (vi) the physician who performed an autopsy upon the decedent; (vii) an individual to whom the physician has delegated authority to complete and ~~sign~~ *file* the

certificate, if such individual has access to the medical history of the case and death is due to natural causes; or (viii) a physician *who is not* licensed ~~in another state~~ *by the Board of Medicine* who was in charge of the patient's care for the illness or condition that resulted in death. *A physician described in clause (viii) who completes a certificate in accordance with this subsection shall not be required to register with the Electronic Death Registration System or complete the certificate electronically.*

D. When inquiry or investigation by the Office of the Chief Medical Examiner is required by § 32.1-283 or 32.1-285.1, the Chief Medical Examiner shall cause an investigation of the cause of death to be made and the medical certification portion of the death certificate to be completed and ~~signed~~ *filed* within 24 hours after being notified of the death. If the Office of the Chief Medical Examiner refuses jurisdiction, the physician last furnishing medical care to the deceased shall prepare and ~~sign~~ *file* the medical certification portion of the death certificate.

E. If the death is a natural death and a death certificate is being prepared pursuant to § 54.1-2972 and the physician, nurse practitioner, or physician assistant is uncertain about the cause of death, he shall use his best medical judgment to certify a reasonable cause of death or contact the health district physician director in the district where the death occurred to obtain guidance in reaching a determination as to a cause of death and document the same.

If the cause of death cannot be determined within 24 hours after death, the medical certification shall be completed as provided by regulations of the Board. The attending physician or the Chief Medical Examiner, an Assistant Chief Medical Examiner, or a medical examiner appointed pursuant to § 32.1-282 shall give the funeral director or person acting as such notice of the reason for the delay, and final disposition of the body shall not be made until authorized by the attending physician, the Chief Medical Examiner, an Assistant Chief Medical Examiner, or a medical examiner appointed pursuant to § 32.1-282.

F. A physician, nurse practitioner, ~~or~~ physician assistant, *or individual delegated authority to complete and file a certificate of death by a physician* who, in good faith, files ~~or signs~~ a certificate of death or determines the cause of death shall be immune from civil liability, only for such ~~signature~~ *filing* and determination of causes of death on such certificate, absent gross negligence or willful misconduct.

§ 54.1-2915. Unprofessional conduct; grounds for refusal or disciplinary action.

A. The Board may refuse to issue a certificate or license to any applicant; reprimand any person; place any person on probation for such time as it may designate; impose a monetary penalty or terms as it may designate on any person; suspend any license for a stated period of time or indefinitely; or revoke any license for any of the following acts of unprofessional conduct:

1. False statements or representations or fraud or deceit in obtaining admission to the practice, or fraud or deceit in the practice of any branch of the healing arts;

2. Substance abuse rendering him unfit for the performance of his professional obligations and duties;

3. Intentional or negligent conduct in the practice of any branch of the healing arts that causes or is likely to cause injury to a patient or patients;

4. Mental or physical incapacity or incompetence to practice his profession with safety to his patients and the public;

5. Restriction of a license to practice a branch of the healing arts in another state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction, or for an entity of the federal government;

6. Undertaking in any manner or by any means whatsoever to procure or perform or aid or abet in procuring or performing a criminal abortion;

7. Engaging in the practice of any of the healing arts under a false or assumed name, or impersonating another practitioner of a like, similar, or different name;

8. Prescribing or dispensing any controlled substance with intent or knowledge that it will be used otherwise than medicinally, or for accepted therapeutic purposes, or with intent to evade any law with respect to the sale, use, or disposition of such drug;

9. Violating provisions of this chapter on division of fees or practicing any branch of the healing arts in violation of the provisions of this chapter;

10. Knowingly and willfully committing an act that is a felony under the laws of the Commonwealth or the United States, or any act that is a misdemeanor under such laws and involves moral turpitude;

11. Aiding or abetting, having professional connection with, or lending his name to any person known to him to be practicing illegally any of the healing arts;

12. Conducting his practice in a manner contrary to the standards of ethics of his branch of the healing arts;

13. Conducting his practice in such a manner as to be a danger to the health and welfare of his patients or to the public;

14. Inability to practice with reasonable skill or safety because of illness or substance abuse;

15. Publishing in any manner an advertisement relating to his professional practice that contains a claim of superiority or violates Board regulations governing advertising;

16. Performing any act likely to deceive, defraud, or harm the public;

17. Violating any provision of statute or regulation, state or federal, relating to the manufacture, distribution, dispensing, or administration of drugs;

18. Violating or cooperating with others in violating any of the provisions of Chapters 1 (§ 54.1-100 et seq.), 24 (§ 54.1-2400 et seq.) and this chapter or regulations of the Board;

19. Engaging in sexual contact with a patient concurrent with and by virtue of the practitioner and patient relationship or otherwise engaging at any time during the course of the practitioner and patient relationship in conduct of a sexual nature that a reasonable patient would consider lewd and offensive;

20. Conviction in any state, territory, or country of any felony or of any crime involving moral turpitude;

21. Adjudication of legal incompetence or incapacity in any state if such adjudication is in effect and the person has not been declared restored to competence or capacity; ~~or~~

22. Performing the services of a medical examiner as defined in 49 C.F.R. § 390.5 if, at the time such services are performed, the person performing such services is not listed on the National Registry of Certified Medical Examiners as provided in 49 C.F.R. § 390.109 or fails to meet the requirements for continuing to be listed on the National Registry of Certified Medical Examiners as provided in 49 C.F.R. § 390.111*; or*

23. Failing or refusing to complete and file electronically using the Electronic Death Registration System any medical certification in accordance with the requirements of subsection C of § 32.1-263. However, failure to complete and file a medical certification electronically using the Electronic Death Registration System in accordance with the requirements of subsection C of § 32.1-263 shall not constitute unprofessional conduct if such failure was the result of a temporary technological or electrical failure or other temporary extenuating circumstance that prevented the electronic completion and filing of the medical certification using the Electronic Death Registration System.

B. The commission or conviction of an offense in another state, territory, or country, which if committed in Virginia would be a felony, shall be treated as a felony conviction or commission under this section regardless of its designation in the other state, territory, or country.

C. The Board shall refuse to issue a certificate or license to any applicant if the candidate or applicant has had his certificate or license to practice a branch of the healing arts revoked or suspended, and has not had his certificate or license to so practice reinstated, in another state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction.

2. That the provisions of the first enactment of this act shall become effective on January 1, 2020.

3. That every licensed physician of medicine or osteopathy, physician assistant, and nurse practitioner who practices (i) as a hospitalist or in the specialty of emergency medicine in a hospital or as a medical director at a nursing home located in the Commonwealth shall register with the Electronic Death Registration System and shall file each medical certification of death completed in accordance with the requirements of § 32.1-263 of the Code of Virginia, as amended by this act, electronically with the Electronic Death Registration System beginning July 1, 2019; (ii) in the specialty of family medicine or internal medicine shall register with the Electronic Death Registration System and shall file each medical certification of death completed in accordance with the requirements of § 32.1-263 of the Code of Virginia, as amended by this act, electronically with the Electronic Death Registration System beginning October 1, 2019; (iii) in the specialty of oncology or general surgery shall register with the Electronic Death Registration System and shall file each medical certification of death completed in accordance with the requirements of § 32.1-263 of the Code of Virginia, as amended by this act, electronically with the Electronic Death Registration System beginning November 1, 2019; and (iv) in any other specialty and completes medical certifications of death pursuant to § 32.1-263 of the Code of Virginia shall register with the Electronic Death Registration System and shall file each medical certification of death completed in accordance with the requirements of § 32.1-263 of the Code of Virginia electronically with the Electronic Death Registration System beginning December 1, 2019.

4. That the Department of Health shall work with the Medical Society of Virginia, Virginia Hospital and Healthcare Association, Virginia Funeral Directors Association, Virginia Morticians' Association, Inc., Association of Independent Funeral Homes of Virginia, and other stakeholders to educate and encourage physicians, physician assistants, and nurse practitioners to timely register with and utilize the Electronic Death Registration System.

VIRGINIA ACTS OF ASSEMBLY -- 2019 SESSION

CHAPTER 681

An Act to amend and reenact §§ 54.1-3408.3 and 54.1-3442.6 of the Code of Virginia, relating to Board of Pharmacy; cannabidiol oil and THC-A oil; regulation of pharmaceutical processors.

[S 1557]

Approved March 21, 2019

Be it enacted by the General Assembly of Virginia:

1. That §§ 54.1-3408.3 and 54.1-3442.6 of the Code of Virginia are amended and reenacted as follows:

§ 54.1-3408.3. Certification for use of cannabidiol oil or THC-A oil for treatment.

A. As used in this section:

"Cannabidiol oil" means ~~a~~ *any formulation of* processed Cannabis plant extract that contains at least 15 percent cannabidiol but no more than five percent tetrahydrocannabinol, or a dilution of the resin of the Cannabis plant that contains at least five milligrams of cannabidiol per ~~milliliter~~ *dose* but not more than five percent tetrahydrocannabinol.

"Practitioner" means a practitioner of medicine or osteopathy licensed by the Board of Medicine, *a physician assistant licensed by the Board of Medicine, or a nurse practitioner jointly licensed by the Board of Medicine and the Board of Nursing.*

"THC-A oil" means ~~a~~ *any formulation of* processed Cannabis plant extract that contains at least 15 percent tetrahydrocannabinol acid but not more than five percent tetrahydrocannabinol, or a dilution of the resin of the Cannabis plant that contains at least five milligrams of tetrahydrocannabinol acid per ~~milliliter~~ *dose* but not more than five percent tetrahydrocannabinol.

B. A practitioner in the course of his professional practice may issue a written certification for the use of cannabidiol oil or THC-A oil for treatment or to alleviate the symptoms of any diagnosed condition or disease determined by the practitioner to benefit from such use.

C. The written certification shall be on a form provided by the Office of the Executive Secretary of the Supreme Court developed in consultation with the Board of Medicine. Such written certification shall contain the name, address, and telephone number of the practitioner, the name and address of the patient issued the written certification, the date on which the written certification was made, and the signature of the practitioner. Such written certification issued pursuant to subsection B shall expire no later than one year after its issuance unless the practitioner provides in such written certification an earlier expiration.

D. No practitioner shall be prosecuted under § 18.2-248 or 18.2-248.1 for dispensing or distributing cannabidiol oil or THC-A oil for the treatment or to alleviate the symptoms of a patient's diagnosed condition or disease pursuant to a written certification issued pursuant to subsection B. Nothing in this section shall preclude the Board of Medicine from sanctioning a practitioner for failing to properly evaluate or treat a patient's medical condition or otherwise violating the applicable standard of care for evaluating or treating medical conditions.

E. A practitioner who issues a written certification to a patient pursuant to this section shall register with the Board. The Board shall, in consultation with the Board of Medicine, set a limit on the number of patients to whom a practitioner may issue a written certification.

F. A patient who has been issued a written certification shall register with the Board or, if such patient is a minor or an incapacitated adult as defined in § 18.2-369, a patient's parent or legal guardian shall register and shall register such patient with the Board.

G. The Board shall promulgate regulations to implement the registration process. Such regulations shall include (i) a mechanism for sufficiently identifying the practitioner issuing the written certification, the patient being treated by the practitioner, and, if such patient is a minor or an incapacitated adult as defined in § 18.2-369, the patient's parent or legal guardian; (ii) a process for ensuring that any changes in the information are reported in an appropriate timeframe; and (iii) a prohibition for the patient to be issued a written certification by more than one practitioner during any given time period.

H. Information obtained under the registration process shall be confidential and shall not be subject to the disclosure provisions of the Virginia Freedom of Information Act (§ 2.2-3700 et seq.). However, reasonable access to registry information shall be provided to (i) the Chairmen of the House and Senate Committees for Courts of Justice, (ii) state and federal agencies or local law enforcement for the purpose of investigating or prosecuting a specific individual for a specific violation of law, (iii) licensed physicians or pharmacists for the purpose of providing patient care and drug therapy management and monitoring of drugs obtained by a registered patient, (iv) a pharmaceutical processor involved in the treatment of a registered patient, or (v) a registered patient or, if such patient is a minor or an incapacitated adult as defined in § 18.2-369, the patient's parent or legal guardian, but only with respect

to information related to such registered patient.

§ 54.1-3442.6. Permit to operate pharmaceutical processor.

A. No person shall operate a pharmaceutical processor without first obtaining a permit from the Board. The application for such permit shall be made on a form provided by the Board and signed by a pharmacist who will be in full and actual charge of the pharmaceutical processor. The Board shall establish an application fee and other general requirements for such application.

B. Each permit shall expire annually on a date determined by the Board in regulation. The number of permits that the Board may issue or renew in any year is limited to one for each health service area established by the Board of Health. Permits shall be displayed in a conspicuous place on the premises of the pharmaceutical processor.

C. The Board shall adopt regulations establishing health, safety, and security requirements for pharmaceutical processors. Such regulations shall include requirements for (i) physical standards; (ii) location restrictions; (iii) security systems and controls; (iv) minimum equipment and resources; (v) recordkeeping; (vi) labeling and packaging; (vii) quarterly inspections; (viii) processes for safely and securely cultivating Cannabis plants intended for producing cannabidiol oil and THC-A oil, producing cannabidiol oil and THC-A oil, and dispensing and delivering in person cannabidiol oil and THC-A oil to a registered patient or, if such patient is a minor or an incapacitated adult as defined in § 18.2-369, such patient's parent or legal guardian; (ix) a maximum number of marijuana plants a pharmaceutical processor may possess at any one time; (x) the secure disposal of plant remains; ~~and~~ (xi) a process for registering a cannabidiol oil and THC-A oil product*; and (xii) dosage limitations, which shall provide that each dispensed dose of cannabidiol oil or THC-A not exceed 10 milligrams of tetrahydrocannabinol.*

D. Every pharmaceutical processor shall be under the personal supervision of a licensed pharmacist on the premises of the pharmaceutical processor.

E. The Board shall require an applicant for a pharmaceutical processor permit to submit to fingerprinting and provide personal descriptive information to be forwarded along with his fingerprints through the Central Criminal Records Exchange to the Federal Bureau of Investigation for the purpose of obtaining criminal history record information regarding the applicant. The cost of fingerprinting and the criminal history record search shall be paid by the applicant. The Central Criminal Records Exchange shall forward the results of the criminal history background check to the Board or its designee, which shall be a governmental entity.

F. No person who has been convicted of a felony or of any offense in violation of Article 1 (§ 18.2-247 et seq.) or Article 1.1 (§ 18.2-265.1 et seq.) of Chapter 7 of Title 18.2 shall be employed by or act as an agent of a pharmaceutical processor.

2. That the Secretary of Health and Human Resources and the Secretary of Agriculture and Forestry shall convene a work group to review and recommend an appropriate structure for oversight in Virginia. The work group shall report, by November 1, 2019, its findings and recommendations to the Chairmen of the Senate Committees on Agriculture, Conservation and Natural Resources and Education and Health and the House Committees on Agriculture, Chesapeake and Natural Resources and Health, Welfare and Institutions.

Colanthia Opher

From: Harp, William
Sent: Thursday, February 28, 2019 10:00 AM
To: Colanthia Opher; Deschenes, Jennifer; Yeatts, Elaine
Subject: Re: FW: Re: VIRGINIA CPA QUESTION

Dear Mr. Orfield:

The essential change in the law for physician assistants is that a "supervising" physician is no longer required, but rather a "patient care team physician" with whom the PA has a practice agreement that outlines how "collaboration" and "consultation" are to be accomplished. Here are the definitions of collaboration and consultation.

Bill Tracking - 2019 session > Legislation > HB 1952

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

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

At a minimum, the practice agreement needs to address the issues in the definitions of collaboration and consultation and those addressed in 18VAC85-50-101, which reads as follows:

18VAC85-50-101. Requirements for a Practice Agreement.

Part IV. Practice Requirements

A. Prior to initiation of practice, a physician assistant and his supervising physician shall enter into a written or electronic practice agreement that spells out the roles and functions of the assistant.

1. The supervising physician shall be a doctor of medicine, osteopathy, or podiatry licensed in the Commonwealth who has accepted responsibility for the supervision of the service that a physician assistant renders.

2. Any such practice agreement shall take into account such factors as the physician assistant's level of competence, the number of patients, the types of illness treated by the physician, the nature of the treatment, special procedures, and the nature of the physician availability in ensuring direct physician involvement at an early stage and regularly thereafter.

3. The practice agreement shall also provide an evaluation process for the physician assistant's performance, including a requirement specifying the time period, proportionate to the acuity of care and practice setting, within which the supervising physician shall review the record of services rendered by the physician assistant.

4. The practice agreement may include requirements for periodic site visits by supervising licensees who supervise and direct assistants who provide services at a location other than where the licensee regularly practices.

B. The board may require information regarding the level of supervision with which the supervising physician plans to supervise the physician assistant for selected tasks. The board may also require the supervising physician to document the assistant's competence in performing such tasks.

C. If the role of the assistant includes prescribing drugs and devices, the written practice agreement shall include those schedules and categories of drugs and devices that are within the scope of practice and proficiency of the supervising physician.

D. If the initial practice agreement did not include prescriptive authority, there shall be an addendum to the practice agreement for prescriptive authority.

E. If there are any changes in supervision, authorization, or scope of practice, a revised practice agreement shall be entered into at the time of the change.

The language of the regulations will need to be revised based upon the 2019 law that will most likely become effective July 1st.

However, this section of the regulations will still serve as a guide for PA's and doctors that are forming a patient care team relationship.

Note that there is no longer a practice agreement "form."

The derivation of and the safekeeping of the practice agreement, which can be kept electronically, rests with the PA and the patient care team doctor.

I hope this is helpful you.

With kindest regards,

On Wed, Feb 27, 2019 at 5:24 PM Colanthia Opher <coco.morton@dhp.virginia.gov> wrote:

---------- Forwarded message ---------
From: **Donnie Orfield** <Donnie_Orfield@teamhealth.com>
Date: Wed, Feb 27, 2019 at 2:29 PM
Subject: RE: Re: VIRGINIA CPA QUESTION
To: Clanton, Sharon <sharon.clanton@dhp.virginia.gov>

Hi Sharon,

I just left you a message. I was curious with this new change in July coming up for the Physician Assistants, I was curious with the following:

- When will the new collaborative forms be available or any other forms?

- Is there going to be a grace period on the transition to these forms?

- What are the major changes in layman's' terms?

Thanks!

Donnie

Donnie Orfield

Credentialing Coordinator, Centerpoint Office

TeamHealth Emergency Medicine, Mid-Atlantic Region

Office& Text: 865.985.7476 | Fax: 865.692.5857

From: Clanton, Sharon <sharon.clanton@dhp.virginia.gov>
Sent: Tuesday, January 8, 2019 11:47 AM
To: Wood, Jennie <jennie.wood@dhp.virginia.gov>

Cc: Donnie Orfield <Donnie_Orfield@teamhealth.com>
Subject: [EXTERNAL] Re: VIRGINIA CPA QUESTION

Good Morning,

Just the name and license number

On Mon, Jan 7, 2019 at 1:04 PM Wood, Jennie <jennie.wood@dhp.virginia.gov> wrote:

ShaRon,

Can you answer Mr. Orfield's question regarding the form on a PA's alternate physician supervisor below.

Thanks,

j

Jennie F. Wood

Case Manager, Discipline & Compliance

804-367-4571

Virginia Board of Medicine

9960 Mayland Drive, Suite 300

Henrico, Virginia 23233

---------- Forwarded message ---------
From: **Donnie Orfield** <Donnie_Orfield@teamhealth.com>
Date: Mon, Jan 7, 2019 at 12:42 PM
Subject: VIRGINIA CPA QUESTION
To: jennie.wood@dhp.virginia.gov <jennie.wood@dhp.virginia.gov>

Jennie,

Sorry I missed your call.

My question is, on the Secondary Patient Care Team list, does the alternate physicians' privilege dates have to be on the list or can it be just their names?

Thanks!

Donnie

Donnie Orfield

Credentialing Coordinator, Centerpoint Office

TeamHealth Emergency Medicine, Mid-Atlantic Region

1431 Centerpoint Blvd | Suite #100 | Knoxville, TN 37932

Office & Text: 865.985.7476 | Fax: 865.692.5857 | Email: Donnie_Orfield@teamhealth.com

www.teamhealth.com | facebook.com/teamhealth | @TeamHealth

Named among "The World's Most Admired Companies" by Fortune magazine for 2015.

Named among "Great Places to Work" by Becker's Hospital Review in 2015.

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S. T. Clanton, Licensing Specialist

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9960 Mayland Drive, Suite 300

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State-by-State Variations in PA Licensure: A Policy Analysis

Erika E. Miller

ABSTRACT: State licensure procedures for PAs (physician assistants) vary significantly, as does the average time necessary for states to process a PA license. This article discusses these variations and presents evidence that states with the highest number of extra requirements for PA licensure tend to have longer license processing times. It also includes an analysis showing that states with modernized PA practice laws (e.g., laws that allow PAs to practice to the full extent of their education and experience) tend to have fewer extra licensure requirements. Finally, this article discusses potential benefits of reducing extra PA licensure requirements, including mitigation of health care practitioner shortages without compromising patient safety and greater adoption of the Uniform Application (UA) for PAs.

Introduction

PAs (physician assistants), like other health care practitioners, are licensed by the state in which they practice. PAs seeking licensure submit an application, pay fees, and provide proof of graduation from an accredited PA program and passage of the Physician Assistant National Certifying Examination (PANCE) administered by the National Commission on Certification of Physician Assistants (NCCPA). A criminal background check and information regarding prior practice are also generally required.

However, many states have extra—and often burdensome—licensure requirements, including personal interviews, identification of a supervising or collaborating physician, submission of letters of recommendation or other supplemental forms, board approval of the PA's practice agreement, passage of a jurisprudence examination, and/or direct action by board members to either ratify or approve licensure. These extra requirements—and the time it takes for state licensing boards to process a PA's request for licensure—vary widely from state to state.

In 2016 and 2017, the American Academy of PAs (AAPA) sought information from state licensing boards on the overall use of extra PA licensure requirements, as well as the estimated time necessary for licensing boards to process a typical PA license. The goal of this research was to determine which licensing boards had the highest number of licensure requirements for PAs and whether these boards also had the longest processing times for licensure. AAPA also sought to determine whether states with the most modernized PA practice laws (e.g., those which allow PAs to practice to the full extent of their education and experience) were among those with fewer extra licensure requirements.

AAPA policy supports a simple approach to PA licensure. Applicants who meet a state's qualifications should be issued a license, and there should be no extra steps which slow the licensure process without enhancing public safety.[1] This is similar to the Federation of State Medical Boards' (FSMB) policy, which supports licensure procedures for physicians that do not include extraneous steps.[2] This article will discuss the variations in PA licensure procedures among the states, show how these differences may be connected to a state's PA practice laws, and provide arguments for creating a system of PA licensure which protects the public while reducing extra requirements.

APPLICANTS WHO MEET A STATE'S QUALIFICATIONS SHOULD BE ISSUED A LICENSE, AND THERE SHOULD BE NO EXTRA STEPS WHICH SLOW THE LICENSURE PROCESS WITHOUT ENHANCING PUBLIC SAFETY.

Background on the PA Profession

The first PA educational program was established in 1965 by Duke University's then-chairman of the Department of Medicine, Dr. Eugene A. Stead, Jr.[3] This new profession was created to increase patient access to health care and create civilian jobs for the thousands of returning service personnel who had gained significant medical training and

experience while in the military.[4] Students in the inaugural program completed a course of study which was based on the medical school model and included 12 months of science education and 15 months of clinical instruction.[5]

The first PA students — all former U.S. Navy corpsmen — graduated in 1967.[6,7] However, there were no laws or regulations in North Carolina which addressed PA practice or licensure aside from a ruling by the state's Attorney General that PAs could perform medical services under physician delegation and supervision.[3] As interest in PAs spread to other states, the federal government contracted with Duke University's Department of Community Health Sciences to create model

TODAY, THERE ARE MORE THAN 123,000 PAs, AND THE TYPICAL PA EDUCATIONAL PROGRAM, WHICH GENERALLY REQUIRES BASIC SCIENCE PRE-REQUISITE COURSES AND A BACHELOR'S DEGREE, NOW LASTS FOR THREE ACADEMIC YEARS...

legislation for the uniform regulation of PAs. The model allowed PAs to perform any "act, task or function . . . at the direction and under the supervision of a physician licensed by the Board of Medical Examiners."[3] The proposal was adopted by the North Carolina General Assembly in 1971, and it became a model for other states seeking to regulate this new profession.[3]

Today, there are more than 123,000 PAs, and the typical PA educational program, which generally requires basic science pre-requisite courses and a bachelor's degree, now lasts for three academic years, with PA students completing an average of 2,000 hours of supervised clinical practice prior to graduation.[8] PAs are licensed in every state, the District of Columbia, and every U.S. territory with the exception of Puerto Rico. In most jurisdictions, PAs are licensed by the medical licensing board. In these cases, the medical board includes a designated PA seat, has an established PA advisory committee or council, or both. Seven states license PAs under separate osteopathic medical boards if they are supervised by or collaborate with an osteopathic physician.

Eight states have distinct PA boards. Three of these boards, located in California, Michigan and Texas, must seek final approval from the medical board for rulemaking and various other regulatory functions. Four of the other five PA boards, in Arizona, Massachusetts, Rhode Island and Utah, have full authority over PA licensure, practice, regulation and discipline. The Iowa PA board has full authority over PA licensure and discipline, but regulations related to some aspects of PA practice must be jointly approved by the medical board.

Methodology

In July 2016, AAPA sought information from state licensing boards to verify whether any of the following items beyond an application, standard documentation, and fees were required for PA licensure:

- Personal interview
- Identification of a supervising or collaborating physician
- Submission of letters of recommendation or other supplemental forms besides transcripts
- Board approval of the PA's practice agreement
- Passage of a jurisprudence examination
- Direct action by board members to either ratify or approve licensure

For the purposes of this analysis, these are referred to as "extra requirements." This inquiry focused on uncomplicated license applications only — those without "yes" answers to questions related to criminal history or past disciplinary action. AAPA also verified with each board the average time to process a PA license application.

Much of the information sought by AAPA was available in statutes, regulations, or on the licensing boards' web sites. However, AAPA staff also contacted several boards directly to supplement or clarify this information. Once assembled, the results were shared within AAPA's community of PAs who serve on state licensing boards (PA regulators). These individuals provided additional information and clarification regarding a handful of provisions.

From July 2016 until July 2017, AAPA staff tracked changes in PA licensure procedures as they occurred. At the end of the one-year tracking period, AAPA again accessed state licensing boards' web sites and the relevant statutes and regulations for the most up-to-date information on licensure procedures. As in 2016, AAPA staff contacted individual licensing

boards for clarification and updated PA license processing times. They also consulted with PA regulators for additional information.

AAPA sought to ensure accuracy and consistency in collecting this information. However, there were instances in which corrections were made after the initial information requests, either by PA regulators or through additional communication with licensing board staff. There were also a handful of instances in which different information was obtained via board staff or resources from one year to the next, even though no legislative or regulatory change had occurred. AAPA's process for gathering this information often relied on estimates or interpretations regarding procedures and timelines. The subjective nature of some of this information may have resulted in seemingly unexplained changes between 2016 and 2017, particularly as it relates to estimated license processing times. The discussion which follows notes these changes only if they were a direct result of amendments to laws, regulations, or board policies or procedures.

MOST LICENSING BOARDS AVOIDED QUOTING A DEFINITIVE PROCESSING TIMELINE, EVEN FOR UNCOMPLICATED APPLICATIONS, OPTING INSTEAD TO PROVIDE AN AVERAGE RANGE OF TIME FOR LICENSURE.

Results

AAPA's research and subsequent analysis resulted in two significant findings. First, licensing boards with a higher number of extra requirements for PA applicants generally take longer to issue a license. Second, states with modernized PA practice laws tend to have fewer extra licensure requirements and, therefore, tend to take less time to issue a license.

Discussion

AAPA's 2016 and 2017 surveys found that 11 licensing boards had no extra PA licensure requirements. Maryland is included in this list because even though it requires board approval of both a PA's practice agreement and final licensure if the PA will be performing "advanced duties," this does not apply to all PAs. "Advanced duties" are defined by the Maryland Board of Physicians as "medical acts that require additional training beyond the basic physician assistant education program required for licensure" to include "(c)osmetic procedures, lumbar punctures, central or arterial line insertions, endoscopic procedures, (and) stress testing."[9] The remaining 47 boards which license PAs have at least one extra requirement.

Personal Interviews. Six licensing boards required all applicants for PA licensure to undergo an in-person or telephone interview in 2016. Notably, these states did not have the same requirement for physician licensure. This number decreased to five in 2017 due to Mississippi's removal of its interview requirement.

Physician Identification. Fifteen licensing boards required PAs to identify a supervising or collaborating physician as a condition of licensure in 2016. This requirement is different—and more onerous—than the requirement in many states that a PA identify a supervising or collaborating physician prior to beginning practice, as it requires a PA to be employed before a license may be issued. This number decreased to 14 in 2017 due to Virginia's elimination of this requirement.

Letters of Recommendation. In 2016, 21 licensing boards required every applicant to provide at least one letter of recommendation or form other than a transcript to be filled out and returned by a school, instructor or former employer. Such letters or documentation were also required for physicians regulated by all but three of these boards. While South Dakota requires a letter of recommendation at the board's discretion and Colorado requires a letter of recommendation if the applicant was previously licensed in another jurisdiction, these boards were not included in this category because the requirements do not apply to all PAs. This number decreased to 19 in 2017 due to both Florida boards' elimination of this requirement.

Approval of the PA's Practice Agreement. In 2016 and 2017, eight licensing boards required approval of an applicant's practice agreement as a condition of licensure. In Maryland, a PA's practice agreement must be approved prior to licensure only if the PA will be performing advanced duties; however, it was not included in this category because the requirement does not apply to all PAs. Like the physician identification requirement, this requirement means a PA must be employed prior to becoming licensed.

Jurisprudence Examination. In 2016 and 2017, 10 licensing boards required applicants to take and pass an examination on state laws and regulations, or jurisprudence exam. Applicants in Arkansas must sign an affidavit stating that they have read the PA practice act and associated regulations; however, it was not included in this category because an actual examination is not required for licensure.

Direct Action by Board Members Required for Licensure. In 2016 and 2017, 23 boards were required to ratify licensing decisions before they became final, though much of the review process is handled administratively. Such ratification typically occurs at regularly scheduled board meetings.

Twelve boards were required in 2016 to review and approve every PA license, a process which, like ratification, generally occurs at regularly scheduled board meetings. Maryland only requires such approval if the PA will be providing advanced duties, so it is not included in this category. This number decreased to 11 in 2017 due to changes in Texas licensing procedures.

Twenty-two licensing boards allowed PAs to become licensed as an administrative action, without board member ratification or approval. Maryland is included in this category because it allows administrative approval of licenses for PAs who will not be performing advanced duties. This number increased to 23 in 2017, when Texas began to allow administrative license approval.

Average Length of Time for Licensure. Most licensing boards avoided quoting a definitive processing timeline, even for uncomplicated applications, opting instead to provide an average range of time for licensure. These ranges are categorized here as "short," "medium," and "long." Average time ranges did not change significantly between 2016 and 2017 unless specifically noted.

Nine boards reported short average licensure times—as little as two weeks. As of 2017, five[10] of these boards were among those which did not require any extra requirements, and only two required specific board ratification or approval for licensure. Put differently, the boards with the shortest estimated processing time for licensure also tended to have few to no extra requirements and were likely to process, approve and issue licenses as an administrative function.

Twenty-seven boards reported medium average licensure times in 2016, with a fastest possible license processing time of three or four weeks. This number increased to 28 in 2017 due to Texas's changed procedures, which reduced the expected processing time from approximately 16 weeks to four weeks. As of 2017, five of these boards had no extra requirements. In all but two of the remaining boards in this category, board members had to ratify or approve licensure; however, in 10 of these states, this was the only extra requirement. Thirteen boards in this category had two or more extra requirements. In other words, PAs licensed by boards that fell in the middle in terms of license processing time seemed to fall in the middle in terms of extra requirements.

Twenty-one boards reported long average licensure times in 2016, with a fastest possible license processing time of six weeks or longer. This category had the most variation in reported average processing times, with the longest reported time being 16 weeks or more. This number decreased to 20 in 2017 due to Texas's change in procedures. As of 2017, all but one of the boards reporting long estimated processing times had at least one extra requirement, and 11 had two or more. Seventeen of these boards had at least one of the rarer extra requirements, such as personal interviews, physician identification, letters of recommendation or other forms, approval of practice agreements, and jurisprudence exams. In other words, the licensing boards with the longest average processing times tended to have the highest number of extra requirements.

> ...STATES WITH MODERNIZED PA PRACTICE LAWS TEND TO HAVE FEWER EXTRA LICENSURE REQUIREMENTS AND, THEREFORE, TEND TO TAKE LESS TIME TO ISSUE A LICENSE.

Practice Environment. AAPA also evaluated whether there was a relationship between boards' licensure procedures and processing times and the corresponding state's practice environment for PAs. Much like licensure laws, PA practice laws vary from state to state. AAPA tracks six components of PA laws and regulations, referred to as the Six Key Elements of a Modern PA Practice Act (key elements), the presence of which indicate

enhanced ability for PAs to practice in a particular state.[11] They include:

- Using "licensure" as the regulatory term
- Full prescriptive authority, including Schedule II-V controlled medications
- Determination of scope of practice at the practice level
- Adaptable collaboration requirements, including allowing decisions about practice location, physician proximity, and timing and manner of PA-physician interaction to be determined by the practice
- Allowing chart co-signature to be determined at the practice level
- Allowing a physician to practice with an unrestricted number of PAs

The key elements serve as a metric for determining how effectively PAs are able to provide care to patients in each state. When the licensing information collected from state regulatory boards in 2017 was compared with AAPA's tracking of the key elements during the same time, it appears states that had more of the key elements also tended to have fewer extra licensure requirements.[12] For instance, four of the seven states with all six key elements had one or no extra requirements.Eight of the 14 states with five key elements had one or no extra requirements. Eight of the 15 states with four key elements had one or no extra requirements, two of the seven states with three key elements had one or no extra requirements, and two of the six states with two key elements had one or no extra requirements. However, this correlation was not absolute: The two states that had only one key element (Iowa and West Virginia) had zero and one extra requirement, respectively. (See Table 1.)

Similarly, states with more key elements tended to have faster license processing times than did states with fewer key elements. Only two of the seven states with six key elements quoted a long average licensing timeline (six weeks or longer). Likewise, four of the 14 states with five key elements, five of the 15 states with four key elements, four of the seven states with three key elements, and one of the two states with one key element estimated a long average processing time. States with two key elements were the outlier from this pattern — only one of these states quoted this longer timeline, with the majority falling into the medium category of average processing times. Still, it appears that states with more modernized PA practice laws are generally also home to boards that have fewer extra requirements for PA licensure and can also issue a license faster than states with more restrictive practice laws. (See Table 2.)

...IT APPEARS THAT STATES WITH MORE MODERNIZED PA PRACTICE LAWS ARE GENERALLY ALSO HOME TO BOARDS THAT HAVE FEWER EXTRA REQUIREMENTS FOR PA LICENSURE.

It is also worth considering whether the establishment of autonomous PA boards results in fewer extra requirements for PA licensure. When compared with states that regulate PAs solely through their medical or osteopathic medical boards, the information collected by AAPA shows that the eight states with separate PA boards tended to have fewer extra requirements and faster average licensing times. In both 2016 and 2017, five of the PA boards had no extra requirements. Two PA boards had one extra requirement, and one had two extra

Table 1
Key Elements and Extra Requirements

Number of Key Elements	Total Number of States	States with One/Zero Extra Requirements	Percent
6	7	4	57%
5	14	8	57%
4	15	8	53%
3	7	2	28%
2	6	2	33%
1	2	2	100%

Table 2
Key Elements and Processing Times

Number of Key Elements	Total Number of States	States with Longest Processing Time (6+ Weeks)	Percent
6	7	2	28.5%
5	14	4	28.5%
4	15	5	33%
3	7	4	57%
2	6	1	16%
1	2	1	50%

requirements. This means a strong majority of PA boards had no extra requirements, compared with under a quarter of all boards.

Likewise, PA boards tended to have faster license processing times than other boards. Four of the PA boards quoted average processing times of as little as two weeks, two PA boards quoted a three-week average, and three PA boards quoted a four-week average. Put differently, half of the PA boards could issue a license in two weeks, but less than one-fifth of all boards estimated that they could do the same. None of the PA boards reported average processing times of six weeks or longer, though over one third of all boards reported average processing times within that range.

There are several possible explanations for why PA licensure has fewer extra requirements and takes less time when handled by PA boards. First, members of PA boards are often either PAs themselves or physicians who are familiar with PA education and practice. This may reduce the need for extraneous documentation to evaluate a PA's eligibility for licensure. Additionally, PA boards usually have the authority to adopt regulations, including those related to licensure procedures. Even in the three states that do not have a fully autonomous PA board, the mere existence of a separate PA board allows PAs to have a greater than typical role in crafting—and enforcing—the standards to which they are held. This may lead such boards to reject extra licensure requirements which have no clear public benefit.

States should consider following the lead of PA boards by reducing extra requirements and shortening licensure times for PAs, for several reasons. First, faster PA licensure can improve overall health care delivery. Numerous studies have shown that PAs increase access to health care in primary care and specialty settings.[13,14,15] Studies have also shown that PAs provide quality care while decreasing overall health care costs.[16,17,18,19] Removing administrative delays associated with PA licensure allows states to maximize these benefits by enabling PAs to practice more quickly and encouraging more PAs to seek a license in the state.

Additionally, licensure relies on state resources, which are often scarce. Requiring every PA to undergo additional scrutiny takes up valuable staff and board time. Several studies have found that PAs provide safe care to patients.[20,21] One such study showed that over a 17-year period, just over three percent of PAs made a malpractice payment, compared to 37% of physicians.[22] Moreover, the percentage of PAs who make a malpractice payment remains extremely small whether a PA practices in a state with extra licensure requirements or one with none. According to the National Practitioner Data Bank, an average of 0.10% of PAs in states with three to five additional requirements made a malpractice payment in 2017, compared to an average of 0.15% of PAs in states with no additional requirements.[23] This data shows that on the whole, PAs are providing safe patient care and little, if any, benefit is derived from the imposition of extra licensure requirements.

Finally, a more standardized licensure process for PAs would make it easier for states to adopt FSMB's Uniform Application (UA) for PA Licensure, modeled after the UA used by physicians. The UA for PAs is accepted by the Oklahoma Board of Medical Licensure and Supervision, the Maine Board of Licensure in Medicine, the Maine Board of Osteopathic Licensure, the Washington Medical Commission, and the Montana Board of Medical Examiners. Additional licensing boards are expected to follow. Wider adoption of the UA for PAs would make it significantly easier for PAs in these states to become licensed in the event they relocate or opt to practice in more than one state.

Conclusion

Many states' licensure procedures create barriers or delays for qualified PAs who are newly entering the workforce or beginning practice in a new state. AAPA's analysis suggests the existence of these barriers may also indicate a state's PA laws do not allow PAs to practice to the full extent of their education and experience. These combined limitations on the PA profession may impact patient access to care, which is especially concerning in states experiencing health care provider shortages. They also appear to have little, if any, effect on patient safety. As such, states should evaluate whether their current licensure procedures are a barrier to PAs becoming licensed and, if so, determine how they may promote the best use of available health care workforce resources. (See Table 3.)

Author's Note: In August 2018, AAPA compiled updated information from state licensure boards regarding extra requirements and average license processing times. Since 2017, the New Mexico Board of Osteopathic Medicine has eliminated all of its extra licensure requirements and the South Carolina Board of Medical Examiners has eliminated its letters of recommendation requirement. ■

Table 3
PA Licensure Procedures and Number of PA Licenses by State, 2017

State	Number of Active PA Licenses	Average Length of Time for Licensure	Total Number of Extra Requirements	Personal Interview Required of Every Applicant	Physician Identification Required Prior to Licensure	Letter(s) of Recommendation or Additional School/ Employer Form Required	Practice Agreement Approved by Regulatory Agency	Test on State Law (Jurisprudence Exam) Required	Licensure Requires Direct Board Action
Alabama	756	Medium	1	No	No	No	No	No	Yes — Board approves
Alaska	565	Long	3	No	Yes	No	Yes	No	Yes — Board approves
Arizona	2,339	Medium	0	No	No	No	No	No	No
Arkansas	363	Long	5	Yes	Yes	Yes	Yes	No	Yes — Board approves
California	11,529	Medium	0	No	No	No	No	No	No
Colorado	3,193	Long	1	No	No	Only if previously licensed	No	No	Yes — Board ratifies
Connecticut	2,448	Medium	0	No	No	No	No	No	No
Delaware	588	Medium	1	No	No	No	No	No	Yes — Board ratifies
District of Columbia	707	Long	2	No	No	Yes	No	No	Yes — Board ratifies
Florida	8,733	Medium	1	No	No	No	No	No	Yes — Board ratifies
Osteopathic	***	*Medium*	*1*	*No*	*No*	*No*	*No*	*No*	*Yes — Board ratifies*
Georgia	4,725	Medium	2	No	No	Yes	No	No	Yes — Board ratifies
Hawaii	340	Medium	1	No	No	No	No	No	Yes — Board ratifies
Idaho	913	Medium	3	No	Yes	Yes	No	No	Yes — Board ratifies
Illinois	3,648	Long	1	No	No	No	No	No	Yes — Board ratifies
Indiana	1,230	Medium	1	No	No	No	No	No	Yes — Board ratifies
Iowa	1,453	Short	0	No	No	No	No	No	No
Kansas	995	Medium	2	No	No	Yes	No	No	Yes — Board ratifies
Kentucky	1,216	Long	3	No	Yes	No	Yes	No	Yes — Board approves
Louisiana	1,108	Medium	1	No	No	No	No	Yes	No
Maine	804	Long	2	No	No	No	No	Yes	Yes — Board ratifies
Osteopathic	*64*	*Long*	*2*	*No*	*No*	*No*	*No*	*Yes*	*Yes — Board ratifies*
Maryland	2,770	Short	0	No	No	No	No — Unless "advanced duties"	No	No — Unless "advanced duties"
Massachusetts	3,339	Medium	1	No	No	No	No	No	Yes — Board approves
Michigan	5,338	Short	0	No	No	No	No	No	No
Minnesota	2,676	Medium	2	No	No	Yes	No	No	Yes — Board approves
Mississippi	217	Medium	2	No	No	No	No	Yes	Yes — Board ratifies
Missouri	1,161	Medium	3	No	Yes	Yes	No	No	Yes — Board approves
Montana	727	Medium	2	Yes	Yes	No	No	No	No
Nebraska	1,300	Long	0	No	No	No	No	No	No

Table 3, *continued*
PA Licensure Procedures and Number of PA Licenses by State, 2017

State	Number of Active PA Licenses	Average Length of Time for Licensure	Total Number of Extra Requirements	Personal Interview Required of Every Applicant	Physician Identification Required Prior to Licensure	Letter(s) of Recommendation or Additional School/ Employer Form Required	Practice Agreement Approved by Regulatory Agency	Test on State Law (Jurisprudence Exam) Required	Licensure Requires Direct Board Action
Nevada	815	Short	1	No	No	No	No	Yes	No
Osteopathic	100***	*Short*	*3*	*No*	*Yes*	*Yes*	*No*	*No*	*Yes — Board ratifies*
New Hampshire	870	Medium	3	No	Yes	Yes	No	No	Yes — Board approves
New Jersey	3,365	Medium	0	No	No	No	No	No	No
New Mexico	891	Long	1	No	No	Yes	No	No	No
Osteopathic	*23*	*Long*	*4*	*Yes*	*Yes*	*No*	*Yes*	*No*	*Yes — Board approves*
New York	15,099	Medium	0	No	No	No	No	No	No
North Carolina	6,330	Short	1	No	No	Yes	No	No	No
North Dakota	378	Long	2	No	Yes	No	Yes	No	No
Ohio	3,501	Medium	1	No	No	No	No	No	Yes — Board ratifies
Oklahoma	1,585	Long	2	No	No	No	No	Yes	Yes — Board approves
Oregon	1,870	Long	1	No	No	No	No	Yes	No
Pennsylvania	7,672	Short	0	No	No	No	No	No	No
Osteopathic	*1,758****	*Short*	*1*	*No*	*No*	*No*	*No*	*No*	*Yes — Board ratifies*
Rhode Island	492	Medium	1	No	No	No	No	No	Yes — Board approves
South Carolina	1,706	Medium	5	Yes	Yes	Yes	No	Yes	Yes — Board approves
South Dakota	616	Medium	1	No	No	Board's discretion	No	No	Yes — Board ratifies
Tennessee	2,097	Long	2	No	No	Yes	No	No	Yes — Board ratifies
Texas	8,589	Medium	2	No	No	Yes	No	Yes	No
Utah	1,470	Short	0	No	No	No	No	No	No
Vermont	373	Long	2	No	No	Yes	No	No	Yes — Board ratifies
Virginia	3,565	Long	1	No	No	Yes	No	No	No
Washington	3,556	Medium	3	No	Yes	No	Yes	No	Yes — Board ratifies
Osteopathic	**	*Medium*	*3*	*No*	*Yes*	*No*	*Yes*	*No*	*Yes — Board ratifies*
West Virginia	882	Long	1	No	No	Yes	No	No	No
Osteopathic	*240****	*Long*	*1*	*No*	*No*	*Yes*	*No*	*No*	*No*
Wisconsin	2,790	Long	1	No	No	No	No	Yes	No
Wyoming	318	Medium	5	Yes	Yes	Yes	Yes	No	Yes — Board ratifies

* "Short" refers to an average licensure time of as little as two weeks; "medium" refers to an average licensure time of as little as three weeks; "long" refers to an average licensure time of six weeks or longer.
** PAs are regulated by state medical boards/osteopathic boards, but licensure is a function of separate state agencies.
*** State may double-count allopathic/osteopathic licensees.

Information applies only to individuals with "clean" applications — those who did not check "yes" to questions on the application regarding criminal history or disciplinary action.

Number of licenses per state is the most recent information available from state medical boards as of Aug. 5, 2017.

About the Author

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Commonwealth of Virginia

REGULATIONS

GOVERNING THE PRACTICE OF PHYSICIAN ASSISTANTS

VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18 VAC 85-50-10 et seq.

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

Revised Date: March 22, 2019

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Part I. General Provisions.

18VAC85-50-10. Definitions.

A. The following words and terms shall have the meanings ascribed to them in §54.1-2900 of the Code of Virginia:

"Board."

"Physician assistant."

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

"Group practice" means the practice of a group of two or more doctors of medicine, osteopathy, or podiatry licensed by the board who practice as a partnership or professional corporation.

"Institution" means a hospital, nursing home or other health care facility, community health center, public health center, industrial medicine or corporation clinic, a medical service facility, student health center, or other setting approved by the board.

"NCCPA" means the National Commission on Certification of Physician Assistants.

"Practice agreement" means a written agreement developed by the supervising physician and the physician assistant that defines the supervisory relationship between the physician assistant and the physician, the prescriptive authority of the physician assistant, and the circumstances under which the physician will see and evaluate the patient.

"Supervision" means the supervising physician has on-going, regular communication with the physician assistant on the care and treatment of patients, is easily available, and can be physically present or accessible for consultation with the physician assistant within one hour.

18VAC85-50-20. (Repealed.)

18VAC85-50-21. Current name and address.

Each licensee shall furnish the board his current name and address of record. All notices required by law or by this chapter to be given by the board to any such licensee shall be validly given when sent to the latest address of record provided or served to the licensee. Any change of name or address of record or the public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

18VAC85-50-30. Public participation guidelines.

A separate board regulation, 18VAC85-11, entitled Public Participation Guidelines, provides for involvement of the public in the development of all regulations of the Virginia Board of Medicine.

18VAC85-50-35. Fees.

Unless otherwise provided, the following fees shall not be refundable:

1. The initial application fee for a license, payable at the time application is filed, shall be $130.

2. The biennial fee for renewal of an active license shall be $135 and for renewal of an inactive license shall be $70, payable in each odd-numbered year in the birth month of the licensee. For 2019, the fee for renewal of an active license shall be $108 and the fee for renewal of an inactive license shall be $54.

3. The additional fee for late renewal of licensure within one renewal cycle shall be $50.

4. A restricted volunteer license shall expire 12 months from the date of issuance and may be renewed without charge by receipt of a renewal application that verifies that the physician assistant continues to comply with provisions of §54.1-2951.3 of the Code of Virginia.

5. The fee for review and approval of a new protocol submitted following initial licensure shall be $15.

6. The fee for reinstatement of a license pursuant to §54.1-2408.2 of the Code of Virginia shall be $2,000.

7. The fee for a duplicate license shall be $5, and the fee for a duplicate wall certificate shall be $15.

8. The fee for a returned check shall be $35.

9. The fee for a letter of good standing/verification to another jurisdiction shall be $10.

10. The fee for an application or for the biennial renewal of a restricted volunteer license shall be $35, due in the licensee's birth month. An additional fee for late renewal of licensure shall be $15 for each renewal cycle.

Part II. Requirements for Practice as a physician assistant.

18VAC85-50-40. General requirements.

A. No person shall practice as a physician assistant in the Commonwealth of Virginia except as provided in this chapter.

B. All services rendered by a physician assistant shall be performed only under the continuous supervision of a doctor of medicine, osteopathy, or podiatry licensed by this board to practice in the Commonwealth.

18VAC85-50-50. Licensure: entry requirements and application.

The applicant seeking licensure as a physician assistant shall submit:

1. A completed application and fee as prescribed by the board.

2. Documentation of successful completion of an educational program as prescribed in §54.1-2951.1 of the Code of Virginia.

3. Documentation of passage of the certifying examination administered by the National Commission on Certification of Physician Assistants.

4. Documentation that the applicant has not had a license or certification as a physician assistant suspended or revoked and is not the subject of any disciplinary proceedings in another jurisdiction.

18VAC85-50-55. Provisional licensure.

Pending the outcome of the next examination administered by the NCCPA, an applicant who has met all other requirements of 18VAC85-50-50 at the time his initial application is submitted may be granted provisional licensure by the board. The provisional licensure shall be valid until the applicant takes the next subsequent NCCPA examination and its results are reported, but this period of validity shall not exceed 30 days following the reporting of the examination scores, after which the provisional license shall be invalid.

18VAC85-50-56. Renewal of license.

A. Every licensed physician assistant intending to continue to practice shall biennially renew the license in each odd numbered year in the licensee's birth month by:

1. Returning the renewal form and fee as prescribed by the board; and

2. Verifying compliance with continuing medical education standards established by the NCCPA.

B. Any physician assistant who allows his NCCPA certification to lapse shall be considered not licensed by the board. Any such assistant who proposes to resume his practice shall make a new application for licensure.

18VAC85-50-57. Discontinuation of employment.

If for any reason the assistant discontinues working in the employment and under the supervision of a licensed practitioner, a new practice agreement shall be entered into in order for the assistant either to be reemployed by the same practitioner or to accept new employment with another supervising physician.

18VAC85-50-58. Inactive licensure.

A. A physician assistant who holds a current, unrestricted license in Virginia shall, upon a request on the renewal application and submission of the required fee, be issued an inactive license.

1. The holder of an inactive license shall not be required to maintain certification by the NCCPA.

2. An inactive licensee shall not be entitled to practice as a physician assistant in Virginia.

B. An inactive licensee may reactivate his license upon submission of:

1. The required application;

2. Payment of the difference between the current renewal fee for inactive licensure and the renewal fee for active licensure for the biennium in which the license is being reactivated; and

3. Documentation of having maintained certification or having been recertified by the NCCPA.

C. The board reserves the right to deny a request for reactivation to any licensee who has been determined to have committed an act in violation of §54.1-2915 of the Code of Virginia or any provisions of this chapter.

18VAC85-50-59. Registration for voluntary practice by out-of-state licensees.

Any physician assistant who does not hold a license to practice in Virginia and who seeks registration to practice under subdivision 27 of §54.1-2901 of the Code of Virginia on a voluntary basis under the auspices of a publicly supported, all volunteer, nonprofit organization that sponsors the provision of health care to populations of underserved people shall:

1. File a complete application for registration on a form provided by the board at least five business days prior to engaging in such practice. An incomplete application will not be considered;

2. Provide a complete record of professional licensure in each state in which he has held a license and a copy of any current license;

3. Provide the name of the nonprofit organization, the dates and location of the voluntary provision of services;

4. Pay a registration fee of $10; and

5. Provide a notarized statement from a representative of the nonprofit organization attesting to its compliance with provisions of subdivision 27 of §54.1-2901 of the Code of Virginia.

18VAC85-50-60. (Repealed.)

18VAC85-50-61. Restricted volunteer license.

A. A physician assistant who held an unrestricted license issued by the Virginia Board of Medicine or by a board in another state as a licensee in good standing at the time the license expired or became inactive may be issued a restricted volunteer license to practice without compensation in a clinic that is organized in whole or in part for the delivery of health care services without charge in accordance with §54.1-106 of the Code of Virginia.

B. To be issued a restricted volunteer license, a physician assistant shall submit an application to the board that documents compliance with requirements of §54.1-2928.1 of the Code of Virginia and the application fee prescribed in 18VAC85-50-35.

C. The licensee who intends to continue practicing with a restricted volunteer license shall renew biennially during his birth month, meet the continued competency requirements prescribed in subsection D of this section, and pay to the board the renewal fee prescribed in 18VAC85-50-35.

D. The holder of a restricted volunteer license shall not be required to attest to hours of continuing education for the first renewal of such a license. For each renewal thereafter, the licensee shall attest to obtaining 50 hours of continuing education during the biennial renewal period with at least 25 hours in Type 1 and no more than 25 hours in Type 2 as acceptable to the NCCPA.

18VAC85-50-70 to 18VAC85-50-100. (Repealed.)

Part IV. Practice Requirements .

18VAC85-50-101. Requirements for a practice agreement.

A. Prior to initiation of practice, a physician assistant and his supervising physician shall enter into a written or electronic practice agreement that spells out the roles and functions of the assistant.

1. The supervising physician shall be a doctor of medicine, osteopathy, or podiatry licensed in the Commonwealth who has accepted responsibility for the supervision of the service that a physician assistant renders.

2. Any such practice agreement shall take into account such factors as the physician assistant's level of competence, the number of patients, the types of illness treated by the physician, the nature of the treatment, special procedures, and the nature of the physician availability in ensuring direct physician involvement at an early stage and regularly thereafter.

3. The practice agreement shall also provide an evaluation process for the physician assistant's performance, including a requirement specifying the time period, proportionate to the acuity of care and practice setting, within which the supervising physician shall review the record of services rendered by the physician assistant.

4. The practice agreement may include requirements for periodic site visits by supervising licensees who supervise and direct assistants who provide services at a location other than where the licensee regularly practices.

B. The board may require information regarding the level of supervision with which the supervising physician plans to supervise the physician assistant for selected tasks. The board may also require the supervising physician to document the assistant's competence in performing such tasks.

C. If the role of the assistant includes prescribing for drugs and devices, the written practice agreement shall include those schedules and categories of drugs and devices that are within the scope of practice and proficiency of the supervising physician.

D. If the initial practice agreement did not include prescriptive authority, there shall be an addendum to the practice agreement for prescriptive authority.

E. If there are any changes in supervision, authorization, or scope of practice, a revised practice agreement shall be entered into at the time of the change.

18VAC85-50-110. Responsibilities of the supervisor.

The supervising physician shall:

1. Review the clinical course and treatment plan for any patient who presents for the same acute complaint twice in a single episode of care and has failed to improve as expected. The supervising physician shall be involved with any patient with a continuing illness as noted in the written or electronic practice agreement for the evaluation process.

2. Be responsible for all invasive procedures.

a. Under supervision, a physician assistant may insert a nasogastric tube, bladder catheter, needle, or peripheral intravenous catheter, but not a flow-directed catheter, and may perform minor suturing, venipuncture, and subcutaneous intramuscular or intravenous injection.

b. All other invasive procedures not listed in subdivision 2 a of this section must be performed under supervision with the physician in the room unless, after directly observing the performance of a specific invasive procedure three times or more, the supervising physician attests on the practice agreement to the competence of the physician assistant to perform the specific procedure without direct observation and supervision.

3. Be responsible for all prescriptions issued by the assistant and attest to the competence of the assistant to prescribe drugs and devices.

18VAC85-50-115. Responsibilities of the physician assistant.

A. The physician assistant shall not render independent health care and shall:

1. Perform only those medical care services that are within the scope of the practice and proficiency of the supervising physician as prescribed in the physician assistant's practice agreement. When a physician assistant is to be supervised by an alternate supervising physician outside the scope of specialty of the supervising physician, then the physician assistant's functions shall be limited to those areas not requiring specialized clinical judgment, unless a separate practice agreement for that alternate supervising physician is approved and on file with the board.

2. Prescribe only those drugs and devices as allowed in Part V (18VAC85-50-130 et seq.) of this chapter.

3. Wear during the course of performing his duties identification showing clearly that he is a physician assistant.

B. An alternate supervising physician shall be a member of the same group or professional corporation or partnership of any licensee who supervises a physician assistant or shall be a member of the same hospital or commercial enterprise with the supervising physician. Such alternating supervising physician shall be a physician licensed in the Commonwealth who has registered with the board and who has accepted responsibility for the supervision of the service that a physician assistant renders.

C. If, due to illness, vacation, or unexpected absence, the supervising physician or alternate supervising physician is unable to supervise the activities of his assistant, such supervising physician may temporarily delegate the responsibility to another doctor of medicine, osteopathic medicine, or podiatry.

Temporary coverage may not exceed four weeks unless special permission is granted by the board.

D. With respect to assistants employed by institutions, the following additional regulations shall apply:

1. No assistant may render care to a patient unless the physician responsible for that patient has signed the practice agreement to act as supervising physician for that assistant. The board shall make available appropriate forms for physicians to join the practice agreement for an assistant employed by an institution.

2. Any such practice agreement as described in subdivision 1 of this subsection shall delineate the duties which said physician authorizes the assistant to perform.

3. The assistant shall, as soon as circumstances may dictate, report an acute or significant finding or change in clinical status to the supervising physician concerning the examination of the patient. The assistant shall also record his findings in appropriate institutional records.

E. Practice by a physician assistant in a hospital, including an emergency department, shall be in accordance with § 54.1-2952 of the Code of Virginia.

18VAC85-50-116. Volunteer restricted license for certain physician assistants.

The issuance of a volunteer restricted license and the practice of a physician assistant under such a license shall be in accordance with the provisions of §54.1-2951.3 of the Code of Virginia.

18VAC85-50-117. Authorization to use fluoroscopy.

A physician assistant working under the supervision of a licensed doctor of medicine or osteopathy specializing in the field of radiology is authorized to use fluoroscopy for guidance of diagnostic and therapeutic procedures provided such activity is specified in his protocol and he has met the following qualifications:

1. Completion of at least 40 hours of structured didactic educational instruction and at least 40 hours of supervised clinical experience as set forth in the Fluoroscopy Educational Framework for the Physician Assistant created by the American Academy of Physician Assistants (AAPA) and the American Society of Radiologic Technologists (ASRT); and

2. Successful passage of the American Registry of Radiologic Technologists (ARRT) Fluoroscopy Examination.

Part V. Prescriptive Authority.

18VAC85-50-120. [Repealed]

18VAC85-50-130. Qualifications for approval of prescriptive authority.

An applicant for prescriptive authority shall meet the following requirements:

1. Hold a current, unrestricted license as a physician assistant in the Commonwealth;

2. Submit a practice agreement acceptable to the board prescribed in 18VAC85-50-101. This practice agreement must be approved by the board prior to issuance of prescriptive authority;

3. Submit evidence of successful passing of the NCCPA exam; and

4. Submit evidence of successful completion of a minimum of 35 hours of acceptable training to the board in pharmacology.

18VAC85-50-140. Approved drugs and devices.

A. The approved drugs and devices which the physician assistant with prescriptive authority may prescribe, administer, or dispense manufacturer's professional samples shall be in accordance with provisions of §54.1-2952.1 of the Code of Virginia:

B. The physician assistant may prescribe only those categories of drugs and devices included in the practice agreement as submitted for authorization. The supervising physician retains the authority to restrict certain drugs within these approved categories.

C. The physician assistant, pursuant to §54.1-2952.1 of the Code of Virginia, shall only dispense manufacturer's professional samples or administer controlled substances in good faith for medical or therapeutic purposes within the course of his professional practice.

18VAC85-50-150. (Repealed.)

18VAC85-50-160. Disclosure.

A. Each prescription for a Schedule II through V drug shall bear the name of the supervising physician and of the physician assistant.

B. The physician assistant shall disclose to the patient that he is a licensed physician assistant, and also the name, address and telephone number of the supervising physician. Such disclosure shall either be included on the prescription or be given in writing to the patient.

18VAC85-50-170. (Repealed.)

Part V. Standards of Professional Conduct.

18VAC85-50-175. Confidentiality.

A. A practitioner shall not willfully or negligently breach 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.

B. Unauthorized use or disclosure of confidential information received from the Prescription Monitoring Program shall be grounds for disciplinary action

18VAC85-50-176. Treating and prescribing for self or family.

A. Treating or prescribing shall be based on a bona fide practitioner-patient relationship, and prescribing shall meet the criteria set forth in § 54.1-3303 of the Code of Virginia.

B. A practitioner shall not prescribe a controlled substance to himself or a family member, other than Schedule VI as defined in § 54.1-3455 of the Code of Virginia, unless the prescribing occurs in an emergency situation or in isolated settings where there is no other qualified practitioner available to the patient, or it is for a single episode of an acute illness through one prescribed course of medication.

C. When treating or prescribing for self or family, the practitioner shall maintain a patient record documenting compliance with statutory criteria for a bona fide practitioner-patient relationship.

18VAC85-50-177. Patient records.

A. Practitioners shall comply with provisions of § 32.1-127.1:03 related to the confidentiality and disclosure of patient records.

B. Practitioners shall properly manage patient records and shall maintain timely, accurate, legible and complete records.

C. Practitioners shall provide patient records to another practitioner or to the patient or his personal representative in a timely manner and in accordance with provisions of § 32.1-127.1:03 of the Code of Virginia.

18VAC85-50-178. Practitioner-patient communication.

A. Except as provided in § 32.1-127.1:03 F of the Code of Virginia, a practitioner shall accurately inform a patient or his legally authorized representative of his medical diagnoses, prognosis and prescribed treatment or plan of care. A practitioner shall not deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a medication, treatment, or procedure prescribed or directed by the practitioner in the treatment of any disease or condition.
B. A practitioner shall present information relating to the patient's care to a patient or his legally authorized representative in understandable terms and encourage participation in the decisions regarding the patient's care.

C. Before surgery or any invasive procedure is performed, informed consent shall be obtained from the patient in accordance with the policies of the health care entity. Practitioners shall inform patients of the risks, benefits, and alternatives of the recommended surgery or invasive procedure that a reasonably prudent practitioner in similar practice in Virginia would tell a patient.

1. In the instance of a minor or a patient who is incapable of making an informed decision on his own behalf or is incapable of communicating such a decision due to a physical or mental disorder, the legally authorized person available to give consent shall be informed and the consent documented.

2. An exception to the requirement for consent prior to performance of surgery or an invasive procedure may be made in an emergency situation when a delay in obtaining consent would likely result in imminent harm to the patient.

3. For the purposes of this provision, "invasive procedure" shall mean any diagnostic or therapeutic procedure performed on a patient that is not part of routine, general care and for which the usual practice within the health care entity is to document specific informed consent from the patient or surrogate decision-maker prior to proceeding.

18VAC85-50-179. Practitioner responsibility.

A. A practitioner shall not:

1. Perform procedures or techniques that are outside the scope of his practice or for which he is not trained and individually competent;

2. Knowingly allow subordinates to jeopardize patient safety or provide patient care outside of the subordinate's scope of practice or area of responsibility. Practitioners shall delegate patient care only to subordinates who are properly trained and supervised;

3. Engage in an egregious pattern of disruptive behavior or interaction in a health care setting that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient; or

4. Exploit the practitioner/patient relationship for personal gain.

B. Advocating for patient safety or improvement in patient care within a health care entity shall not constitute disruptive behavior provided the practitioner does not engage in behavior prohibited in A 3 of this section.

18VAC85-50-180. Vitamins, minerals and food supplements.

A. The recommendation or direction for the use of vitamins, minerals or food supplements and the rationale for that recommendation shall be documented by the practitioner. The recommendation or direction shall be based upon a reasonable expectation that such use will result in a favorable patient outcome, including preventive practices, and that a greater benefit will be achieved than that which can be expected without such use.

B. Vitamins, minerals, or food supplements, or a combination of the three, shall not be sold, dispensed, recommended, prescribed, or suggested in doses that would be contraindicated based on the individual patient's overall medical condition and medications.

C. The practitioner shall conform to the standards of his particular branch of the healing arts in the therapeutic application of vitamins, minerals or food supplement therapy.

18VAC85-50-181. Pharmacotherapy for weight loss.

A.A practitioner shall not prescribe amphetamine, Schedule II, for the purpose of weight reduction or control.

B. A practitioner shall not prescribe controlled substances, Schedules III through VI, for the purpose of weight reduction or control in the treatment of obesity, unless the following conditions are met:

1. An appropriate history and physical examination, are performed and recorded at the time of initiation of pharmacotherapy for obesity by the prescribing physician, and the physician reviews the results of laboratory work, as indicated, including testing for thyroid function;

2. If the drug to be prescribed could adversely affect cardiac function, the physician shall review the results of an electrocardiogram performed and interpreted within 90 days of initial prescribing for treatment of obesity;

3. A diet and exercise program for weight loss is prescribed and recorded;

4. The patient is seen within the first 30 days following initiation of pharmacotherapy for weight loss, by the prescribing physician or a licensed practitioner with prescriptive authority working under the supervision of the prescribing physician, at which time a recording shall be made of blood pressure, pulse, and any other tests as may be necessary for monitoring potential adverse effects of drug therapy;

5. The treating physician shall direct the follow-up care, including the intervals for patient visits and the continuation of or any subsequent changes in pharmacotherapy. Continuation of prescribing for treatment of obesity shall occur only if the patient has continued progress toward achieving or maintaining a target weight and has no significant adverse effects from the prescribed program.

C. If specifically authorized in his practice agreement with a supervising physician, a physician assistant may perform the physical examination, review tests, and prescribe Schedules III through VI controlled substances for treatment of obesity as specified in subsection B of this section.

18VAC85-50-182. Anabolic steroids.

A physician assistant shall not prescribe or administer anabolic steroids to any patient for other than accepted therapeutic purposes.

18VAC85-50-183. Sexual contact.

A. For purposes of § 54.1-2915 A 12 and A 19 of the Code of Virginia and this section, sexual contact includes, but is not limited to, sexual behavior or verbal or physical behavior which:

1. May reasonably be interpreted as intended for the sexual arousal or gratification of the practitioner, the patient, or both; or

2. May reasonably be interpreted as romantic involvement with a patient regardless of whether such involvement occurs in the professional setting or outside of it.

B. Sexual contact with a patient.

1. The determination of when a person is a patient for purposes of § 54.1-2915 A 19 of the Code of Virginia is made on a case-by-case basis with consideration given to the nature, extent, and context of the professional relationship between the practitioner and the person. The fact that a person is not

actively receiving treatment or professional services from a practitioner is not determinative of this issue. A person is presumed to remain a patient until the patient-practitioner relationship is terminated.

2. The consent to, initiation of, or participation in sexual behavior or involvement with a practitioner by a patient does not change the nature of the conduct nor negate the statutory prohibition.

C. Sexual contact between a practitioner and a former patient.

Sexual contact between a practitioner and a former patient after termination of the practitioner-patient relationship may still constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge, or influence of emotions derived from the professional relationship.

D. Sexual contact between a practitioner and a key third party shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care. For purposes of this section, key third party of a patient shall mean: spouse or partner, parent or child, guardian, or legal representative of the patient.

E. Sexual contact between a supervisor and a trainee shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care.

18VAC85-50-184. Refusal to provide information.

A practitioner shall not willfully refuse to provide information or records as requested or required by the board or its representative pursuant to an investigation or to the enforcement of a statute or regulation.

DOCUMENTS INCORPORATED BY REFERENCE

Fluoroscopy Educational Framework for the Physician Assistant, December 2009, American Academy of Physician Assistants, 950 North Washington Street, Alexandria, VA 22314 and the American Society of Radiologic Technologists, 15000 Central Avenue, SE, Albuquerque, NM 87123