Executive Committee Meeting

Virginia Board of Medicine
August 6, 2021
8:30 a.m.

Executive Committee

Friday, August 6, 2021 @ 8:30 a.m.
Perimeter Center
9960 Mayland Drive, Suite 201, Board Room 4
Henrico, VA 23233

Call to Order and Roll Call

Emergency Egress Procedures

Approval of Minutes from April 9, 2021 1

Adoption of Agenda

Public Comment on Agenda Items

DHP Director's Report .....-----

Reports of President and Executive Director .....

- President.....-------
- Executive Director .....-------

New Business:

1. Regulatory and Legislative Issues – Elaine Yeatts

- Chart of Regulatory Actions as of July 28, 2021 8
- DHP Regulatory/Policy Actions – 2021 General Assembly for Board of Medicine 9

2. Regulatory Action – Adoption of emergency regulations – OT Interjurisdictional Compact..... 12

3. Adoption of Exempt Regulations Pursuant to 2021 Legislation 29

4. Adoption of Proposed Regulations for Clinical Nurse Specialist Registration as a Fast-Track Action.....57

5. Board Action – Adoption of Notice of Intended Regulatory Action (NOIRA) Licensed Certified Midwives.....61

6. Adoption of Final Regulation for Waiver of Electronic Prescribing (Nurse Practitioners) 81

7. Guidance Document – Revision of 90-56 (Practice Agreements for Nurse Practitioners) 83

8. Report on the Implementation of HB 793 (2018).....86

9. Announcements/Reminders .....

====No motion needed to adjourn if all business has been conducted====

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

Board Room 4

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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---

VIRGINIA BOARD OF MEDICINE
EXECUTIVE COMMITTEE MINUTES – VIRTUAL MEETING

Friday, April 9, 2021 Department of Health Professions Henrico, VA

CALL TO ORDER: Mr. Marchese called the virtual meeting of the Executive Committee to order at 8:33 a.m.

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

MEMBERS PRESENT:
Blanton Marchese – Vice-President
David Archer, MD - Secretary-Treasurer
Alvin Edwards, MDiv, PhD
Jane Hickey, JD
Karen Ransone, MD
Joel Silverman, MD
Brenda Stokes, MD

MEMBERS ABSENT: Lori Conklin, MD – President, Chair

STAFF PRESENT:
William L. Harp, MD - Executive Director
Jennifer Deschenes, JD – Deputy Exec. Director for Discipline
Colanthia Morton Opher - Deputy Exec. Director for Administration
Michael Sobowale, LLM - Deputy Exec. Director for Licensure
David Brown, DC - DHP Director
Barbara Allison-Bryan, MD - DHP Deputy Director
Elaine Yeatts - DHP Senior Policy Analyst
Erin Barrett, JD - Assistant Attorney General

OTHERS PRESENT:
Richard Grossman
Valentina Vega
Jennie Wood – Board Staff
Ben Traynham, JD – Hancock Daniel
Tamika Hines - Board Staff
Christina …
LeVar Bowers
Clark Barrineau -MSV
Alicia Cundiff –Spotts Fain
Scott Castro - MSV
K. Wilkinson

EMERGENCY EGRESS INSTRUCTIONS

Mr. Marchese provided the emergency egress instructions for those in the building.

MOMENT OF SILENCE

The Board observed a moment of silence for the passing of the Honorable William E. Quarles, Jr., member of the Board of Medicine's Advisory Board on Radiologic Technology.

PUBLIC HEARING

Mr. Marchese opened the floor for public comment on the proposed regulations prohibiting Conversion Therapy.

Hearing no comment, Mr. Marchese reminded everyone that comment can still be posted on Regulatory Townhall or sent by email to Elaine Yeatts, Policy until April 16, 2021.

APPROVAL OF MINUTES OF DECEMBER 4, 2020

Dr. Ransone moved to approve the meeting minutes from December 4, 2020 as presented. The motion was seconded by Dr. Edwards and carried unanimously.

ADOPTION OF AGENDA

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

PUBLIC COMMENT

The Board acknowledged written comment submitted by the Medical Society of Virginia (MSV). The letter supported the recommendation of the Board's Legislative Committee not to join the Interstate Medical Licensure Compact at this time and encouraged the Executive Committee to confirm it. Additionally, MSV voiced its continued support of the licensure by endorsement pathway as well as revision of the medical malpractice question to better focus on paid claims or pending claims. MSV commented that the revision would not disqualify an applicant solely on the basis of a frivolous or retributive lawsuit.

DHP DIRECTOR'S REPORT

Dr. Brown provided an update on Diversity, Equity and Inclusion (DEI) in the Commonwealth and at DHP. He advised that Governor Northam appointed Dr. Underwood to a cabinet level position as the Chief Diversity Officer for Virginia. The 2021 General Assembly passed legislation mandating that all state agencies adopt a strategic plan on DEI. DHP was one of the pilot agencies to develop this process, which is consistent with DHP's past efforts addressing other government-wide issues. Dr. Brown said that several years ago, the agency was mandated to do a succession planning report. One of the weaknesses identified was the lack of diversity in senior management. Since that time, this issue has been addressed by expanding the hiring process to ensure a more diverse pool of applicants for positions that have a path to leadership in the agency. He noted that the last in-house staff training day in 2019 was entirely devoted to DEI issues, that there is an ongoing series of Lunch and Learns on unconscious bias, and that DHP has established an internal DEI Council. DHP intends to

present this topic at the next in-person board member training with assistance from organizations that support the boards in DHP, such as the Federation of State Medical Boards (FSMB).

Dr. Brown then provided an update on the recently approved legislation to legalize adult use of marijuana. He said it has been signed into law even though some of the programmatic effects are a couple of years away. Effective July 1, 2021, possession of small amounts of marijuana will be legal. The law will need to be re-enacted next year as the legislators will take a careful look at it this year. The law also reflected a change in the Governor's original idea by creating a new agency to regulate marijuana. The new agency will not only regulate adult use, but it will also regulate medical use. Accordingly, the pharmaceutical processor program will be transferred from the Board of Pharmacy to the new agency in 2023. The entire scope of these processes is expected to be in effect in 2024. Dr. Brown also provided an update to the changes in the medical cannabis oil-based program.

Dr. Allison-Bryan provided an update on the vaccine efforts in Virginia. She noted that 1/3 of the population has gotten at least one shot of vaccine. The numbers continue to go up daily, nearly 80,000 a day. The big news is that all of Virginia will enter Phase 2 on April 18. Dr. Allison-Bryan then shared a website called the Kaiser Family Foundation COVID Website. She said that it looks at some of the demographics related to the vaccine. The website is updated every two weeks, and it addresses some very interesting questions. In February, vaccine hesitancy among different ethnic/racial groups equalized, and now the African-American population is getting the vaccine at a higher rate. Dr. Allison-Bryan thinks this speaks well of the efforts that the local health departments have put into education and reassurance about the vaccines.

Dr. Edwards commented on the statement about the health departments' efforts to educate and reassure the African-American population about the vaccine. He said there were some vaccination disparities, and that it was not until the pastors' council got involved and approached Dr. Oliver, Commissioner of Health. The pastors explained what they thought was going on, and subsequently more African-Americans were able to obtain the vaccine. Mr. Marchese said that from his observation, the trust level in the African-American community changed once the churches got involved.

Dr. Ransone asked what role physicians will play once it is legal for adults to possess marijuana. Dr. Brown said there is an expectation that there will always be a role for the physician-supervised medical use of cannabis. The medical program is moving forward witn the pharmaceutical processors having up to 5 additional dispensaries in their region. As far as adult use goes, localities may have opt-in or opt-out choices.

Dr. Harp added the law regarding medicinal marijuana products requires that the Supreme Court to work with the Board of Medicine to update the certificate form, DC-307. The revised form should be available July 1, 2021 and most likely the language will refer to cannabis products instead of cannabis-based oils.

PRESIDENT'S REPORT

No report.

EXECUTIVE DIRECTOR'S REPORT

Dr. Harp provided a brief report on the Board's finances, case hours for Enforcement and Administrative Proceedings, and the Health Practitioners' Monitoring Program.

Dr. Harp also provided an update on opioid waiver requests, electronic meetings, and reciprocity with contiguous jurisdictions.

Dr. Brown informed the members that the COVID-19 landscape is improving quickly with some geographic variance throughout the state. He said that as the Commonwealth is opening up, DHP will revisit the policy on resuming in-person meetings.

Dr. Harp ended his report by announcing that FSMB has awarded the John H. Clark, MD Award for Leadership to Kevin O'Connor, MD, past president of the Board of Medicine.

NEW BUSINESS

1. Chart of Regulatory Actions and Reaffirmation of Guidance Document 85-14

Ms. Yeatts presented the chart for review only.

She then addressed Guidance Document 85-14 – Enforcement of Continuing Competency Requirements, and said that every 4 years, guidance documents must be reviewed and reaffirmed, amended, or repealed. She noted that staff recommends the Board reaffirm the current guidance in 85-14.

MOTION: Dr. Stokes moved to reaffirm 85-14 as included in the agenda packet. The motion was seconded by Dr. Ransone and carried unanimously.

2. Recommendation from the Legislative Committee regarding the Interstate Medical Licensure Compact (IMLC)

Mr. Marchese reminded the members of the letter of support received from MSV presented during public comment. He said that the Legislative Committee met on January 15, 2021 and discussed the advantages and disadvantages of joining the IMLC. After deliberation, the recommendation of the Legislative Committee was not to join the IMLC at this time.

MOTION: Dr. Ransone moved to confirm the recommendation of the Legislative Committee not to join the IMLC at this time. The motion was seconded by Dr. Archer and carried unanimously.

3. Recommendation of the Advisory Board on Midwifery regarding Guidance Document 85-10

Dr. Harp said this was a pro forma item; it was originally to be addressed at the February Board meeting. He provided the history on the development of Guidance Document 85-10. The

document is due to be reviewed for reaffirmation or possible updating. Dr. Harp said the Advisory Board had already identified some points in the document that may need to be updated. The original document was developed by a work group of Advisory Board members and Board of Medicine members. Repeating this process will ensure that agreed upon, evidence-based revisions will occur. At this time, no date has been set, but it is anticipated that Dr. Barner, Dr. Archer, Kim Pekin, CPM, Becky Banks, CPM, Erin Hammer, CPM, and Dr. Conklin as chair will constitute this work group.

MOTION: Dr. Ransone moved to approve the formation of a work group of 3 Advisory Board members and 3 Board of Medicine members to review and revise Guidance Document 85-10. The motion was seconded by Dr. Stokes and carried unanimously.

4. Recommendations from Board Staff on the Licensure by Endorsement Pathway

Dr. Harp reminded the Committee of the requirements for licensure by endorsement. He then said endorsement is supposed to be the "express train", with no equivocal information or answers. He pointed out that the current structure of the application intends that all the answers be "No", including the malpractice question. Staff has noticed that there are applications where the answer to the current malpractice question is "No", but NPDB comes back with a report that may indicate there are other malpractice suits that have been closed. Staff thinks that the application, the applicants and the process would be better served if the current question was changed to "**Have you had any malpractice paid claims in the last 10 years, or do you have any pending malpractice suits?"** Dr. Harp stated that this change would provide better protection for the public, close a loophole, and make the application more pristine. He then suggested that this same language be used in the traditional pathway application.

MOTION: Dr. Ransone moved to accept the suggested language change for both the endorsement and the traditional applications. The motion was seconded by Dr. Edwards and carried unanimously.

Dr. Harp said when the Board contemplated joining the IMLC in 2016, speed of licensure was one aspect that was considered. In 2021, the question remains if the Board can, through endorsement, match or exceed the speed that the Compact provides. Dr. Harp stated that as the Board has gained experience with the endorsement process, it has become evident that there are two groups that apply through endorsement - those who want a license quickly and those that want an easier process. The IMLC is about expeditious licensure, and going forward, if the Board is to compare licensure by endorsement to the Compact, he suggested a binary count to capture more accurate processing times for endorsement. Staff considered processing times and agreed that 45 days or less to licensure would be about speed, and longer than 45 days to licensure would reflect the group that wanted an easy pathway. Being able to separate these 2 groups statistically would provide a clearer picture for the Board as it assesses the endorsement pathway and the IMLC in the future.

MOTION: Dr. Archer moved to accept the binary count with 45 days being the breakpoint. Dr. Ransone seconded.

Dr. Stokes asked for clarification of the process for applications over 45 days.

Mr. Sobowale said there are some individuals that submit required documentation in the 12th month of an endorsement application. This inflates the numbers for endorsement processing times. The plan will be to send a reminder at the 30-day mark to all who have applied through endorsement. After 45 days, those who have not responded to the notification will be moved to the traditional pathway.

Mr. Marchese reminded the members that the burden is on the applicant to get their supporting documentation to the Board, and that with this notification, staff is going above and beyond to move the process along.

Dr. Archer asked if it would be advantageous to add a checkbox for the applicant to indicate if their desire was to obtain the license quickly, thereby giving staff some preview as to what the intentions were. If so, staff could complete the process in 45 days or less.

Following up on Mr. Sobowale's comments and Dr. Archer's question, Dr. Harp stated that there was no way to exclude any applicant that qualifies for licensure by endorsement with a checkbox at the beginning of the application process. He also stated that after 45 days, incomplete applications should not be transitioned to the traditional pathway, but rather kept in endorsement and just provide the binary numbers which will be helpful when revisiting the Compact. Moving an application to the traditional pathway after 45 days may ruffle some feathers.

After some discussion, the motion carried unanimously.

Licensing Report

Mr. Sobowale provided statistics from July 2020 to the present. The Board has issued over 5,000 new licenses, more than half of which were in the 5 expedited professions. He noted that last fall the Board gained a new profession, licensed surgical assistants. Mr. Sobowale said that across all the professions, the license processing time is approximately 60 days from start to finish. From April 1, 2020 to April 1, 2021, there have been 2,787 MD licenses and 508 DO licenses issued with the number of days ranging from 1 – 366 days. For the first quarter of this year, the Board has issued 421 MD and 82 DO licenses. This report was for information only and did not require any action.

Mr. Marchese expressed his appreciation for the expertise and knowledge Mr. Sobowale brings to the job, and the work he is doing to streamline the licensing process.

Discipline Report

Ms. Deschenes briefly went over the discipline numbers pre-pandemic and during COVID-19. She pointed to the notable number of 97 PHCO's in 2020 compared to 68 in 2019. Adjudication has not slowed much during the pandemic. She noted that one concern is the formal hearings that need to be scheduled; most of them are not amenable to being held virtually.

ANNOUNCEMENTS

---DRAFT UNAPPROVED---

There were no announcements.

The next meeting of the Executive Committee will be August 6, 2021 @ 8:30 a.m.

ADJOURNMENT

With no additional business, the meeting adjourned at 10:16 a.m.

Blanton Marchese
Vice- President

William L. Harp, MD
Executive Director

Colanthia M. Opher
Recording Secretary

Agenda Item:
Regulatory Actions - Chart of Regulatory Actions
As of July 28, 2021

Chapter		Action / Stage Information
[18 VAC 85 20]	Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic	Conversion therapy [Action 5412] Final - *At Secretary's Office for 1 day*
[18 VAC 85 50]	Regulations Governing the Practice of Physician Assistants	(E) Conforming regulations to 2021 legislation - patient care team physician [Action 5762] Final - *Register Date: 8/16/21* *Effective: 9/15/21*
[18 VAC 85 160]	Regulations Governing the Licensure of Surgical Assistants and Registration of Surgical Technologists	Amendments for surgical assistants consistent with a licensed profession [Action 5639] Proposed - *AT Attorney General's Office* [Stage 9324]
[18 VAC 85 160]	Regulations Governing the Licensure of Surgical Assistants and Registration of Surgical Technologists	(E) Conforming regulations to 2021 legislation - certification of surgical technologists [Action 5761] Final - *Register Date: 8/2/21* *Effective: 9/15/21*
[18 VAC 85 170]	Regulations Governing the Practice of Genetic Counselors	(E) Conforming to 2021 legislation - repeal of conscience clause [Action 5764] Final - *Register Date: 8/2/21* *Effective: 9/15/21*

Department of Health Professions
Regulatory/Policy Actions – 2021 General Assembly
Board on Medicine

EMERGENCY REGULATIONS:

Legislative source	Mandate	Promulgating agency	Board adoption date	Effective date Within 280 days of enactment
SB1189	Occupational therapy compact	Medicine	8/6/21	**By 12/23/21**

EXEMPT REGULATORY ACTIONS

Legislative source	Mandate	Promulgating agency	Adoption date	Effective date
HB1737	Revise autonomous practice reg consistent with 2 years	Nursing & Medicine	N – 7/20/21 M – 8/6/21	
HB1747	Licensure of CNS as nurse practitioners – Amend Chapters 30 and 40 Delete sections of Chapter 20 with reference to registration of CNS	Nursing & Medicine	N – 7/20/21 M – 8/6/21	
HB1817	Autonomous practice for CNMs with 1,000 hours	Nursing & Medicine	N – 7/20/21 M – 8/6/21	
HB1988	Changes to pharmaceutical processors	Pharmacy	7/6/21	By Sept. 1st
HB2218/SB1333	Sale of cannabis botanical products	Pharmacy	7/6/21	By Sept. 1st
HB2039	Conform PA regs to Code	Medicine	6/24/21	After July 1
HB2220	Change registration of surgical technologists to certification	Medicine	6/21/21	After July 1
SB1178	Delete reference to conscience clause in regs for genetic counselors	Medicine	6/24/21	After July 1

APA REGULATORY ACTIONS

Legislative source	Mandate	Promulgating agency	Adoption date	Effective date
HB1953	Licensure of certified midwives	Nursing & Medicine	NOIRA Nursing – 7/20/21 Medicine – 8/6/21	Unknown

NON-REGULATORY ACTIONS

Legislative source	Affected agency	Action needed	Due date
HB1747	Nursing	Notification to registered certified	After March 31,

		nurse specialists that they must have a practice agreement with a physician before licensure as a nurse practitioner as of July 1, 2021	2021
HB793 (2018)	Medicine & Nursing	To report data on the number of nurse practitioners who have been authorized to practice without a practice agreement, the geographic and specialty areas in which nurse practitioners are practicing without a practice agreement, and any complaints or disciplinary actions taken against such nurse practitioners, along with any recommended modifications to the requirements of this act including any modifications to the clinical experience requirements for practicing without a practice agreement	November 1, 2021
SB431	Behavioral health/medicine/legal	Continuance of study of mental health services to minors and access to records *Requested an extension of 2020 study*	November 1, 2021
Budget bill	Department	To study and make recommendations regarding the oversight and regulation of advanced practice registered nurses (APRNs). The department shall review recommendations of the National Council of State Boards of Nursing, analyze the oversight and regulations governing the practice of APRNs in other states, and review research on the impact of statutes and regulations on practice and patient outcomes.	November 1, 2021
HB1953	Department	To convene a work group to study and report on the licensure and regulation of certified nurse midwives, certified midwives, and certified professional midwives to determine the appropriate licensing entity for such professionals.	November 1, 2021
HB1987	Boards with prescriptive authority	Revise guidance documents with references to 54.1-3303	As boards meet after July 1
HB2079	Pharmacy (with Medicine & VDH)	To establish protocols for the initiation of treatment with and dispensing and administering of drugs, devices, controlled paraphernalia, and supplies and	Concurrent with emergency regulations

		equipment available over-the-counter by pharmacists in accordance with § **54.1-3303.1**. Such protocols shall address training and continuing education for pharmacists regarding the initiation of treatment with and dispensing and administering of drugs, devices, controlled paraphernalia, and supplies and equipment.	
HB2079	Pharmacy	To convene a work group to provide recommendations regarding the development of protocols for the initiation of treatment with and dispensing and administering of drugs, devices, controlled paraphernalia, and supplies and equipment by pharmacists to persons 18 years of age or older, including (i) controlled substances, devices, controlled paraphernalia, and supplies and equipment for the treatment of diseases or conditions for which clinical decision-making can be guided by a clinical test that is classified as waived under the federal Clinical Laboratory Improvement Amendments of 1988, including influenza virus, urinary tract infection, and group A Streptococcus bacteria, and (ii) drugs approved by the U.S. Food and Drug Administration for tobacco cessation therapy, including nicotine replacement therapy. The work group shall focus its work on developing protocols that can improve access to these treatments while maintaining patient safety.	November 1, 2021

Future Policy Actions:

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**.

Agenda Item: Regulatory Action – Adoption of emergency regulations

Staff Note:

SB1189 of the 2021 General Assembly adopted the Occupational Therapy Interjurisdictional Compact with Virginia to become the first member state.

Regulations to implement the Compact must include a fee for a compact privilege to practice in Virginia and changes to ensure OTs and OTAs practicing in Virginia on a compact privilege are held to the same standards of practice and ethical conduct as those licensed by the Virginia Board of Medicine.

Regulations were discussed with the Advisory Board of Occupational Therapy on May 25th.

The Administrative Process Act authorizes a regulatory board to adopt "emergency" regulations when the legislation requires regulations to be effective within 280 days of enactment.

Action: Motion to approve emergency regulations for implementation of the Occupational Therapy Compact and to adopt a Notice of Intended Regulatory Action to replace the emergency regulations.

VIRGINIA ACTS OF ASSEMBLY -- 2021 SPECIAL SESSION I

CHAPTER 242

An Act to amend the Code of Virginia by adding a section numbered 54.1-2956.7:1, relating to Occupational Therapy Interjurisdictional Licensure Compact.

[S 1189]

Approved March 18, 2021

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 54.1-2956.7:1 as follows:

§ 54.1-2956.7:1. Occupational Therapy Interjurisdictional Licensure Compact.

The General Assembly hereby enacts, and the Commonwealth of Virginia hereby enters into, the Occupational Therapy Interjurisdictional Licensure Compact with any and all states legally joining therein according to its terms, in the form substantially as follows:

OCCUPATIONAL THERAPY INTERJURISDICTIONAL LICENSURE COMPACT.

Article I. Purpose.

The purpose of this Compact is to facilitate interstate practice of occupational therapy with the goal of improving public access to occupational therapy services. The practice of occupational therapy occurs in the state where the patient/client is located at the time of the patient/client encounter. The Compact preserves the regulatory authority of states to protect public health and safety through the current system of state licensure.

This Compact is designed to achieve the following objectives:

1. Increase public access to occupational therapy services by providing for the mutual recognition of other member state licenses;

2. Enhance the states' ability to protect the public's health and safety;

3. Encourage the cooperation of member states in regulating multi-state occupational therapy practice;

4. Support spouses of relocating military members;

5. Enhance the exchange of licensure, investigative, and disciplinary information between member states;

6. Allow a remote state to hold a provider of services with a compact privilege in that state accountable to that state's practice standards; and

7. Facilitate the use of telehealth technology in order to increase access to occupational therapy services.

Article II. Definitions.

As used in this Compact, and except as otherwise provided, the following definitions shall apply:

"Active duty military" means full-time duty status in the active uniformed service of the United States, including members of the National Guard and Reserve on active duty orders pursuant to 10 U.S.C. Chapter 1209 and Section 1211.

"Adverse action" means any administrative, civil, equitable, or criminal action permitted by a state's laws which is imposed by a licensing board or other authority against an occupational therapist or occupational therapy assistant, including actions against an individual's license or compact privilege such as censure, revocation, suspension, probation, monitoring of the licensee, or restriction on the licensee's practice.

"Alternative program" means a non-disciplinary monitoring process approved by an occupational therapy licensing board.

"Compact" means the Occupational Therapy Interjurisdictional Licensure Compact.

"Compact privilege" means the authorization, which is equivalent to a license, granted by a remote state to allow a licensee from another member state to practice as an occupational therapist or practice as an occupational therapy assistant in the remote state under its laws and rules. The practice of occupational therapy occurs in the member state where the patient/client is located at the time of the patient/client encounter.

"Continuing competence/education" means a requirement, as a condition of license renewal, to provide evidence of participation in, and/or completion of, educational and professional activities relevant to practice or area of work.

"Current significant investigative information" means investigative information that a licensing board, after an inquiry or investigation that includes notification and an opportunity for the occupational therapist or occupational therapy assistant to respond, if required by state law, has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction.

"Data system" means a repository of information about licensees, including but not limited to license status, investigative information, compact privileges, and adverse actions.

"Encumbered license" means a license in which an adverse action restricts the practice of occupational therapy by the licensee or said adverse action has been reported to the National Practitioners Data Bank (NPDB).

"Executive committee" means a group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the Commission.

"Home state" means the member state that is the licensee's primary state of residence.

"Impaired practitioner" means individuals whose professional practice is adversely affected by substance abuse, addiction, or other health-related conditions.

"Investigative information" means information, records, and/or documents received or generated by an occupational therapy licensing board pursuant to an investigation.

"Jurisprudence requirement" means the assessment of an individual's knowledge of the laws and rules governing the practice of occupational therapy in a state.

"Licensee" means an individual who currently holds an authorization from the state to practice as an occupational therapist or as an occupational therapy assistant.

"Member state" means a state that has enacted the Compact.

"Occupational therapist" means an individual who is licensed by a state to practice occupational therapy.

"Occupational therapy assistant" means an individual who is licensed by a state to assist in the practice of occupational therapy.

"Occupational therapy," "occupational therapy practice," and the "practice of occupational therapy" mean the care and services provided by an occupational therapist or an occupational therapy assistant as set forth in the member state's statutes and regulations.

"Occupational Therapy Compact Commission" or "Commission" means the national administrative body whose membership consists of all states that have enacted the Compact.

"Occupational therapy licensing board" or "licensing board" means the agency of a state that is authorized to license and regulate occupational therapists and occupational therapy assistants.

"Primary state of residence" means the state (also known as the home state) in which an occupational therapist or occupational therapy assistant who is not active duty military declares a primary residence for legal purposes as verified by: driver's license, federal income tax return, lease, deed, mortgage or voter registration or other verifying documentation as further defined by Commission rules.

"Remote state" means a member state other than the home state, where a licensee is exercising or seeking to exercise the compact privilege.

"Rule" means a regulation promulgated by the Commission that has the force of law.

"State" means any state, commonwealth, district, or territory of the United States of America that regulates the practice of occupational therapy.

"Single-state license" means an occupational therapist or occupational therapy assistant license issued by a member state that authorizes practice only within the issuing state and does not include a compact privilege in any other member state.

"Telehealth" means the application of telecommunication technology to deliver occupational therapy services for assessment, intervention, and/or consultation.

Article III. State Participation in the Compact.

A. To participate in the Compact, a member state shall:

1. License occupational therapists and occupational therapy assistants;

2. Participate fully in the Commission's data system, including but not limited to using the Commission's unique identifier as defined in rules of the Commission;

3. Have a mechanism in place for receiving and investigating complaints about licensees;

4. Notify the Commission, in compliance with the terms of the Compact and rules, of any adverse action or the availability of investigative information regarding a licensee;

5. Implement or utilize procedures for considering the criminal history records of applicants for an initial compact privilege. These procedures shall include the submission of fingerprints or other biometric-based information by applicants for the purpose of obtaining an applicant's criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that state's criminal records;

a. A member state shall, within a time frame established by the Commission, require a criminal background check for a licensee seeking/applying for a compact privilege whose primary state of residence is that member state, by receiving the results of the Federal Bureau of Investigation criminal record search, and shall use the results in making licensure decisions.

b. Communication between a member state, the Commission and among member states regarding the verification of eligibility for licensure through the Compact shall not include any information received from the Federal Bureau of Investigation relating to a federal criminal records check performed by a member state under P.L. 92-544.

6. Comply with the rules of the Commission;

7. Utilize only a recognized national examination as a requirement for licensure pursuant to the

rules of the Commission; and

8. Have continuing competence/education requirements as a condition for license renewal.

B. A member state shall grant the compact privilege to a licensee holding a valid unencumbered license in another member state in accordance with the terms of the Compact and rules.

C. Member states may charge a fee for granting a compact privilege.

D. A member state shall provide for the state's delegate to attend all Occupational Therapy Compact Commission meetings.

E. Individuals not residing in a member state shall continue to be able to apply for a member state's single-state license as provided under the laws of each member state. However, the single-state license granted to these individuals shall not be recognized as granting the compact privilege in any other member state.

F. Nothing in this Compact shall affect the requirements established by a member state for the issuance of a single-state license.

Article IV. Compact Privilege.

A. To exercise the compact privilege under the terms and provisions of the Compact, the licensee shall:

1. Hold a license in the home state;

2. Have a valid United States social security number or national practitioner identification number;

3. Have no encumbrance on any state license;

4. Be eligible for a compact privilege in any member state in accordance with subsections D, F, G, and H;

5. Have paid all fines and completed all requirements resulting from any adverse action against any license or compact privilege, and two years have elapsed from the date of such completion;

6. Notify the Commission that the licensee is seeking the compact privilege within a remote state(s);

7. Pay any applicable fees, including any state fee, for the compact privilege;

8. Complete a criminal background check in accordance with subdivision A 5 of Article III. The licensee shall be responsible for the payment of any fee associated with the completion of a criminal background check;

9. Meet any jurisprudence requirements established by the remote state(s) in which the licensee is seeking a compact privilege; and

10. Report to the Commission adverse action taken by any non-member state within 30 days from the date the adverse action is taken.

B. The compact privilege is valid until the expiration date of the home state license. The licensee must comply with the requirements of subsection A to maintain the compact privilege in the remote state.

C. a licensee providing occupational therapy in a remote state under the compact privilege shall function within the laws and regulations of the remote state.

D. Occupational therapy assistants practicing in a remote state shall be supervised by an occupational therapist licensed or holding a compact privilege in that remote state.

E. A licensee providing occupational therapy in a remote state is subject to that state's regulatory authority. A remote state may, in accordance with due process and that state's laws, remove a licensee's compact privilege in the remote state for a specific period of time, impose fines, and/or take any other necessary actions to protect the health and safety of its citizens. The licensee may be ineligible for a compact privilege in any state until the specific time for removal has passed and all fines are paid.

F. If a home state license is encumbered, the licensee shall lose the compact privilege in any remote state until the following occur:

1. The home state license is no longer encumbered; and

2. Two years have elapsed from the date on which the home state license is no longer encumbered in accordance with subdivision 1.

G. Once an encumbered license in the home state is restored to good standing, the licensee must meet the requirements of subsection A to obtain a compact privilege in any remote state.

H. If a licensee's compact privilege in any remote state is removed, the individual may lose the compact privilege in any other remote state until the following occur:

1. The specific period of time for which the compact privilege was removed has ended;

2. All fines have been paid and all conditions have been met;

3. Two years have elapsed from the date of completing requirements for subdivisions 1 and 2; and

4. The compact privileges are reinstated by the Commission, and the compact data system is updated to reflect reinstatement.

I. If a licensee's compact privilege in any remote state is removed due to an erroneous charge, privileges shall be restored through the compact data system.

J. Once the requirements of subsection H have been met, the license must meet the requirements in subsection A to obtain a compact privilege in a remote state.

Article V. Obtaining a New Home State License by Virtue of Compact Privilege.

A. An occupational therapist or occupational therapy assistant may hold a home state license, which

allows for compact privileges in member states, in only one member state at a time.

B. If an occupational therapist or occupational therapy assistant changes primary state of residence by moving between two member states:

1. The occupational therapist or occupational therapy assistant shall file an application for obtaining a new home state license by virtue of a compact privilege, pay all applicable fees, and notify the current and new home state in accordance with applicable rules adopted by the Commission.

2. Upon receipt of an application for obtaining a new home state license by virtue of compact privilege, the new home state shall verify that the occupational therapist or occupational therapy assistant meets the pertinent criteria outlined in Article IV via the data system, without need for primary source verification except for:

a. An FBI fingerprint based criminal background check if not previously performed or updated pursuant to applicable rules adopted by the Commission in accordance with P.L. 92-544;

b. Other criminal background check as required by the new home state; and

c. Submission of any requisite jurisprudence requirements of the new home state.

3. The former home state shall convert the former home state license into a compact privilege once the new home state has activated the new home state license in accordance with applicable rules adopted by the Commission.

4. Notwithstanding any other provision of this Compact, if the occupational therapist or occupational therapy assistant cannot meet the criteria in Article IV, the new home state shall apply its requirements for issuing a new single-state license.

5. The occupational therapist or the occupational therapy assistant shall pay all applicable fees to the new home state in order to be issued a new home state license.

C. If an occupational therapist or occupational therapy assistant changes primary state of residence by moving from a member state to a non-member state, or from a non-member state to a member state, the state criteria shall apply for issuance of a single-state license in the new state.

D. Nothing in this compact shall interfere with a licensee's ability to hold a single-state license in multiple states; however, for the purposes of this compact, a licensee shall have only one home state license.

E. Nothing in this Compact shall affect the requirements established by a member state for the issuance of a single-state license.

Article VI. Active Duty Military Personnel or their Spouses.

Active duty military personnel, or their spouses, shall designate a home state where the individual has a current license in good standing. The individual may retain the home state designation during the period the service member is on active duty. Subsequent to designating a home state, the individual shall only change their home state through application for licensure in the new state or through the process described in Article V.

Article VII. Adverse Actions.

A. A home state shall have exclusive power to impose adverse action against an occupational therapist's or occupational therapy assistant's license issued by the home state.

B. In addition to the other powers conferred by state law, a remote state shall have the authority, in accordance with existing state due process law, to:

1. Take adverse action against an occupational therapist's or occupational therapy assistant's compact privilege within that member state.

2. Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses as well as the production of evidence. Subpoenas issued by a licensing board in a member state for the attendance and testimony of witnesses or the production of evidence from another member state shall be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage and other fees required by the service statutes of the state in which the witnesses or evidence are located.

C. For purposes of taking adverse action, the home state shall give the same priority and effect to reported conduct received from a member state as it would if the conduct had occurred within the home state. In so doing, the home state shall apply its own state laws to determine appropriate action.

D. The home state shall complete any pending investigations of an occupational therapist or occupational therapy assistant who changes primary state of residence during the course of the investigations. The home state, where the investigations were initiated, shall also have the authority to take appropriate action(s) and shall promptly report the conclusions of the investigations to the OT Compact Commission data system. The occupational therapy compact commission data system administrator shall promptly notify the new home state of any adverse actions.

E. A member state, if otherwise permitted by state law, may recover from the affected occupational therapist or occupational therapy assistant the costs of investigations and disposition of cases resulting from any adverse action taken against that occupational therapist or occupational therapy assistant.

F. A member state may take adverse action based on the factual findings of the remote state, provided that the member state follows its own procedures for taking the adverse action.

G. Joint investigations.

1. In addition to the authority granted to a member state by its respective state occupational therapy laws and regulations or other applicable state law, any member state may participate with other member states in joint investigations of licensees.

2. Member states shall share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the Compact.

H. If an adverse action is taken by the home state against an occupational therapist's or occupational therapy assistant's license, the occupational therapist's or occupational therapy assistant's compact privilege in all other member states shall be deactivated until all encumbrances have been removed from the state license. All home state disciplinary orders that impose adverse action against an occupational therapist's or occupational therapy assistant's license shall include a statement that the occupational therapist's or occupational therapy assistant's compact privilege is deactivated in all member states during the pendency of the order.

I. If a member state takes adverse action, it shall promptly notify the administrator of the data system. The administrator of the data system shall promptly notify the home state of any adverse actions by remote states.

J. Nothing in this Compact shall override a member state's decision that participation in an alternative program may be used in lieu of adverse action.

Article VIII. Establishment of the Occupational Therapy Compact Commission.

A. The Compact member states hereby create and establish a joint public agency known as the Occupational Therapy Compact Commission:

1. The Commission is an instrumentality of the compact states.

2. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

3. Nothing in this Compact shall be construed to be a waiver of sovereign immunity.

B. Membership, voting, and meetings.

1. Each member state shall have and be limited to one delegate selected by that member state's licensing board.

2. The delegate shall be either:

a. A current member of the licensing board, who is an occupational therapist, occupational therapy assistant, or public member; or

b. An administrator of the licensing board.

3. Any delegate may be removed or suspended from office as provided by the law of the state from which the delegate is appointed.

4. The member state board shall fill any vacancy occurring in the Commission within 90 days.

5. Each delegate shall be entitled to one vote with regard to the promulgation of rules and creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission. A delegate shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for delegates' participation in meetings by telephone or other means of communication.

6. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws.

7. The Commission shall establish by rule a term of office for delegates.

C. The Commission shall have the following powers and duties:

1. Establish a code of ethics for the Commission;

2. Establish the fiscal year of the Commission;

3. Establish bylaws;

4. Maintain its financial records in accordance with the bylaws;

5. Meet and take such actions as are consistent with the provisions of this Compact and the bylaws;

6. Promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rules shall have the force and effect of law and shall be binding in all member states;

7. Bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any state occupational therapy licensing board to sue or be sued under applicable law shall not be affected;

8. Purchase and maintain insurance and bonds;

9. Borrow, accept, or contract for services of personnel, including, but not limited to, employees of a member state;

10. Hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the Compact, and establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;

11. Accept any and all appropriate donations and grants of money, equipment, supplies, materials

and services, and receive, utilize and dispose of the same; provided that at all times the Commission shall avoid any appearance of impropriety and/or conflict of interest;

12. Lease, purchase, accept appropriate gifts or donations of, or otherwise own, hold, improve or use, any property, real, personal or mixed; provided that at all times the Commission shall avoid any appearance of impropriety;

13. Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property real, personal, or mixed;

14. Establish a budget and make expenditures;

15. Borrow money;

16. Appoint committees, including standing committees composed of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the bylaws;

17. Provide and receive information from, and cooperate with, law enforcement agencies;

18. Establish and elect an executive committee; and

19. Perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of occupational therapy licensure and practice.

D. The executive committee.

The executive committee shall have the power to act on behalf of the Commission according to the terms of this Compact.

1. The executive committee shall be composed of nine members:

a. Seven voting members who are elected by the Commission from the current membership of the Commission;

b. One ex-officio, nonvoting member from a recognized national occupational therapy professional association; and

c. One ex officio, nonvoting member from a recognized national occupational therapy certification organization.

2. The ex officio members will be selected by their respective organizations.

3. The Commission may remove any member of the executive committee as provided in bylaws.

4. The executive committee shall meet at least annually.

5. The executive committee shall have the following duties and responsibilities:

a. Recommend to the entire Commission changes to the rules or bylaws, changes to this Compact legislation, fees paid by compact member states such as annual dues, and any commission compact fee charged to licensees for the compact privilege;

b. Ensure Compact administration services are appropriately provided, contractual or otherwise;

c. Prepare and recommend the budget;

d. Maintain financial records on behalf of the Commission;

e. Monitor Compact compliance of member states and provide compliance reports to the Commission;

f. Establish additional committees as necessary; and

g. Perform other duties as provided in rules or bylaws.

E. Meetings of the Commission.

1. All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rulemaking provisions in Article X.

2. The Commission or the executive committee or other committees of the Commission may convene in a closed, non-public meeting if the Commission or executive committee or other committees of the Commission must discuss:

a. Non-compliance of a member state with its obligations under the Compact;

b. The employment, compensation, discipline or other matters, practices or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;

c. Current, threatened, or reasonably anticipated litigation;

d. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate;

e. Accusing any person of a crime or formally censuring any person;

f. Disclosure of trade secrets or commercial or financial information that is privileged or confidential;

g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

h. Disclosure of investigative records compiled for law enforcement purposes;

i. Disclosure of information related to any investigative reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility of investigation or determination of compliance issues pursuant to the Compact; or

j. Matters specifically exempted from disclosure by federal or member state statute.

3. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant

exempting provision.

4. The Commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release by a majority vote of the Commission or order of a court of competent jurisdiction.

F. Financing of the Commission.

1. The Commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

2. The Commission may accept any and all appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

3. The Commission may levy on and collect an annual assessment from each member state or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff, which must be in a total amount sufficient to cover its annual budget as approved by the Commission each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Commission, which shall promulgate a rule binding upon all member states.

4. The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the Commission pledge the credit of any of the member states, except by and with the authority of the member state.

5. The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant, and the report of the audit shall be included in and become part of the annual report of the Commission.

G. Qualified immunity, defense, and indemnification.

1. The members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the grossly negligent, intentional or willful or wanton misconduct of that person.

2. The Commission shall defend any member, officer, executive director, employee, or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel, and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

3. The Commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

Article IX. Data System.

A. The Commission shall provide for the development, maintenance, and utilization of a coordinated database and reporting system containing licensure, adverse action, and investigative information on all licensed individuals in member states.

B. A member state shall submit a uniform data set to the data system on all individuals to whom this Compact is applicable (utilizing a unique identifier) as required by the rules of the Commission, including:

1. Identifying information;

2. Licensure data;

3. Adverse actions against a license or compact privilege;

4. Non-confidential information related to alternative program participation;

5. Any denial of application for licensure, and the reason(s) for such denial;

6. Other information that may facilitate the administration of this Compact, as determined by the rules of the Commission; and

7. Current significant investigative information.

C. Current significant investigative information and other investigative information pertaining to a Licensee in any member state will only be available to other member states.

D. The Commission shall promptly notify all member states of any adverse action taken against a licensee or an individual applying for a license. Adverse action information pertaining to a licensee in any member state will be available to any other member state.

E. Member states contributing information to the data system may designate information that may not be shared with the public without the express permission of the contributing state.

F. Any information submitted to the data system that is subsequently required to be expunged by the laws of the member state contributing the information shall be removed from the data system.

Article X. Rulemaking.

A. The Commission shall exercise its rulemaking powers pursuant to the criteria set forth in this article and the rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment.

B. The Commission shall promulgate reasonable rules in order to effectively and efficiently achieve the purposes of the Compact. Notwithstanding the foregoing, in the event the Commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of the Compact, or the powers granted hereunder, then such an action by the Commission shall be invalid and have no force and effect.

C. If a majority of the legislatures of the member states rejects a rule, by enactment of a statute or resolution in the same manner used to adopt the Compact within four years of the date of adoption of the rule, then such rule shall have no further force and effect in any member state.

D. Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.

E. Prior to promulgation and adoption of a final rule or rules by the Commission, and at least 30 days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a notice of proposed rulemaking:

1. On the website of the Commission or other publicly accessible platform; and

2. On the website of each member state occupational therapy licensing board or other publicly accessible platform or the publication in which each state would otherwise publish proposed rules.

F. The notice of proposed rulemaking shall include:

1. The proposed time, date, and location of the meeting in which the rule will be considered and voted upon;

2. The text of the proposed rule or amendment and the reason for the proposed rule;

3. A request for comments on the proposed rule from any interested person; and

4. The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.

G. Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public.

H. The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

1. At least 25 persons;

2. A state or federal governmental subdivision or agency; or

3. An association or organization having at least 25 members.

I. If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing. If the hearing is held via electronic means, the Commission shall publish the mechanism for access to the electronic hearing.

1. All persons wishing to be heard at the hearing shall notify the executive director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five business days before the scheduled date of the hearing.

2. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

3. All hearings will be recorded. A copy of the recording will be made available on request.

4. Nothing in this article shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this article.

J. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

K. If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

L. The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

M. Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual

rulemaking procedures provided in the Compact and in this article shall be retroactively applied to the rule as soon as reasonably possible, in no event later than 90 days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

1. Meet an imminent threat to public health, safety, or welfare;

2. Prevent a loss of Commission or member state funds;

3. Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or

4. Protect public health and safety.

N. The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of 30 days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing and delivered to the chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

Article XI. Oversight, Dispute Resolution, and Enforcement.

A. Oversight.

1. The executive, legislative, and judicial branches of state government in each member state shall enforce this Compact and take all actions necessary and appropriate to effectuate the Compact's purposes and intent. The provisions of this Compact and the rules promulgated hereunder shall have standing as statutory law.

2. All courts shall take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of this Compact which may affect the powers, responsibilities, or actions of the Commission.

3. The Commission shall be entitled to receive service of process in any such proceeding, and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the Commission shall render a judgment or order void as to the Commission, this Compact, or promulgated rules.

B. Default, technical assistance, and termination.

1. If the Commission determines that a member state has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:

a. Provide written notice to the defaulting state and other member states of the nature of the default, the proposed means of curing the default and/or any other action to be taken by the Commission; and

b. Provide remedial training and specific technical assistance regarding the default.

2. If a state in default fails to cure the default, the defaulting state may be terminated from the Compact upon an affirmative vote of a majority of the member states, and all rights, privileges and benefits conferred by this Compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

3. Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the Commission to the governor, the majority and minority leaders of the defaulting state's legislature, and each of the member states.

4. A state that has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

5. The Commission shall not bear any costs related to a state that is found to be in default or that has been terminated from the Compact, unless agreed upon in writing between the Commission and the defaulting state.

6. The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the District of Columbia or the federal district where the Commission has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorney fees.

C. Dispute resolution.

1. Upon request by a member state, the Commission shall attempt to resolve disputes related to the Compact that arise among member states and between member and non-member states.

2. The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes as appropriate.

D. Enforcement.

The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of this Compact.

By majority vote, the Commission may initiate legal action in the United States District Court for the

District of Columbia or the federal district where the Commission has its principal offices against a member state in default to enforce compliance with the provisions of the Compact and its promulgated rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorney fees.

The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

Article XII. Date of Implementation of the Interstate Commission for Occupational Therapy Practice and Associated Rules, Withdrawal, and Amendment.

A. The Compact shall come into effect on the date on which the Compact statute is enacted into law in the tenth member state. The provisions, which become effective at that time, shall be limited to the powers granted to the Commission relating to assembly and the promulgation of rules. Thereafter, the Commission shall meet and exercise rulemaking powers necessary to the implementation and administration of the Compact.

B. Any state that joins the Compact subsequent to the Commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the Compact becomes law in that state. Any rule that has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that state.

C. Any member state may withdraw from this Compact by enacting a statute repealing the same.

1. A member state's withdrawal shall not take effect until six months after enactment of the repealing statute.

2. Withdrawal shall not affect the continuing requirement of the withdrawing state's occupational therapy licensing board to comply with the investigative and adverse action reporting requirements of this act prior to the effective date of withdrawal.

D. Nothing contained in this Compact shall be construed to invalidate or prevent any occupational therapy licensure agreement or other cooperative arrangement between a member state and a non-member state that does not conflict with the provisions of this Compact.

E. This Compact may be amended by the member states. No amendment to this Compact shall become effective and binding upon any member state until it is enacted into the laws of all member states.

Article XIII. Construction and Severability.

This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this Compact shall be severable and if any phrase, clause, sentence or provision of this Compact is declared to be contrary to the constitution of any member state or of the United States or the applicability thereof to any government, agency, person, or circumstance is held invalid, the validity of the remainder of this Compact and the applicability thereof to any government, agency, person, or circumstance shall not be affected thereby. If this Compact shall be held contrary to the constitution of any member state, the Compact shall remain in full force and effect as to the remaining member states and in full force and effect as to the member state affected as to all severable matters.

Article XIV. Binding Effect of Compact and Other Laws.

A. A licensee providing occupational therapy in a remote state under the compact privilege shall function within the laws and regulations of the remote state.

B. Nothing herein prevents the enforcement of any other law of a member state that is not inconsistent with the Compact.

C. Any laws in a member state in conflict with the Compact are superseded to the extent of the conflict.

D. Any lawful actions of the Commission, including all rules and bylaws promulgated by the Commission, are binding upon the member states.

E. All agreements between the Commission and the member states are binding in accordance with their terms.

F. In the event any provision of the Compact exceeds the constitutional limits imposed on the legislature of any member state, the provision shall be ineffective to the extent of the conflict with the constitutional provision in question in that member state.

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.

3. That the provisions of this act shall become effective on January 1, 2022.

Project 6878 - Emergency/NOIRA

Board Of Medicine

Interjurisdictional Compact

18VAC85-80-10. Definitions.

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

"Board"

"Compact"

"Compact privilege"

"Occupational therapy assistant"

"Practice of occupational therapy"

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

"ACOTE" means the Accreditation Council for Occupational Therapy Education.

"Active practice" means a minimum of 160 hours of professional practice as an occupational therapist or an occupational therapy assistant within the 24-month period immediately preceding renewal or application for licensure, if previously licensed or certified in another jurisdiction. The active practice of occupational therapy may include supervisory, administrative, educational or consultative activities or responsibilities for the delivery of such services.

"Advisory board" means the Advisory Board of Occupational Therapy.

"Contact hour" means 60 minutes of time spent in continued learning activity.

"NBCOT" means the National Board for Certification in Occupational Therapy, under which the national examination for certification is developed and implemented.

"National examination" means the examination prescribed by NBCOT for certification as an occupational therapist or an occupational therapy assistant and approved for licensure in Virginia.

"Occupational therapy personnel" means appropriately trained individuals who provide occupational therapy services under the supervision of a licensed occupational therapist.

"Practitioner" means an occupational therapist or occupational therapy assistant licensed in Virginia or an occupational therapist or occupational therapy assistant practicing in Virginia with a compact privilege.

18VAC85-80-26. Fees.

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

1. The initial fee for the occupational therapist license shall be $130; for the occupational therapy assistant, it shall be $70.

2. The fee for reinstatement of the occupational therapist license that has been lapsed for two years or more shall be $180; for the occupational therapy assistant, it shall be $90.

3. The fee for active license renewal for an occupational therapist shall be $135; for an occupational therapy assistant, it shall be $70. The fees for inactive license renewal shall be $70 for an occupational therapist and $35 for an occupational therapy assistant. Renewals shall be due in the birth month of the licensee in each even-numbered year. For 2020, the fee for renewal of an active license as an occupational therapist shall be $108; for an occupational therapy assistant, it shall be $54. For renewal of an inactive license in 2020, the fees shall be $54 for an occupational therapist and $28 for an occupational therapy assistant.

4. The additional fee for processing a late renewal application within one renewal cycle shall be $50 for an occupational therapist and $30 for an occupational therapy assistant.

5. The fee for a letter of good standing or verification to another jurisdiction for a license shall be $10.

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

7. The handling fee for a returned check or a dishonored credit card or debit card shall be $50.

8. The fee for a duplicate license shall be $5.00, and the fee for a duplicate wall certificate shall be $15.

9. 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.

10. The fee for issuance of a compact privilege or the biennial renewal of such privilege shall be $75 for an occupational therapist and $40 for an occupational therapy assistant.

B. Unless otherwise provided, fees established by the board shall not be refundable.

18VAC85-80-70. Biennial renewal of licensure.

A. An occupational therapist or an occupational therapy assistant shall renew his license biennially during his birth month in each even-numbered year by:

1. Paying to the board the renewal fee prescribed in 18VAC85-80-26;

2. Indicating that he has been engaged in the active practice of occupational therapy as defined in 18VAC85-80-10; and

3. Attesting to completion of continued competency requirements as prescribed in 18VAC85-80-71.

B. An occupational therapist or an occupational therapy assistant whose license has not been renewed by the first day of the month following the month in which renewal is required shall pay an additional fee as prescribed in 18VAC85-80-26.

C. In order to renew a compact privilege to practice in Virginia, the holder shall comply with the rules adopted by the Occupational Therapy Compact Commission in effect at the time of the renewal.

18VAC85-80-71. Continued competency requirements for renewal of an active license.

A. In order to renew an active license biennially, ~~a practitioner~~ a licensee shall complete at least 20 contact hours of continuing learning activities as follows:

1. A minimum of 10 of the 20 hours shall be in Type 1 activities, which shall consist of an organized program of study, classroom experience, or similar educational experience that is related to a licensee's current or anticipated roles and responsibilities in occupational therapy and approved or provided by one of the following organizations or any of its components:

a. Virginia Occupational Therapy Association;

b. American Occupational Therapy Association;

c. National Board for Certification in Occupational Therapy;

d. Local, state, or federal government agency;

e. Regionally accredited college or university;

f. Health care organization accredited by a national accrediting organization granted authority by the Centers for Medicare and Medicaid Services to assure compliance with Medicare conditions of participation; or

g. An American Medical Association Category 1 Continuing Medical Education program.

2. No more than 10 of the 20 hours may be Type 2 activities, which may include consultation with another therapist, independent reading or research, preparation for a presentation, or other such experiences that promote continued learning. Up to two of the Type 2 continuing education hours may be satisfied through delivery of occupational therapy services, without compensation, to low-income individuals receiving services through a local health department or a free clinic organized in whole or primarily for the delivery of health services. One hour of continuing education may be credited for three hours of providing such volunteer services as documented by the health department or free clinic.

B. ~~A practitioner a practitioner~~ A licensee shall be exempt from the continuing competency requirements for the first biennial renewal following the date of initial licensure in Virginia.

C. The ~~practitioner~~ licensee shall retain in his records all supporting documentation for a period of six years following the renewal of an active license.

D. The board shall periodically conduct a representative random audit of its active licensees to determine compliance. The ~~practitioners~~ licensees selected for the audit shall provide all supporting documentation within 30 days of receiving notification of the audit.

E. Failure to comply with these requirements may subject the licensee to disciplinary action by the board.

F. The board may grant an extension of the deadline for continuing competency requirements for up to one year for good cause shown upon a written request from the licensee prior to the renewal date.

G. The board may grant an exemption for all or part of the requirements for circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters.

Agenda Item:

Regulatory Actions – Adoption of Exempt Regulations pursuant to 2021 legislation

Included in agenda package:

Copy of HB1737 – Practice of NPs without practice agreement (reduction of years in clinical practice from 5 to 2 years for autonomous practice)

Copy of HB1747 – Practice of CNSs as nurse practitioners (elimination of registration of clinical nurse specialists under Board of Nursing and initiation of licensure under the Joint Boards; requirement for a practice agreement; prescriptive authority for CNSs who qualify)

Copy of HB1817 – Practice of CNMs without practice agreement (1,000 hours of clinical practice under a practice agreement with a patient care team physician OR another certified nurse midwife with at least two years of experience required for autonomous practice

Draft regulations for Licensure of Nurse Practitioners (Chapter 30) and Prescriptive Authority for Nurse Practitioners (Chapter 40)

Staff note:

The amendments may be adopted as an exempt action because they have been reviewed by the Assistant Attorneys General and determined to conform regulations to changes in the Code. The draft regulations were reviewed by the Committee of the Joint Boards at its June meeting and recommended for adoption. The Board of Nursing adopted the changes to Chapters 30 and 40 on July 20th.

Action by Board of Medicine: To adopt changes to 30 (Nurse Practitioners) and 40 (Prescriptive Authority for NPs) to conform to changes in the Code of Virginia

CHAPTER 1

An Act to amend and reenact § 54.1-2957 of the Code of Virginia, relating to nurse practitioners; practice without a practice agreement.

[H 1737]

Approved February 25, 2021

Be it enacted by the General Assembly of Virginia:

1. That § 54.1-2957 of the Code of Virginia is amended and reenacted as follows:

§ 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.

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~~ *anesthetist* 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~~ *two* 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~~ *two* 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 provisions of this act shall expire on July 1, 2022.

CHAPTER 157

An Act to amend and reenact §§ 54.1-2900, 54.1-2901, 54.1-2957, 54.1-2957.01, and 54.1-3000 of the Code of Virginia and to repeal § 54.1-3018.1 of the Code of Virginia, relating to clinical nurse specialist; licensure by the Boards of Medicine and Nursing.

[H 1747]

Approved March 18, 2021

Be it enacted by the General Assembly of Virginia:

1. That §§ 54.1-2900, 54.1-2901, 54.1-2957, 54.1-2957.01, and 54.1-3000 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.

"Birth control" means contraceptive methods that are approved by the U.S. Food and Drug Administration. "Birth control" shall not be considered abortion for the purposes of Title 18.2.

"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.

"Clinical nurse specialist" means an advance practice registered nurse who is certified in the specialty of clinical nurse specialist and who is jointly licensed by the Boards of Medicine and Nursing as a nurse practitioner pursuant to § 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 a health care professional who has met the requirements of the Board for licensure 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 (i) requesting, receiving, and reviewing a patient's medical and physical history, including information related to past surgical and nonsurgical treatment of the patient and controlled substances prescribed to the patient, and (ii) documenting in a patient's record information related to the condition and symptoms of the patient, the examination and evaluation of the patient made by the doctor of chiropractic, and treatment provided to the patient by the doctor of chiropractic. "Practice of chiropractic" shall also 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.

"Practice of surgical assisting" means the performance of significant surgical tasks, including manipulation of organs, suturing of tissue, placement of hemostatic agents, injection of local anesthetic, harvesting of veins, implementation of devices, and other duties as directed by a licensed doctor of medicine, osteopathy, or podiatry under the direct supervision of a licensed doctor of medicine, osteopathy, or podiatry.

"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.

"Surgical assistant" means an individual who has met the requirements of the Board for licensure as a surgical assistant and who works under the direct supervision of a licensed doctor of medicine, osteopathy, or podiatry.

§ 54.1-2901. Exceptions and exemptions generally.

A. The provisions of this chapter shall not prevent or prohibit:

1. Any person entitled to practice his profession under any prior law on June 24, 1944, from continuing such practice within the scope of the definition of his particular school of practice;

2. Any person licensed to practice naturopathy prior to June 30, 1980, from continuing such practice in accordance with regulations promulgated by the Board;

3. Any licensed nurse practitioner from rendering care in accordance with the provisions of §§ 54.1-2957 and 54.1-2957.01 ~~or~~, any nurse practitioner licensed by the Boards of Medicine and Nursing in the category of certified nurse midwife practicing pursuant to subsection H of § 54.1-2957, *or any nurse practitioner licensed by the Boards of Medicine and Nursing in the category of clinical nurse specialist practicing pursuant to subsection J of § 54.1-2957* when such services are authorized by regulations promulgated jointly by the Boards of Medicine and Nursing;

4. Any registered professional nurse, licensed nurse practitioner, graduate laboratory technician or other technical personnel who have been properly trained from rendering care or services within the scope of their usual professional activities which shall include the taking of blood, the giving of intravenous infusions and intravenous injections, and the insertion of tubes when performed under the orders of a person licensed to practice medicine or osteopathy, a nurse practitioner, or a physician assistant;

5. Any dentist, pharmacist or optometrist from rendering care or services within the scope of his usual professional activities;

6. Any practitioner licensed or certified by the Board from delegating to personnel supervised by him, such activities or functions as are nondiscretionary and do not require the exercise of professional judgment for their performance and which are usually or customarily delegated to such persons by practitioners of the healing arts, if such activities or functions are authorized by and performed for such practitioners of the healing arts and responsibility for such activities or functions is assumed by such practitioners of the healing arts;

7. The rendering of medical advice or information through telecommunications from a physician licensed to practice medicine in Virginia or an adjoining state, or from a licensed nurse practitioner, to emergency medical personnel acting in an emergency situation;

8. The domestic administration of family remedies;

9. The giving or use of massages, steam baths, dry heat rooms, infrared heat or ultraviolet lamps in public or private health clubs and spas;

10. The manufacture or sale of proprietary medicines in this Commonwealth by licensed pharmacists or druggists;

11. The advertising or sale of commercial appliances or remedies;

12. The fitting by nonitinerant persons or manufacturers of artificial eyes, limbs or other apparatus or appliances or the fitting of plaster cast counterparts of deformed portions of the body by a nonitinerant bracemaker or prosthetist for the purpose of having a three-dimensional record of the deformity, when such bracemaker or prosthetist has received a prescription from a licensed physician, licensed nurse practitioner, or licensed physician assistant directing the fitting of such casts and such activities are conducted in conformity with the laws of Virginia;

13. Any person from the rendering of first aid or medical assistance in an emergency in the absence of a person licensed to practice medicine or osteopathy under the provisions of this chapter;

14. The practice of the religious tenets of any church in the ministration to the sick and suffering by mental or spiritual means without the use of any drug or material remedy, whether gratuitously or for compensation;

15. Any legally qualified out-of-state or foreign practitioner from meeting in consultation with legally licensed practitioners in this Commonwealth;

16. Any practitioner of the healing arts licensed or certified and in good standing with the applicable regulatory agency in another state or Canada when that practitioner of the healing arts is in Virginia temporarily and such practitioner has been issued a temporary authorization by the Board from practicing medicine or the duties of the profession for which he is licensed or certified (i) in a summer camp or in conjunction with patients who are participating in recreational activities, (ii) while participating in continuing educational programs prescribed by the Board, or (iii) by rendering at any site any health care services within the limits of his license, voluntarily and without compensation, to any patient of any clinic which is organized in whole or in part for the delivery of health care services without charge as provided in § 54.1-106;

17. The performance of the duties of any active duty health care provider in active service in the army, navy, coast guard, marine corps, air force, or public health service of the United States at any public or private health care facility while such individual is so commissioned or serving and in accordance with his official military duties;

18. Any masseur, who publicly represents himself as such, from performing services within the scope of his usual professional activities and in conformance with state law;

19. Any person from performing services in the lawful conduct of his particular profession or business under state law;

20. Any person from rendering emergency care pursuant to the provisions of § 8.01-225;

21. Qualified emergency medical services personnel, when acting within the scope of their certification, and licensed health care practitioners, when acting within their scope of practice, from following Durable Do Not Resuscitate Orders issued in accordance with § 54.1-2987.1 and Board of Health regulations, or licensed health care practitioners from following any other written order of a physician not to resuscitate a patient in the event of cardiac or respiratory arrest;

22. Any commissioned or contract medical officer of the army, navy, coast guard or air force rendering services voluntarily and without compensation while deemed to be licensed pursuant to § 54.1-106;

23. Any provider of a chemical dependency treatment program who is certified as an "acupuncture detoxification specialist" by the National Acupuncture Detoxification Association or an equivalent certifying body, from administering auricular acupuncture treatment under the appropriate supervision of a National Acupuncture Detoxification Association certified licensed physician or licensed acupuncturist;

24. Any employee of any assisted living facility who is certified in cardiopulmonary resuscitation (CPR) acting in compliance with the patient's individualized service plan and with the written order of the attending physician not to resuscitate a patient in the event of cardiac or respiratory arrest;

25. Any person working as a health assistant under the direction of a licensed medical or osteopathic doctor within the Department of Corrections, the Department of Juvenile Justice or local correctional facilities;

26. Any employee of a school board, authorized by a prescriber and trained in the administration of insulin and glucagon, when, upon the authorization of a prescriber and the written request of the parents as defined in § 22.1-1, assisting with the administration of insulin or administrating glucagon to a student diagnosed as having diabetes and who requires insulin injections during the school day or for whom glucagon has been prescribed for the emergency treatment of hypoglycemia;

27. Any practitioner of the healing arts or other profession regulated by the Board from rendering free health care to an underserved population of Virginia who (i) does not regularly practice his profession in Virginia, (ii) holds a current valid license or certificate to practice his profession in another state, territory, district or possession of the United States, (iii) volunteers to provide free health care to an underserved area of the Commonwealth under the auspices of a publicly supported all volunteer, nonprofit organization that sponsors the provision of health care to populations of underserved people, (iv) files a copy of the license or certification issued in such other jurisdiction with the Board, (v) notifies the Board at least five business days prior to the voluntary provision of services of the dates and location of such service, and (vi) acknowledges, in writing, that such licensure exemption shall only be valid, in compliance with the Board's regulations, during the limited period that such free health care is made available through the volunteer, nonprofit organization on the dates and at the location filed with the Board. The Board may deny the right to practice in Virginia to any practitioner of the healing arts whose license or certificate has been previously suspended or revoked, who has been convicted of a felony or who is otherwise found to be in violation of applicable laws or regulations. However, the Board shall allow a practitioner of the healing arts who meets the above criteria to provide volunteer services without prior notice for a period of up to three days, provided the nonprofit organization verifies that the practitioner has a valid, unrestricted license in another state;

28. Any registered nurse, acting as an agent of the Department of Health, from obtaining specimens of sputum or other bodily fluid from persons in whom the diagnosis of active tuberculosis disease, as defined in § 32.1-49.1, is suspected and submitting orders for testing of such specimens to the Division of Consolidated Laboratories or other public health laboratories, designated by the State Health Commissioner, for the purpose of determining the presence or absence of tubercle bacilli as defined in § 32.1-49.1;

29. Any physician of medicine or osteopathy or nurse practitioner from delegating to a registered nurse under his supervision the screening and testing of children for elevated blood-lead levels when such testing is conducted (i) in accordance with a written protocol between the physician or nurse practitioner and the registered nurse and (ii) in compliance with the Board of Health's regulations promulgated pursuant to §§ 32.1-46.1 and 32.1-46.2. Any follow-up testing or treatment shall be conducted at the direction of a physician or nurse practitioner;

30. Any practitioner of one of the professions regulated by the Board of Medicine who is in good standing with the applicable regulatory agency in another state or Canada from engaging in the practice of that profession when the practitioner is in Virginia temporarily with an out-of-state athletic team or athlete for the duration of the athletic tournament, game, or event in which the team or athlete is competing;

31. Any person from performing state or federally funded health care tasks directed by the consumer, which are typically self-performed, for an individual who lives in a private residence and who, by reason of disability, is unable to perform such tasks but who is capable of directing the appropriate performance of such tasks; or

32. Any practitioner of one of the professions regulated by the Board of Medicine who is in good standing with the applicable regulatory agency in another state from engaging in the practice of that profession in Virginia with a patient who is being transported to or from a Virginia hospital for care.

B. Notwithstanding any provision of law or regulation to the contrary, military medical personnel, as defined in § 2.2-2001.4, while participating in a program established by the Department of Veterans Services pursuant to § 2.2-2001.4, may practice under the supervision of a licensed physician or podiatrist or the chief medical officer of an organization participating in such program, or his designee who is a licensee of the Board and supervising within his scope of practice.

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

A. As used in this section:

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

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 clinical nurse specialist* 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 licensed by the Boards of Medicine and Nursing as a clinical nurse specialist shall practice pursuant to subsection J.* A nurse practitioner who is a certified registered nurse ~~anesthetists~~ *anesthetist* 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, *or clinical nurse specialist*, 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.

J. Nurse practitioners licensed by the Boards of Medicine and Nursing in the category of clinical nurse specialist 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 practice of clinical nurse specialists shall be consistent with the standards of care for the profession and with applicable laws and regulations.

§ 54.1-2957.01. Prescription of certain controlled substances and devices by licensed nurse practitioners.

A. In accordance with the provisions of this section and pursuant to the requirements of Chapter 33 (§ 54.1-3300 et seq.), a licensed nurse practitioner shall have the authority to prescribe Schedule II through Schedule VI controlled substances and devices as set forth in Chapter 34 (§ 54.1-3400 et seq.).

B. A nurse practitioner who does not meet the requirements for practice without a written or electronic practice agreement set forth in subsection I of § 54.1-2957 shall prescribe controlled substances or devices only if such prescribing is authorized by a written or electronic practice agreement entered into by the nurse practitioner and a patient care team physician. Such nurse practitioner shall provide to the Boards of Medicine and Nursing such evidence as the Boards may jointly require that the nurse practitioner has entered into and is, at the time of writing a prescription, a party to a written or electronic practice agreement with a patient care team physician that clearly states the prescriptive practices of the nurse practitioner. Such written or electronic practice agreements shall include the controlled substances the nurse practitioner is or is not authorized to prescribe and may restrict such prescriptive authority as described in the practice agreement. Evidence of a practice agreement shall be maintained by a nurse practitioner pursuant to § 54.1-2957. Practice agreements authorizing a nurse practitioner to prescribe controlled substances or devices pursuant to this section either shall be signed by the patient care team physician or shall clearly state the name of the patient care team physician who has entered into the practice agreement with the nurse practitioner.

It shall be unlawful for a nurse practitioner to prescribe controlled substances or devices pursuant to this section unless (i) such prescription is authorized by the written or electronic practice agreement or (ii) the nurse practitioner is authorized to practice without a written or electronic practice agreement pursuant to subsection I of § 54.1-2957.

C. The Boards of Medicine and Nursing shall promulgate regulations governing the prescriptive authority of nurse practitioners as are deemed reasonable and necessary to ensure an appropriate standard of care for patients. Such regulations shall include requirements as may be necessary to ensure continued nurse practitioner competency, which may include continuing education, testing, 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.

D. This section shall not limit the functions and procedures of certified registered nurse anesthetists or of any nurse practitioners which are otherwise authorized by law or regulation.

E. The following restrictions shall apply to any nurse practitioner authorized to prescribe drugs and devices pursuant to this section:

1. The nurse practitioner shall disclose to the patient at the initial encounter that he is a licensed nurse practitioner. Any party to a practice agreement shall disclose, upon request of a patient or his legal representative, the name of the patient care team physician and information regarding how to contact the patient care team physician.

2. Physicians shall not serve as a patient care team physician on a patient care team at any one time to more than six nurse practitioners.

F. This section shall not prohibit a licensed nurse practitioner 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.

G. Notwithstanding any provision of law or regulation to the contrary, a nurse practitioner licensed by the Boards of Medicine and Nursing in the category of certified nurse midwife *or clinical nurse specialist* and holding a license for prescriptive authority may prescribe (i) Schedules II through V controlled substances in accordance with any prescriptive authority included in a practice agreement with a licensed physician pursuant to subsection H *or J* of § 54.1-2957 and (ii) Schedule VI controlled substances without the requirement for inclusion of such prescriptive authority in a practice agreement.

H. Notwithstanding any provision of law or regulation to the contrary, a nurse practitioner licensed by the Boards of Medicine and Nursing as a certified registered nurse anesthetist shall have the authority to prescribe Schedule II through Schedule VI controlled substances and devices in accordance with the requirements for practice set forth in subsection C of § 54.1-2957 to a patient requiring anesthesia, as part of the periprocedural care of such patient. As used in this subsection, "periprocedural" means the period beginning prior to a procedure and ending at the time the patient is discharged.

§ 54.1-3000. Definitions.

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

"Advanced practice registered nurse" means a registered nurse who has completed an advanced graduate-level education program in a specialty category of nursing and has passed a national certifying examination for that specialty.

"Board" means the Board of Nursing.

"Certified nurse aide" means a person who meets the qualifications specified in this article and who is currently certified by the Board.

~~"Clinical nurse specialist" means an advanced practice registered nurse who meets the requirements set forth in § 54.1-3018.1 and who is currently registered by the Board. Such a person shall be recognized as being able to provide advanced services according to the specialized training received from a program satisfactory to the Board, but shall not be entitled to perform any act that is not within the scope of practice of professional nursing.~~

"Massage therapist" means a person who meets the qualifications specified in this chapter and who is currently licensed by the Board.

"Massage therapy" means the treatment of soft tissues for therapeutic purposes by the application of massage and bodywork techniques based on the manipulation or application of pressure to the muscular structure or soft tissues of the human body. The term "massage therapy" does not include the diagnosis or treatment of illness or disease or any service or procedure for which a license to practice medicine, nursing, midwifery, chiropractic, physical therapy, occupational therapy, acupuncture, athletic training, or podiatry is required by law or any service described in subdivision A 18 of § 54.1-3001.

"Massage therapy" shall not include manipulation of the spine or joints.

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

"Practical nurse" or "licensed practical nurse" means a person who is licensed or holds a multistate licensure privilege under the provisions of this chapter to practice practical nursing as defined in this section. Such a licensee shall be empowered to provide nursing services without compensation. The abbreviation "L.P.N." shall stand for such terms.

"Practical nursing" or "licensed practical nursing" means the performance for compensation of selected nursing acts in the care of individuals or groups who are ill, injured, or experiencing changes in normal health processes; in the maintenance of health; in the prevention of illness or disease; or, subject to such regulations as the Board may promulgate, in the teaching of those who are or will be nurse aides. Practical nursing or licensed practical nursing requires knowledge, judgment and skill in nursing procedures gained through prescribed education. Practical nursing or licensed practical nursing is performed under the direction or supervision of a licensed medical practitioner, a professional nurse, registered nurse or registered professional nurse or other licensed health professional authorized by regulations of the Board.

"Practice of a nurse aide" or "nurse aide practice" means the performance of services requiring the education, training, and skills specified in this chapter for certification as a nurse aide. Such services are performed under the supervision of a dentist, physician, podiatrist, professional nurse, licensed practical nurse, or other licensed health care professional acting within the scope of the requirements of his profession.

"Professional nurse," "registered nurse" or "registered professional nurse" means a person who is licensed or holds a multistate licensure privilege under the provisions of this chapter to practice professional nursing as defined in this section. Such a licensee shall be empowered to provide professional services without compensation, to promote health and to teach health to individuals and groups. The abbreviation "R.N." shall stand for such terms.

"Professional nursing," "registered nursing" or "registered professional nursing" means the performance for compensation of any nursing acts in the observation, care and counsel of individuals or groups who are ill, injured or experiencing changes in normal health processes or the maintenance of health; in the prevention of illness or disease; in the supervision and teaching of those who are or will be involved in nursing care; in the delegation of selected nursing tasks and procedures to appropriately trained unlicensed persons as determined by the Board; or in the administration of medications and treatments as prescribed by any person authorized by law to prescribe such medications and treatment. Professional nursing, registered nursing and registered professional nursing require specialized education, judgment, and skill based upon knowledge and application of principles from the biological, physical, social, behavioral and nursing sciences.

2. That § 54.1-3018.1 of the Code of Virginia is repealed.

3. That the Boards of Medicine and Nursing shall jointly issue a license to practice as a nurse practitioner without prescriptive authority in the category of clinical nurse specialist to an applicant who is an advance practice registered nurse who has completed an advanced graduate-level education program in the specialty category of clinical nurse specialist and who is registered by the Board of Nursing as a clinical nurse specialist on July 1, 2021. A clinical nurse specialist may be granted prescriptive authority upon submission of satisfactory evidence of qualification as set forth in regulations of the Boards of Medicine and Nursing.

CHAPTER 396

An Act to amend and reenact §§ 54.1-2957, 54.1-2957.01, and 54.1-2957.03 of the Code of Virginia, relating to practice of certified nurse midwives.

[H 1817]
Approved March 25, 2021

Be it enacted by the General Assembly of Virginia:

1. That §§ 54.1-2957, 54.1-2957.01, and 54.1-2957.03 of the Code of Virginia are amended and reenacted as follows:

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

A. As used in this section:,

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

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~~ *anesthetist* 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~~ *Every* 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~~ *accordance with* regulations~~,~~ *adopted by the Boards and* consistent with the Standards for the Practice of Midwifery set by the American College of Nurse-Midwives~~,~~ governing such practice. *A certified nurse midwife who has practiced fewer than 1,000 hours shall practice in consultation with a certified nurse midwife who has practiced for at least two years prior to entering into the practice agreement or a licensed physician, in accordance with a practice agreement. Such practice agreement shall address the availability of the certified nurse midwife who has practiced for at least two years prior to entering into the practice agreement or the licensed physician for routine and urgent consultation on patient care. Evidence of the practice agreement shall be maintained by the certified nurse midwife and provided to the Boards upon request. A certified nurse midwife who has completed 1,000 hours of practice as a certified nurse midwife may practice without a practice agreement upon receipt by the certified nurse midwife of an attestation from the certified nurse midwife who has practiced for at least two years prior to entering into the practice agreement or the licensed physician with whom the certified nurse midwife has entered into a practice agreement stating (i) that such certified nurse midwife or licensed physician has provided consultation to the certified nurse midwife pursuant to a practice agreement meeting the requirements of this section and (ii) the period of time for which such certified nurse midwife or licensed physician practiced in collaboration and consultation with the certified nurse midwife pursuant to the practice agreement. A certified nurse midwife authorized to practice without a practice agreement shall consult and collaborate with and refer patients to such other health care providers as may be appropriate for the care of the patient.*

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.

§ 54.1-2957.01. Prescription of certain controlled substances and devices by licensed nurse practitioners.

A. In accordance with the provisions of this section and pursuant to the requirements of Chapter 33 (§ 54.1-3300 et seq.), a licensed nurse practitioner shall have the authority to prescribe Schedule II through Schedule VI controlled substances and devices as set forth in Chapter 34 (§ 54.1-3400 et seq.).

B. A nurse practitioner who does not meet the requirements for practice without a written or electronic practice agreement set forth in subsection I of § 54.1-2957 shall prescribe controlled substances or devices only if such prescribing is authorized by a written or electronic practice agreement entered into by the nurse practitioner and a patient care team physician. Such nurse practitioner shall provide to the Boards of Medicine and Nursing such evidence as the Boards may jointly require that the nurse practitioner has entered into and is, at the time of writing a prescription, a party to a written or electronic practice agreement with a patient care team physician that clearly states the prescriptive practices of the nurse practitioner. Such written or electronic practice agreements shall include the controlled substances the nurse practitioner is or is not authorized to prescribe and may restrict such prescriptive authority as described in the practice agreement. Evidence of a practice agreement shall be maintained by a nurse practitioner pursuant to § 54.1-2957. Practice agreements authorizing a nurse practitioner to prescribe controlled substances or devices pursuant to this section either shall be signed by the patient care team physician or shall clearly state the name of the patient care team physician who has entered into the practice agreement with the nurse practitioner.

It shall be unlawful for a nurse practitioner to prescribe controlled substances or devices pursuant to this section unless (i) such prescription is authorized by the written or electronic practice agreement or (ii) the nurse practitioner is authorized to practice without a written or electronic practice agreement pursuant to subsection I of § 54.1-2957.

C. The Boards of Medicine and Nursing shall promulgate regulations governing the prescriptive authority of nurse practitioners as are deemed reasonable and necessary to ensure an appropriate standard of care for patients. Such regulations shall include requirements as may be necessary to ensure continued nurse practitioner competency, which may include continuing education, testing, 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.

D. This section shall not limit the functions and procedures of certified registered nurse anesthetists or of any nurse practitioners which are otherwise authorized by law or regulation.

E. The following restrictions shall apply to any nurse practitioner authorized to prescribe drugs and devices pursuant to this section:

1. The nurse practitioner shall disclose to the patient at the initial encounter that he is a licensed nurse practitioner. Any party to a practice agreement shall disclose, upon request of a patient or his legal representative, the name of the patient care team physician and information regarding how to contact the patient care team physician.

2. Physicians shall not serve as a patient care team physician on a patient care team at any one time to more than six nurse practitioners.

F. This section shall not prohibit a licensed nurse practitioner 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.

G. Notwithstanding any provision of law or regulation to the contrary, a nurse practitioner licensed by the Boards of Medicine and Nursing in the category of certified nurse midwife and holding a license for prescriptive authority may prescribe ~~(i)~~ Schedules II through ~~V~~ *VI* controlled substances. *However, if the nurse practitioner licensed by the Boards of Medicine and Nursing in the category of certified nurse midwife is required, pursuant to subsection H of § 54.1-2957, to practice pursuant to a practice agreement, such prescribing shall also be* in accordance with any prescriptive authority included in ~~a~~ *such* practice agreement ~~with a licensed physician pursuant to subsection H of § 54.1-2957 and (ii) Schedule VI controlled substances without the requirement for inclusion of such prescriptive authority in a practice agreement~~.

H. Notwithstanding any provision of law or regulation to the contrary, a nurse practitioner licensed by the Boards of Medicine and Nursing as a certified registered nurse anesthetist shall have the authority to prescribe Schedule II through Schedule VI controlled substances and devices in accordance with the requirements for practice set forth in subsection C of § 54.1-2957 to a patient requiring anesthesia, as part of the periprocedural care of such patient. As used in this subsection, "periprocedural" means the period beginning prior to a procedure and ending at the time the patient is discharged.

§ 54.1-2957.03. Certified nurse midwives; required disclosures; liability.

A. As used in this section, "birthing center" means a facility outside a hospital that provides maternity services.

B. A certified nurse midwife who provides health care services to a patient outside of a hospital or birthing center shall disclose to that patient, when appropriate, information on health risks associated with births outside of a hospital or birthing center, including but not limited to risks associated with vaginal births after a prior cesarean section, breech births, births by women experiencing high-risk pregnancies, and births involving multiple gestation.

C. ~~The~~ *A* certified nurse midwife who ~~provided~~ *provides* health care to a patient shall be liable for the midwife's negligent, grossly negligent, or willful and wanton acts or omissions. Except as otherwise provided by law, any (i) doctor of medicine or osteopathy who did not collaborate or consult with the midwife regarding the patient and who has not previously treated the patient for this pregnancy, (ii) *physician assistant, (iii)* nurse *practitioner,* ~~(iii)~~ *(iv)* prehospital emergency medical personnel, or ~~(iv)~~ *(v)* hospital as defined in § 32.1-123, or ~~agents thereof, who~~ *any employee of, person providing services pursuant to a contract with, or agent of such hospital, that* provides screening and stabilization health care services to a patient as a result of a certified nurse midwife's negligent, grossly negligent, or willful and wanton acts or omissions, shall be immune from liability for acts or omissions constituting ordinary negligence.

2. That any certified nurse midwife who has practiced as a certified nurse midwife in the Commonwealth for at least 1,000 hours, as determined by the Boards of Medicine and Nursing, prior to the effective date of this act shall be deemed to have met the requirements of subsection H of § 54.1-2957 of the Code of Virginia, as amended by this act, related to requirements for practice as a certified nurse midwife without a practice agreement and shall be eligible to practice as a certified nurse midwife in the Commonwealth without a practice agreement.

REGULATIONS

GOVERNING THE LICENSURE OF NURSE PRACTITIONERS

VIRGINIA BOARD OF NURSING
VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18 VAC 90-30-10 et seq.

Statutory Authority: §§ 54.1-2400 and 54.1-2957 of the *Code of Virginia*

Revised Date:

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PART I. GENERAL PROVISIONS.

18VAC90-30-10. Definitions.

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

"Approved program" means a nurse practitioner education program that is accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs/Schools, American College of Nurse Midwives, Commission on Collegiate Nursing Education, or the National League for Nursing Accrediting Commission or is offered by a school of nursing or jointly offered by a school of medicine and a school of nursing that grant a graduate degree in nursing and that hold a national accreditation acceptable to the boards.

"Autonomous practice" means practice in a category in which a nurse practitioner is certified and licensed without a written or electronic practice agreement with a patient care team physician in accordance with 18VAC90-30-86.

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

"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 of the Code of Virginia, 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.

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

"Collaboration" means the communication and decision-making process among members of a patient care team related to the 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.

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

"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.

"Licensed nurse practitioner" means an advanced practice registered nurse who has met the requirements for licensure as stated in Part II (18VAC90-30-60 et seq.) of this chapter.

"National certifying body" means a national organization that is accredited by an accrediting agency recognized by the U.S. Department of Education or deemed acceptable by the National Council of State Boards of Nursing and has as one of its purposes the certification of nurse anesthetists, nurse midwives, clinical nurse specialists, or nurse practitioners, referred to in this chapter as professional certification, and whose certification of such persons by examination is accepted by the committee.

"Patient care team physician" means a person who holds an active, unrestricted license issued by the Virginia Board of Medicine to practice medicine or osteopathic medicine.

"Practice agreement" means a written or electronic statement, jointly developed by the collaborating patient care team physician and the licensed nurse practitioner that describes the procedures to be followed and the acts appropriate to the specialty practice area to be performed by the licensed nurse practitioner in the care and management of patients. The practice agreement also describes the prescriptive authority of the nurse practitioner, if applicable. For a nurse practitioner licensed in the category of certified nurse midwife, the practice agreement is a statement jointly developed with the consulting physician or a certified nurse midwife with at least two years of clinical experience. For a nurse practitioner licensed in the category of clinical nurse specialist, the practice agreement shall be between the nurse practitioner and a consulting physician.

18VAC90-30-70. Categories of licensed nurse practitioners.

A. The boards shall license nurse practitioners consistent with their specialty education and certification in the following categories (a two-digit suffix appears on licenses to designate category):

1. Adult/geriatric acute care nurse practitioner (01);
2. Family nurse practitioner (02);
3. Pediatric/primary care nurse practitioner (03);
4. Adult/geriatric primary care nurse practitioner (07);
5. Certified registered nurse anesthetist (08);
6. Certified nurse midwife (09);
7. Neonatal nurse practitioner (13);
8. Women's health nurse practitioner (14);
9. Psychiatric nurse/mental health practitioner (17); ~~and~~
10. Pediatric/acute care nurse practitioner (18); and
11. Clinical nurse specialist (19).

B. Other categories of licensed nurse practitioners shall be licensed if the Committee of the Joint Boards of Nursing and Medicine determines that the category meets the requirements of this chapter.

C. Nurse practitioners licensed prior to January 15, 2016, may:

1. Retain the specialty category in which they were initially licensed; or

2. If the specialty category has been subsequently deleted and if qualified by certification, be issued a license in a specialty category listed in subsection A of this section that is consistent with such certification.

18VAC90-30-86. Autonomous practice for nurse practitioners other than certified nurse midwives, ~~or~~ certified registered nurse anesthetists, or clinical nurse specialists.

A. A nurse practitioner with a current, unrestricted license, other than someone licensed in the category of certified nurse midwife, ~~or~~ certified registered nurse anesthetist, or clinical nurse specialist, may qualify for autonomous practice by completion of the equivalent of ~~five~~ two years of full-time clinical experience as a nurse practitioner until July 1, 2022. Thereafter, the requirement shall be the equivalent of five years of full-time clinical experience to qualify for autonomous practice.

1. ~~Five years of full-time~~ Full-time clinical experience shall be defined as 1,800 hours per year ~~for a total of 9,000 hours~~.

2. Clinical experience shall be defined as the postgraduate delivery of health care directly to patients pursuant to a practice agreement with a patient care team physician.

B. Qualification for authorization for autonomous practice shall be determined upon submission of a fee as specified in 18VAC90-30-50 and an attestation acceptable to the boards. The attestation shall be signed by the nurse practitioner and the nurse practitioner's patient care team physician stating that:

1. The patient care team physician 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 chapter and §§ 54.1-2957 and 54.1-2957.01 of the Code of Virginia;

2. 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, as specified in 18VAC90-30-70, for which the nurse practitioner was certified and licensed; and

3. The period of time and hours of practice during which the patient care team physician practiced with the nurse practitioner under such a practice agreement.

C. The nurse practitioner may submit attestations from more than one patient care team physician with whom the nurse practitioner practiced during the equivalent of five years of practice, but all attestations shall be submitted to the boards at the same time.

D. If a nurse practitioner is licensed and certified in more than one category as specified in 18VAC90-30-70, a separate fee and attestation that meets the requirements of subsection B of this section shall be submitted for each category. If the hours of practice are applicable to the patient population and in practice areas included within each of the categories of licensure and certification, those hours may be counted toward a second attestation.

E. In the event a patient care team physician has died, become disabled, retired, or relocated to another state, or in the event of any other circumstance that inhibits the ability of the nurse practitioner from obtaining an attestation as specified in subsection B of this section, the nurse practitioner may submit other evidence of meeting the qualifications for autonomous practice along with an attestation signed by the nurse practitioner. Other evidence may include employment

records, military service, Medicare or Medicaid reimbursement records, or other similar records that verify full-time clinical practice in the role of a nurse practitioner in the category for which the nurse practitioner is licensed and certified. The burden shall be on the nurse practitioner to provide sufficient evidence to support the nurse practitioner's inability to obtain an attestation from a patient care team physician.

F. A nurse practitioner to whom a license is issued by endorsement may engage in autonomous practice if such application includes an attestation acceptable to the boards that the nurse practitioner has completed the equivalent of five years of full-time clinical experience as specified in subsection A of this section and in accordance with the laws of the state in which the nurse practitioner was previously licensed.

G. A nurse practitioner authorized to practice autonomously shall:

1. Only practice within the scope of the nurse practitioner's clinical and professional training and limits of the nurse practitioner's knowledge and experience and consistent with the applicable standards of care;

2. Consult and collaborate with other health care providers based on the clinical conditions of the patient to whom health care is provided; and

3. Establish a plan for referral of complex medical cases and emergencies to physicians or other appropriate health care providers.

18VAC90-30-87. Autonomous practice for nurse practitioners licensed as certified nurse midwives.

A. A certified nurse midwife who has completed 1,000 hours of practice as a certified nurse midwife may practice without a practice agreement upon receipt by the certified nurse midwife of an attestation from a certified nurse midwife who has practiced for at least two years prior to entering into the practice agreement or the licensed physician with whom the certified nurse midwife has entered into a practice agreement stating (i) that such certified nurse midwife or licensed physician has provided consultation to the certified nurse midwife pursuant to a practice agreement meeting the requirements of § 54.1-2957 H of the Code of Virginia, and (ii) the period of time for which such certified nurse midwife or licensed physician practiced in collaboration and consultation with the certified nurse midwife pursuant to the practice agreement.

B. A certified nurse midwife authorized to practice without a practice agreement shall consult and collaborate with and refer patients to such other health care providers as may be appropriate for the care of the patient.

PART III. PRACTICE OF LICENSED NURSE PRACTITIONERS.

18VAC90-30-120. Practice of licensed nurse practitioners other than certified registered nurse anesthetists, ~~or~~ certified nurse midwives, or clinical nurse specialists.

A. A nurse practitioner licensed in a category other than certified registered nurse anesthetist, ~~or~~ certified nurse midwife, or clinical nurse specialist shall be authorized to render care in collaboration and consultation with a licensed patient care team physician as part of a patient care

team or if determined by the boards to qualify in accordance with 18VAC90-30-86, authorized to practice autonomously without a practice agreement with a patient care team physician.

B. The practice shall be based on specialty education preparation as an advanced practice registered nurse in accordance with standards of the applicable certifying organization, as identified in 18VAC90-30-90.

C. All nurse practitioners licensed in any category other than certified registered nurse anesthetist, ~~or~~ certified nurse midwife, or clinical nurse specialist shall practice in accordance with a written or electronic practice agreement as defined in 18VAC90-30-10 or in accordance with 18VAC90-30-86.

D. The written or electronic practice agreement shall include provisions for:

1. The periodic review of patient charts or electronic patient records by a patient care team physician and may include provisions for visits to the site where health care is delivered in the manner and at the frequency determined by the patient care team;

2. Appropriate physician input in complex clinical cases and patient emergencies and for referrals; and

3. The nurse practitioner's authority for signatures, certifications, stamps, verifications, affidavits, and endorsements provided it is:

a. In accordance with the specialty license of the nurse practitioner and within the scope of practice of the patient care team physician;

b. Permitted by § 54.1-2957.02 or applicable sections of the Code of Virginia; and

c. Not in conflict with federal law or regulation.

E. The practice agreement shall be maintained by the 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; however, the nurse practitioner shall be responsible for providing a copy to the boards upon request.

18VAC90-30-123. Practice of nurse practitioners licensed as certified nurse midwives.

A. A nurse practitioner licensed in the category of certified nurse midwife who has practiced fewer than 1,000 hours shall practice in consultation with a licensed physician in accordance with a practice agreement between the nurse practitioner and the physician or with a certified nurse midwife who has practiced for at least two years prior to entering into the practice agreement. Such practice agreement shall address the availability of the physician or the certified nurse midwife for routine and urgent consultation on patient care.

B. The practice agreement shall be maintained by the nurse midwife and provided to the boards upon request. For nurse midwives providing care to patients within a hospital or health care system, the practice agreement may be included as part of documents delineating the nurse midwife's clinical privileges or the electronic or written delineation of duties and responsibilities; however, the nurse midwife shall be responsible for providing a copy to the boards upon request.

C. A nurse practitioner licensed in the category of a certified nurse midwife shall practice in accordance with the Standards for the Practice of Midwifery (Revised 2011) defined by the American College of Nurse-Midwives.

18VAC90-30-123.1. Practice of nurse practitioners licensed as clinical nurse specialists.

A. Nurse practitioners licensed in the category of clinical nurse specialist shall practice in consultation with a licensed physician in accordance with a practice agreement between the nurse practitioner and the licensed physician.

B. 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.

C. The practice of clinical nurse specialists shall be consistent with the standards of care for the profession and with applicable laws and regulations.

Commonwealth of Virginia

REGULATIONS
FOR
PRESCRIPTIVE AUTHORITY FOR NURSE PRACTITIONERS

VIRGINIA BOARD OF NURSING
VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18 VAC 90-40-10 et seq.

Statutory Authority: §§ 54.1-2400 and 54.1-2957.01 of the *Code of Virginia*

Revised Date:

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Part I. General Provisions.

18VAC90-40-10. Definitions.

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

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

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

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

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

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

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

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

"MME" means morphine milligram equivalent.

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

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

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

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

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

18VAC90-40-90. Practice agreement.

A. With the exceptions listed in subsection E of this section, a nurse practitioner with prescriptive authority may prescribe only within the scope of the written or electronic practice agreement with a patient care team physician.

B. At any time there are changes in the patient care team physician, authorization to prescribe, or scope of practice, the nurse practitioner shall revise the practice agreement and maintain the revised agreement.

C. The practice agreement shall contain the following:

1. A description of the prescriptive authority of the nurse practitioner within the scope allowed by law and the practice of the nurse practitioner.

2. An authorization for categories of drugs and devices within the requirements of § 54.1-2957.01 of the Code of Virginia.

3. The signature of the patient care team physician who is practicing with the nurse practitioner or a clear statement of the name of the patient care team physician who has entered into the practice agreement.

D. In accordance with § 54.1-2957.01 of the Code of Virginia, a physician shall not serve as a patient care team physician to more than six nurse practitioners with prescriptive authority at any one time.

E. Exceptions.

1. A nurse practitioner licensed in the category of certified nurse midwife and holding a license for prescriptive authority may prescribe in accordance with a written or electronic practice agreement with a consulting physician ~~or may prescribe Schedule VI controlled substances without the requirement for inclusion of such prescriptive authority in a practice agreement~~ or with a certified nurse midwife who has practiced for at least two years prior to entering into a practice agreement. A nurse practitioner in the category of certified nurse midwife who has qualified for autonomous practice as set forth in 18VAC90-30-87 may prescribe without a practice agreement.

2. A nurse practitioner licensed in the category of a clinical nurse specialist and holding authorization for prescriptive authority may prescribe in accordance with a written or electronic practice agreement with a consulting physician or may prescribe Schedule VI controlled substances without the requirement for inclusion of such prescriptive authority in a practice agreement.

~~2.~~ 3. A nurse practitioner who is licensed in a category other than certified nurse midwife, ~~or~~ certified registered nurse anesthetist, or clinical nurse specialist, and who has met the qualifications for autonomous practice as set forth in 18VAC90-30-86 may prescribe without a practice agreement with a patient care team physician.

Agenda Item: Adoption of proposed regulations for clinical nurse specialist registration as a fast-track action

Enclosed is:

Copy of proposed regulations

Staff note:

Certain changes to regulations are necessary for renewal of licenses for clinical nurse specialists (HB1747) but the changes are not conforming to the Code so they are not deemed to be exempt regulatory actions.

The Board of Nursing adopted the changes on July 20th.

Board action:

To adopt the amendments as proposed regulations by a fast-track action

Regulations Governing the Licensure of Nurse Practitioners

18VAC90-30-80. Qualifications for initial licensure.

A. An applicant for initial licensure as a nurse practitioner shall:

1. Hold a current, active license as a registered nurse in Virginia or hold a current multistate licensure privilege as a registered nurse;

2. Submit evidence of a graduate degree in nursing or in the appropriate nurse practitioner specialty from an educational program designed to prepare ~~nurse practitioners~~ advanced practice registered nurses that is an approved program as defined in 18VAC90-30-10. Evidence shall include a transcript that shows that the applicant has successfully completed core coursework that prepares the applicant for licensure in the appropriate specialty;

3. Submit evidence of professional certification that is consistent with the specialty area of the applicant's educational preparation issued by an agency accepted by the boards as identified in 18VAC90-30-90;

4. File the required application; and

5. Pay the application fee prescribed in 18VAC90-30-50.

B. Provisional licensure may be granted to an applicant who satisfies all requirements of this section with the exception of subdivision A 3 of this section, provided the board has received evidence of the applicant's eligibility to sit for the certifying examination directly from the national certifying body. An applicant may practice with a provisional license for either six months from the date of issuance or until issuance of a permanent license or until he receives notice that he has failed the certifying examination, whichever occurs first.

18VAC90-30-105. Continuing competency requirements.

A. In order to renew a license biennially, a nurse practitioner initially licensed on or after May 8, 2002, shall hold current professional certification in the area of specialty practice from one of the certifying agencies designated in 18VAC90-30-90, except for those licensed in accordance with subsection B of this section.

B. In order to renew a license biennially, nurse practitioners licensed prior to May 8, 2002 or clinical nurse specialists who were registered by the Board of Nursing with a retired certification, shall meet one of the following requirements:

1. Hold current professional certification in the area of specialty practice from one of the certifying agencies designated in 18VAC90-30-90; or

2. Complete at least 40 hours of continuing education in the area of specialty practice approved by one of the certifying agencies designated in 18VAC90-30-90 or approved by Accreditation Council for Continuing Medical Education (ACCME) of the American Medical Association as a Category I Continuing Medical Education (CME) course.

C. The nurse practitioner shall retain evidence of compliance and all supporting documentation for a period of four years following the renewal period for which the records apply.

D. The boards shall periodically conduct a random audit of their licensees to determine compliance. The nurse practitioners selected for the audit shall provide the evidence of compliance and supporting documentation within 30 days of receiving notification of the audit.

E. The boards may delegate the authority to grant an extension or exemption for all or part of the requirements for circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters.

Regulations for Prescriptive Authority for Nurse Practitioners

18VAC90-40-40. Qualifications for initial approval of prescriptive authority.

An applicant for prescriptive authority shall meet the following requirements:

1. Hold a current, unrestricted license as a nurse practitioner in the Commonwealth of Virginia;

2. Provide evidence of one of the following:

a. Continued professional certification as required for initial licensure as a nurse practitioner;

b. Satisfactory completion of a graduate level course in pharmacology or pharmacotherapeutics obtained as part of the ~~nurse practitioner or~~ advance practice registered nurse education program within the five years prior to submission of the application;

c. Practice as a nurse practitioner for no less than 1000 hours and 15 continuing education units related to the area of practice for each of the two years immediately prior to submission of the application; or

d. Thirty contact hours of education in pharmacology or pharmacotherapeutics acceptable to the boards taken within five years prior to submission of the application. The 30 contact hours may be obtained in a formal academic setting as a discrete offering or as noncredit continuing education offerings and shall include the following course content:

(1) Applicable federal and state laws;

(2) Prescription writing;

(3) Drug selection, dosage, and route;

(4) Drug interactions;

(5) Information resources; and

(6) Clinical application of pharmacology related to specific scope of practice.

3. Develop a practice agreement between the nurse practitioner and the patient care team physician as required in 18VAC90-40-90; and

4. File a completed application and pay the fees as required in 18VAC90-40-70.

Agenda Item: Board Action – Adoption of Notice of Intended Regulatory Action (NOIRA) – Licensed certified midwives

Included in your agenda package:

- Copy of HB1953

Staff note:

The NOIRA will identify the general requirements for licensure, renewal and practice of licensed certified midwives under the joint regulation of the Boards of Nursing and Medicine.

The Board of Nursing adopted the NOIRA on July 20th.

Board Action:

Motion to approve issuance of a Notice of Intended Regulatory Action to promulgate a new chapter in the Administrative Code for the licensure of certified midwives

CHAPTER 200

*An Act to amend and reenact §§ **54.1-2900**, **54.1-3005**, **54.1-3303**, and **54.1-3408** of the Code of Virginia and to amend the Code of Virginia by adding a section numbered **54.1-2957.04**, relating to licensed certified midwives; licensure; practice.*

[H 1953]

Approved March 18, 2021

Be it enacted by the General Assembly of Virginia:

1. That §§ **54.1-2900**, **54.1-3005**, **54.1-3303**, and **54.1-3408** of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered **54.1-2957.04** 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.

"Birth control" means contraceptive methods that are approved by the U.S. Food and Drug Administration. "Birth control" shall not be considered abortion for the purposes of Title 18.2.

"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.

"Licensed certified midwife" means a person who is licensed as a certified midwife by the Boards of Medicine and Nursing.

"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 a health care professional who has met the requirements of the Board for licensure 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 (i) requesting, receiving, and reviewing a patient's medical and physical history, including information related to past surgical and nonsurgical treatment of the patient and controlled substances prescribed to the patient, and (ii) documenting in a patient's record information related to the condition and symptoms of the patient, the examination and evaluation of the patient made by the doctor of chiropractic, and treatment provided to the patient by the doctor of chiropractic. "Practice of chiropractic" shall also 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 licensed certified midwifery" means the provision of primary health care for preadolescents, adolescents, and adults within the scope of practice of a certified midwife established in accordance with the Standards for the Practice of Midwifery set by the American College of Nurse-Midwives, including (i) providing sexual and reproductive care and care during pregnancy and childbirth, postpartum care, and care for the newborn for up to 28 days following the birth of the child; (ii) prescribing of pharmacological and non-pharmacological therapies within the scope of the practice of midwifery; (iii) consulting or collaborating with or referring patients to such other health care providers as

may be appropriate for the care of the patients; and (iv) serving as an educator in the theory and practice of midwifery.

"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.

"Practice of surgical assisting" means the performance of significant surgical tasks, including manipulation of organs, suturing of tissue, placement of hemostatic agents, injection of local anesthetic, harvesting of veins, implementation of devices, and other duties as directed by a licensed doctor of medicine, osteopathy, or podiatry under the direct supervision of a licensed doctor of medicine, osteopathy, or podiatry.

"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.

"Surgical assistant" means an individual who has met the requirements of the Board for licensure as a surgical assistant and who works under the direct supervision of a licensed doctor of medicine, osteopathy, or podiatry.

*§ **54.1-2957.04**. Licensure as a licensed certified midwife; practice as a licensed certified midwife; use of title; required disclosures.*

A. It shall be unlawful for any person to practice or to hold himself out as practicing as a licensed certified midwife or use in connection with his name the words "Licensed Certified Midwife" unless he holds a license as such issued jointly by the Boards of Medicine and Nursing.

B. The Boards of Medicine and Nursing shall jointly adopt regulations for the licensure of licensed certified midwives, which shall include criteria for licensure and renewal of a license as a certified midwife that shall include a requirement that the applicant provide evidence satisfactory to the Boards of current certification as a certified

midwife by the American Midwifery Certification Board and that shall be consistent with the requirements for certification as a certified midwife established by the American Midwifery Certification Board.

C. The Boards of Medicine and Nursing may issue a license by endorsement to an applicant to practice as a licensed certified midwife if the applicant has been licensed as a certified midwife under the laws of another state and, pursuant to regulations of the Boards, the applicant meets the qualifications for licensure as a licensed certified midwife in the Commonwealth.

D. Licensed certified midwives shall practice in consultation with a licensed physician in accordance with a practice agreement between the licensed certified midwife 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 the licensed certified midwife and provided to the Board upon request. The Board shall adopt regulations for the practice of licensed certified midwives, which shall be in accordance with regulations jointly adopted by the Boards of Medicine and Nursing, which shall be consistent with the Standards for the Practice of Midwifery set by the American College of Nurse-Midwives governing the practice of midwifery.

E. Notwithstanding any provision of law or regulation to the contrary, a licensed certified midwife may prescribe Schedules II through VI controlled substances in accordance with regulations of the Boards of Medicine and Nursing.

*F. A licensed certified midwife who provides health care services to a patient outside of a hospital or birthing center shall disclose to that patient, when appropriate, information on health risks associated with births outside of a hospital or birthing center, including but not limited to risks associated with vaginal births after a prior cesarean section, breech births, births by women experiencing high-risk pregnancies, and births involving multiple gestation. As used in this subsection, "birthing center" shall have the same meaning as in § **54.1-2957.03**.*

*G. A licensed certified midwife who provides health care to a patient shall be liable for the midwife's negligent, grossly negligent, or willful and wanton acts or omissions. Except as otherwise provided by law, any (i) doctor of medicine or osteopathy who did not collaborate or consult with the midwife regarding the patient and who has not previously treated the patient for this pregnancy, (ii) physician assistant, (iii) nurse practitioner, (iv) prehospital emergency medical personnel, or (v) hospital as defined in § **32.1-123**, or any employee of, person providing services pursuant to a contract with, or agent of such hospital, that provides screening and stabilization health care services to a patient as a result of a licensed certified midwife's negligent, grossly negligent, or willful and wanton acts or omissions shall be immune from liability for acts or omissions constituting ordinary negligence.*

§ **54.1-3005**. Specific powers and duties of Board.

In addition to the general powers and duties conferred in this title, the Board shall have the following specific powers and duties:

1. To prescribe minimum standards and approve curricula for educational programs preparing persons for licensure or certification under this chapter;

2. To approve programs that meet the requirements of this chapter and of the Board;

3. To provide consultation service for educational programs as requested;

4. To provide for periodic surveys of educational programs;

5. To deny or withdraw approval from educational or training programs for failure to meet prescribed standards;

6. To provide consultation regarding nursing practice for institutions and agencies as requested and investigate illegal nursing practices;

7. To keep a record of all its proceedings;

8. To certify and maintain a registry of all certified nurse aides and to promulgate regulations consistent with federal law and regulation. The Board shall require all schools to demonstrate their compliance with § **54.1-3006.2** upon application for approval or reapproval, during an on-site visit, or in response to a complaint or a report of noncompliance. The Board may impose a fee pursuant to § **54.1-2401** for any violation thereof. Such regulations may include standards for the authority of licensed practical nurses to teach nurse aides;

9. To maintain a registry of clinical nurse specialists and to promulgate regulations governing clinical nurse specialists;

10. To license and maintain a registry of all licensed massage therapists and to promulgate regulations governing the criteria for licensure as a massage therapist and the standards of professional conduct for licensed massage therapists;

11. To promulgate regulations for the delegation of certain nursing tasks and procedures not involving assessment, evaluation or nursing judgment to an appropriately trained unlicensed person by and under the supervision of a registered nurse, who retains responsibility and accountability for such delegation;

12. To develop and revise as may be necessary, in coordination with the Boards of Medicine and Education, guidelines for the training of employees of a school board in the administration of insulin and glucagon for the purpose of assisting with routine insulin injections and providing emergency treatment for life-threatening hypoglycemia. The first set of such guidelines shall be finalized by September 1, 1999, and shall be made available to local school boards for a fee not to exceed the costs of publication;

13. To enter into the Nurse Licensure Compact as set forth in this chapter and to promulgate regulations for its implementation;

14. To collect, store and make available nursing workforce information regarding the various categories of nurses certified, licensed or registered pursuant to § **54.1-3012.1**;

15. To expedite application processing, to the extent possible, pursuant to § **54.1-119** for an applicant for licensure or certification by the Board upon submission of evidence that the applicant, who is licensed or certified in another state, is relocating to the Commonwealth pursuant to a spouse's official military orders;

16. To register medication aides and promulgate regulations governing the criteria for such registration and standards of conduct for medication aides;

17. To approve training programs for medication aides to include requirements for instructional personnel, curriculum, continuing education, and a competency evaluation;

18. To set guidelines for the collection of data by all approved nursing education programs and to compile this data in an annual report. The data shall include but not be limited to enrollment, graduation rate, attrition rate, and number of qualified applicants who are denied admission;

19. (Effective until July 1, 2021) To develop, in consultation with the Board of Pharmacy, guidelines for the training of employees of child day programs as defined in § **63.2-100** and regulated by the State Board of Social Services in the administration of prescription drugs as defined in the Drug Control Act (§ **54.1-3400** et seq.). Such training programs shall be taught by a registered nurse, licensed practical nurse, doctor of medicine or osteopathic medicine, or pharmacist;

19. (Effective July 1, 2021) To develop, in consultation with the Board of Pharmacy, guidelines for the training of employees of child day programs as defined in § **22.1-289.02** and regulated by the Board of Education in the administration of prescription drugs as defined in the Drug Control Act (§ **54.1-3400** et seq.). Such training programs shall be taught by a registered nurse, licensed practical nurse, doctor of medicine or osteopathic medicine, or pharmacist;

20. In order to protect the privacy and security of health professionals licensed, registered or certified under this chapter, to promulgate regulations permitting use on identification badges of first name and first letter only of last name and appropriate title when practicing in hospital emergency departments, in psychiatric and mental health units and programs, or in health care facility units offering treatment for patients in custody of state or local law-enforcement agencies;

21. To revise, as may be necessary, guidelines for seizure management, in coordination with the Board of Medicine, including the list of rescue medications for students with epilepsy and other seizure disorders in the public schools. The revised guidelines shall be finalized and made available to the Board of Education by August 1, 2010. The guidelines shall then be posted on the Department of Education's website; and

22. To promulgate, together with the Board of Medicine, regulations governing the licensure of nurse practitioners pursuant to § **54.1-2957** *and the licensure of licensed certified midwives pursuant to § **54.1-2957.04**.*

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

A. A prescription for a controlled substance may be issued only by a practitioner of medicine, osteopathy, podiatry, dentistry or veterinary medicine who is authorized to prescribe controlled substances, ~~or by~~ a licensed nurse practitioner pursuant to § **54.1-2957.01**, *a licensed certified midwife pursuant to § **54.1-2957.04**,* a licensed physician assistant pursuant to § **54.1-2952.1**, or a TPA-certified optometrist pursuant to Article 5 (§ **54.1-3222** et seq.) of Chapter 32.

B. A prescription shall be issued only to persons or animals with whom the practitioner has a bona fide practitioner-patient relationship or veterinarian-client-patient relationship. If a practitioner is providing expedited partner therapy consistent with the recommendations of the Centers for Disease Control and Prevention, then a bona fide practitioner-patient relationship shall not be required.

A bona fide practitioner-patient relationship shall exist if the practitioner has (i) obtained or caused to be obtained a medical or drug history of the patient; (ii) provided information to the patient about the benefits and risks of the drug being prescribed; (iii) performed or caused to be performed an appropriate examination of the patient, either physically or by the use of instrumentation and diagnostic equipment through which images and medical records may

be transmitted electronically; and (iv) initiated additional interventions and follow-up care, if necessary, especially if a prescribed drug may have serious side effects. Except in cases involving a medical emergency, the examination required pursuant to clause (iii) shall be performed by the practitioner prescribing the controlled substance, a practitioner who practices in the same group as the practitioner prescribing the controlled substance, or a consulting practitioner.

A practitioner who has established a bona fide practitioner-patient relationship with a patient in accordance with the provisions of this subsection may prescribe Schedule II through VI controlled substances to that patient, provided that, in cases in which the practitioner has performed the examination required pursuant to clause (iii) by use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically, the prescribing of such Schedule II through V controlled substance is in compliance with federal requirements for the practice of telemedicine.

For the purpose of prescribing a Schedule VI controlled substance to a patient via telemedicine services as defined in § **38.2-3418.16**, a prescriber may establish a bona fide practitioner-patient relationship by an examination through face-to-face interactive, two-way, real-time communications services or store-and-forward technologies when all of the following conditions are met: (a) the patient has provided a medical history that is available for review by the prescriber; (b) the prescriber obtains an updated medical history at the time of prescribing; (c) the prescriber makes a diagnosis at the time of prescribing; (d) the prescriber conforms to the standard of care expected of in-person care as appropriate to the patient's age and presenting condition, including when the standard of care requires the use of diagnostic testing and performance of a physical examination, which may be carried out through the use of peripheral devices appropriate to the patient's condition; (e) the prescriber is actively licensed in the Commonwealth and authorized to prescribe; (f) if the patient is a member or enrollee of a health plan or carrier, the prescriber has been credentialed by the health plan or carrier as a participating provider and the diagnosing and prescribing meets the qualifications for reimbursement by the health plan or carrier pursuant to § **38.2-3418.16**; and (g) upon request, the prescriber provides patient records in a timely manner in accordance with the provisions of § **32.1-127.1:03** and all other state and federal laws and regulations. Nothing in this paragraph shall permit a prescriber to establish a bona fide practitioner-patient relationship for the purpose of prescribing a Schedule VI controlled substance when the standard of care dictates that an in-person physical examination is necessary for diagnosis. Nothing in this paragraph shall apply to: (1) a prescriber providing on-call coverage per an agreement with another prescriber or his prescriber's professional entity or employer; (2) a prescriber consulting with another prescriber regarding a patient's care; or (3) orders of prescribers for hospital out-patients or in-patients.

For purposes of this section, a bona fide veterinarian-client-patient relationship is one in which a veterinarian, another veterinarian within the group in which he practices, or a veterinarian with whom he is consulting has assumed the responsibility for making medical judgments regarding the health of and providing medical treatment to an animal as defined in § **3.2-6500**, other than an equine as defined in § **3.2-6200**, a group of agricultural animals as defined in § **3.2-6500**, or bees as defined in § **3.2-4400**, and a client who is the owner or other caretaker of the animal, group of agricultural animals, or bees has consented to such treatment and agreed to follow the instructions of the veterinarian. Evidence that a veterinarian has assumed responsibility for making medical judgments regarding the health of and providing medical treatment to an animal, group of agricultural animals, or bees shall include evidence that the veterinarian (A) has sufficient knowledge of the animal, group of agricultural animals, or bees to provide a general or preliminary diagnosis of the medical condition of the animal, group of agricultural animals, or bees; (B) has made an examination of the animal, group of agricultural animals, or bees, either physically or by the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically or has become familiar with the care and keeping of that species of animal or bee on the premises of the client, including other premises within the same operation or production system of the client, through medically

appropriate and timely visits to the premises at which the animal, group of agricultural animals, or bees are kept; and (C) is available to provide follow-up care.

C. A prescription shall only be issued for a medicinal or therapeutic purpose in the usual course of treatment or for authorized research. A prescription not issued in the usual course of treatment or for authorized research is not a valid prescription. A practitioner who prescribes any controlled substance with the knowledge that the controlled substance will be used otherwise than for medicinal or therapeutic purposes shall be subject to the criminal penalties provided in § **18.2-248** for violations of the provisions of law relating to the distribution or possession of controlled substances.

D. No prescription shall be filled unless a bona fide practitioner-patient-pharmacist relationship exists. A bona fide practitioner-patient-pharmacist relationship shall exist in cases in which a practitioner prescribes, and a pharmacist dispenses, controlled substances in good faith to a patient for a medicinal or therapeutic purpose within the course of his professional practice.

In cases in which it is not clear to a pharmacist that a bona fide practitioner-patient relationship exists between a prescriber and a patient, a pharmacist shall contact the prescribing practitioner or his agent and verify the identity of the patient and name and quantity of the drug prescribed.

Any person knowingly filling an invalid prescription shall be subject to the criminal penalties provided in § **18.2-248** for violations of the provisions of law relating to the sale, distribution or possession of controlled substances.

E. Notwithstanding any provision of law to the contrary and consistent with recommendations of the Centers for Disease Control and Prevention or the Department of Health, a practitioner may prescribe Schedule VI antibiotics and antiviral agents to other persons in close contact with a diagnosed patient when (i) the practitioner meets all requirements of a bona fide practitioner-patient relationship, as defined in subsection B, with the diagnosed patient and (ii) in the practitioner's professional judgment, the practitioner deems there is urgency to begin treatment to prevent the transmission of a communicable disease. In cases in which the practitioner is an employee of or contracted by the Department of Health or a local health department, the bona fide practitioner-patient relationship with the diagnosed patient, as required by clause (i), shall not be required.

F. A pharmacist may dispense a controlled substance pursuant to a prescription of an out-of-state practitioner of medicine, osteopathy, podiatry, dentistry, optometry, or veterinary medicine, a nurse practitioner, or a physician assistant authorized to issue such prescription if the prescription complies with the requirements of this chapter and the Drug Control Act (§ **54.1-3400** et seq.).

G. A licensed nurse practitioner who is authorized to prescribe controlled substances pursuant to § **54.1-2957.01** may issue prescriptions or provide manufacturers' professional samples for controlled substances and devices as set forth in the Drug Control Act (§ **54.1-3400** et seq.) in good faith to his patient for a medicinal or therapeutic purpose within the scope of his professional practice.

H. A licensed physician assistant who is authorized to prescribe controlled substances pursuant to § **54.1-2952.1** may issue prescriptions or provide manufacturers' professional samples for controlled substances and devices as set forth in the Drug Control Act (§ **54.1-3400** et seq.) in good faith to his patient for a medicinal or therapeutic purpose within the scope of his professional practice.

I. A TPA-certified optometrist who is authorized to prescribe controlled substances pursuant to Article 5 (§ **54.1-3222** et seq.) of Chapter 32 may issue prescriptions in good faith or provide manufacturers' professional samples to his patients for medicinal or therapeutic purposes within the scope of his professional practice for the drugs specified on the TPA-Formulary, established pursuant to § **54.1-3223**, which shall be limited to (i) analgesics included on Schedule II controlled substances as defined in § **54.1-3448** of the Drug Control Act (§ **54.1-3400** et seq.) consisting of hydrocodone in combination with acetaminophen; (ii) oral analgesics included in Schedules III through VI, as defined in §§ **54.1-3450** and **54.1-3455** of the Drug Control Act (§ **54.1-3400** et seq.), which are appropriate to relieve ocular pain; (iii) other oral Schedule VI controlled substances, as defined in § **54.1-3455** of the Drug Control Act, appropriate to treat diseases and abnormal conditions of the human eye and its adnexa; (iv) topically applied Schedule VI drugs, as defined in § **54.1-3455** of the Drug Control Act; and (v) intramuscular administration of epinephrine for treatment of emergency cases of anaphylactic shock.

J. The requirement for a bona fide practitioner-patient relationship shall be deemed to be satisfied by a member or committee of a hospital's medical staff when approving a standing order or protocol for the administration of influenza vaccinations and pneumococcal vaccinations in a hospital in compliance with § **32.1-126.4**.

K. Notwithstanding any other provision of law, a prescriber may authorize a registered nurse or licensed practical nurse to approve additional refills of a prescribed drug for no more than 90 consecutive days, provided that (i) the drug is classified as a Schedule VI drug; (ii) there are no changes in the prescribed drug, strength, or dosage; (iii) the prescriber has a current written protocol, accessible by the nurse, that identifies the conditions under which the nurse may approve additional refills; and (iv) the nurse documents in the patient's chart any refills authorized for a specific patient pursuant to the protocol and the additional refills are transmitted to a pharmacist in accordance with the allowances for an authorized agent to transmit a prescription orally or by facsimile pursuant to subsection C of § **54.1-3408.01** and regulations of the Board.

§ **54.1-3408**. Professional use by practitioners.

A. A practitioner of medicine, osteopathy, podiatry, dentistry, or veterinary medicine ~~or~~, a licensed nurse practitioner pursuant to § **54.1-2957.01**, *a licensed certified midwife pursuant to § 54.1-2907.04*, a licensed physician assistant pursuant to § **54.1-2952.1**, or a TPA-certified optometrist pursuant to Article 5 (§ **54.1-3222** et seq.) of Chapter 32 shall only prescribe, dispense, or administer controlled substances in good faith for medicinal or therapeutic purposes within the course of his professional practice.

B. The prescribing practitioner's order may be on a written prescription or pursuant to an oral prescription as authorized by this chapter. The prescriber may administer drugs and devices, or he may cause drugs or devices to be administered by:

1. A nurse, physician assistant, or intern under his direction and supervision;

2. Persons trained to administer drugs and devices to patients in state-owned or state-operated hospitals or facilities licensed as hospitals by the Board of Health or psychiatric hospitals licensed by the Department of Behavioral Health and Developmental Services who administer drugs under the control and supervision of the prescriber or a pharmacist;

3. Emergency medical services personnel certified and authorized to administer drugs and devices pursuant to regulations of the Board of Health who act within the scope of such certification and pursuant to an oral or written order or standing protocol; or

4. A licensed respiratory therapist as defined in § **54.1-2954** who administers by inhalation controlled substances used in inhalation or respiratory therapy.

C. Pursuant to an oral or written order or standing protocol, the prescriber, who is authorized by state or federal law to possess and administer radiopharmaceuticals in the scope of his practice, may authorize a nuclear medicine technologist to administer, under his supervision, radiopharmaceuticals used in the diagnosis or treatment of disease.

D. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize registered nurses and licensed practical nurses to possess (i) epinephrine and oxygen for administration in treatment of emergency medical conditions and (ii) heparin and sterile normal saline to use for the maintenance of intravenous access lines.

Pursuant to the regulations of the Board of Health, certain emergency medical services technicians may possess and administer epinephrine in emergency cases of anaphylactic shock.

Pursuant to an order or standing protocol issued by the prescriber within the course of his professional practice, any school nurse, school board employee, employee of a local governing body, or employee of a local health department who is authorized by a prescriber and trained in the administration of (a) epinephrine may possess and administer epinephrine and (b) albuterol inhalers or nebulized albuterol may possess or administer an albuterol inhaler or nebulized albuterol to a student diagnosed with a condition requiring an albuterol inhaler or nebulized albuterol when the student is believed to be experiencing or about to experience an asthmatic crisis.

Pursuant to an order or a standing protocol issued by the prescriber within the course of his professional practice, any employee of a school for students with disabilities, as defined in § **22.1-319** and licensed by the Board of Education, or any employee of a private school that is accredited pursuant to § **22.1-19** as administered by the Virginia Council for Private Education who is authorized by a prescriber and trained in the administration of (1) epinephrine may possess and administer epinephrine and (2) albuterol inhalers or nebulized albuterol may possess or administer an albuterol inhaler or nebulized albuterol to a student diagnosed with a condition requiring an albuterol inhaler or nebulized albuterol when the student is believed to be experiencing or about to experience an asthmatic crisis.

Pursuant to an order or a standing protocol issued by the prescriber within the course of his professional practice, any employee of a public institution of higher education or a private institution of higher education who is authorized by a prescriber and trained in the administration of epinephrine may possess and administer epinephrine.

Pursuant to an order or a standing protocol issued by the prescriber within the course of his professional practice, any employee of an organization providing outdoor educational experiences or programs for youth who is authorized by a prescriber and trained in the administration of epinephrine may possess and administer epinephrine.

Pursuant to an order or a standing protocol issued by the prescriber within the course of his professional practice, and in accordance with policies and guidelines established by the Department of Health, such prescriber may authorize any employee of a restaurant licensed pursuant to Chapter 3 (§ **35.1-18** et seq.) of Title 35.1 to possess and administer epinephrine on the premises of the restaurant at which the employee is employed, provided that such person is trained in the administration of epinephrine.

Pursuant to an order issued by the prescriber within the course of his professional practice, an employee of a provider licensed by the Department of Behavioral Health and Developmental Services or a person providing services pursuant to a contract with a provider licensed by the Department of Behavioral Health and Developmental Services

may possess and administer epinephrine, provided such person is authorized and trained in the administration of epinephrine.

Pursuant to an order or standing protocol issued by the prescriber within the course of his professional practice, any employee of a public place, as defined in § **15.2-2820**, who is authorized by a prescriber and trained in the administration of epinephrine may possess and administer epinephrine.

Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize pharmacists to possess epinephrine and oxygen for administration in treatment of emergency medical conditions.

E. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize licensed physical therapists to possess and administer topical corticosteroids, topical lidocaine, and any other Schedule VI topical drug.

F. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize licensed athletic trainers to possess and administer topical corticosteroids, topical lidocaine, or other Schedule VI topical drugs; oxygen for use in emergency situations; epinephrine for use in emergency cases of anaphylactic shock; and naloxone or other opioid antagonist for overdose reversal.

G. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, and in accordance with policies and guidelines established by the Department of Health pursuant to § **32.1-50.2**, such prescriber may authorize registered nurses or licensed practical nurses under the supervision of a registered nurse to possess and administer tuberculin purified protein derivative (PPD) in the absence of a prescriber. The Department of Health's policies and guidelines shall be consistent with applicable guidelines developed by the Centers for Disease Control and Prevention for preventing transmission of mycobacterium tuberculosis and shall be updated to incorporate any subsequently implemented standards of the Occupational Safety and Health Administration and the Department of Labor and Industry to the extent that they are inconsistent with the Department of Health's policies and guidelines. Such standing protocols shall explicitly describe the categories of persons to whom the tuberculin test is to be administered and shall provide for appropriate medical evaluation of those in whom the test is positive. The prescriber shall ensure that the nurse implementing such standing protocols has received adequate training in the practice and principles underlying tuberculin screening.

The Health Commissioner or his designee may authorize registered nurses, acting as agents of the Department of Health, to possess and administer, at the nurse's discretion, tuberculin purified protein derivative (PPD) to those persons in whom tuberculin skin testing is indicated based on protocols and policies established by the Department of Health.

H. Pursuant to a written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize, with the consent of the parents as defined in § **22.1-1**, an employee of (i) a school board, (ii) a school for students with disabilities as defined in § **22.1-319** licensed by the Board of Education, or (iii) a private school accredited pursuant to § **22.1-19** as administered by the Virginia Council for Private Education who is trained in the administration of insulin and glucagon to assist with the administration of insulin or administer glucagon to a student diagnosed as having diabetes and who requires insulin injections during the school day or for whom glucagon has been prescribed for the emergency treatment of hypoglycemia. Such authorization shall only be

effective when a licensed nurse, nurse practitioner, physician, or physician assistant is not present to perform the administration of the medication.

Pursuant to a written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize an employee of a public institution of higher education or a private institution of higher education who is trained in the administration of insulin and glucagon to assist with the administration of insulin or administration of glucagon to a student diagnosed as having diabetes and who requires insulin injections or for whom glucagon has been prescribed for the emergency treatment of hypoglycemia. Such authorization shall only be effective when a licensed nurse, nurse practitioner, physician, or physician assistant is not present to perform the administration of the medication.

Pursuant to a written order issued by the prescriber within the course of his professional practice, such prescriber may authorize an employee of a provider licensed by the Department of Behavioral Health and Developmental Services or a person providing services pursuant to a contract with a provider licensed by the Department of Behavioral Health and Developmental Services to assist with the administration of insulin or to administer glucagon to a person diagnosed as having diabetes and who requires insulin injections or for whom glucagon has been prescribed for the emergency treatment of hypoglycemia, provided such employee or person providing services has been trained in the administration of insulin and glucagon.

I. A prescriber may authorize, pursuant to a protocol approved by the Board of Nursing, the administration of vaccines to adults for immunization, when a practitioner with prescriptive authority is not physically present, by (i) licensed pharmacists, (ii) registered nurses, or (iii) licensed practical nurses under the supervision of a registered nurse. A prescriber acting on behalf of and in accordance with established protocols of the Department of Health may authorize the administration of vaccines to any person by a pharmacist, nurse, or designated emergency medical services provider who holds an advanced life support certificate issued by the Commissioner of Health under the direction of an operational medical director when the prescriber is not physically present. The emergency medical services provider shall provide documentation of the vaccines to be recorded in the Virginia Immunization Information System.

J. A dentist may cause Schedule VI topical drugs to be administered under his direction and supervision by either a dental hygienist or by an authorized agent of the dentist.

Further, pursuant to a written order and in accordance with a standing protocol issued by the dentist in the course of his professional practice, a dentist may authorize a dental hygienist under his general supervision, as defined in § **54.1-2722**, or his remote supervision, as defined in subsection E or F of § **54.1-2722**, to possess and administer topical oral fluorides, topical oral anesthetics, topical and directly applied antimicrobial agents for treatment of periodontal pocket lesions, and any other Schedule VI topical drug approved by the Board of Dentistry.

In addition, a dentist may authorize a dental hygienist under his direction to administer Schedule VI nitrous oxide and oxygen inhalation analgesia and, to persons 18 years of age or older, Schedule VI local anesthesia.

K. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize registered professional nurses certified as sexual assault nurse examiners-A (SANE-A) under his supervision and when he is not physically present to possess and administer preventive medications for victims of sexual assault as recommended by the Centers for Disease Control and Prevention.

L. This section shall not prevent the administration of drugs by a person who has satisfactorily completed a training program for this purpose approved by the Board of Nursing and who administers such drugs in accordance with a prescriber's instructions pertaining to dosage, frequency, and manner of administration, and in accordance with regulations promulgated by the Board of Pharmacy relating to security and record keeping, when the drugs administered would be normally self-administered by (i) an individual receiving services in a program licensed by the Department of Behavioral Health and Developmental Services; (ii) a resident of the Virginia Rehabilitation Center for the Blind and Vision Impaired; (iii) a resident of a facility approved by the Board or Department of Juvenile Justice for the placement of children in need of services or delinquent or alleged delinquent youth; (iv) a program participant of an adult day-care center licensed by the Department of Social Services; (v) a resident of any facility authorized or operated by a state or local government whose primary purpose is not to provide health care services; (vi) a resident of a private children's residential facility, as defined in § **63.2-100** and licensed by the Department of Social Services, Department of Education, or Department of Behavioral Health and Developmental Services; or (vii) a student in a school for students with disabilities, as defined in § **22.1-319** and licensed by the Board of Education.

In addition, this section shall not prevent a person who has successfully completed a training program for the administration of drugs via percutaneous gastrostomy tube approved by the Board of Nursing and been evaluated by a registered nurse as having demonstrated competency in administration of drugs via percutaneous gastrostomy tube from administering drugs to a person receiving services from a program licensed by the Department of Behavioral Health and Developmental Services to such person via percutaneous gastrostomy tube. The continued competency of a person to administer drugs via percutaneous gastrostomy tube shall be evaluated semiannually by a registered nurse.

M. Medication aides registered by the Board of Nursing pursuant to Article 7 (§ **54.1-3041** et seq.) of Chapter 30 may administer drugs that would otherwise be self-administered to residents of any assisted living facility licensed by the Department of Social Services. A registered medication aide shall administer drugs pursuant to this section in accordance with the prescriber's instructions pertaining to dosage, frequency, and manner of administration; in accordance with regulations promulgated by the Board of Pharmacy relating to security and recordkeeping; in accordance with the assisted living facility's Medication Management Plan; and in accordance with such other regulations governing their practice promulgated by the Board of Nursing.

N. In addition, this section shall not prevent the administration of drugs by a person who administers such drugs in accordance with a physician's instructions pertaining to dosage, frequency, and manner of administration and with written authorization of a parent, and in accordance with school board regulations relating to training, security and record keeping, when the drugs administered would be normally self-administered by a student of a Virginia public school. Training for such persons shall be accomplished through a program approved by the local school boards, in consultation with the local departments of health.

O. (Effective until July 1, 2021) In addition, this section shall not prevent the administration of drugs by a person to (i) a child in a child day program as defined in § **63.2-100** and regulated by the State Board of Social Services or a local government pursuant to § **15.2-914**, or (ii) a student of a private school that is accredited pursuant to § **22.1-19** as administered by the Virginia Council for Private Education, provided such person (a) has satisfactorily completed a training program for this purpose approved by the Board of Nursing and taught by a registered nurse, licensed practical nurse, nurse practitioner, physician assistant, doctor of medicine or osteopathic medicine, or pharmacist; (b) has obtained written authorization from a parent or guardian; (c) administers drugs only to the child identified on the prescription label in accordance with the prescriber's instructions pertaining to dosage, frequency, and manner of administration; and (d) administers only those drugs that were dispensed from a pharmacy and maintained in the

original, labeled container that would normally be self-administered by the child or student, or administered by a parent or guardian to the child or student.

O. (Effective July 1, 2021) In addition, this section shall not prevent the administration of drugs by a person to (i) a child in a child day program as defined in § **22.1-289.02** and regulated by the Board of Education or a local government pursuant to § **15.2-914**, or (ii) a student of a private school that is accredited pursuant to § **22.1-19** as administered by the Virginia Council for Private Education, provided such person (a) has satisfactorily completed a training program for this purpose approved by the Board of Nursing and taught by a registered nurse, licensed practical nurse, nurse practitioner, physician assistant, doctor of medicine or osteopathic medicine, or pharmacist; (b) has obtained written authorization from a parent or guardian; (c) administers drugs only to the child identified on the prescription label in accordance with the prescriber's instructions pertaining to dosage, frequency, and manner of administration; and (d) administers only those drugs that were dispensed from a pharmacy and maintained in the original, labeled container that would normally be self-administered by the child or student, or administered by a parent or guardian to the child or student.

P. In addition, this section shall not prevent the administration or dispensing of drugs and devices by persons if they are authorized by the State Health Commissioner in accordance with protocols established by the State Health Commissioner pursuant to § **32.1-42.1** when (i) the Governor has declared a disaster or a state of emergency or the United States Secretary of Health and Human Services has issued a declaration of an actual or potential bioterrorism incident or other actual or potential public health emergency; (ii) it is necessary to permit the provision of needed drugs or devices; and (iii) such persons have received the training necessary to safely administer or dispense the needed drugs or devices. Such persons shall administer or dispense all drugs or devices under the direction, control, and supervision of the State Health Commissioner.

Q. Nothing in this title shall prohibit the administration of normally self-administered drugs by unlicensed individuals to a person in his private residence.

R. This section shall not interfere with any prescriber issuing prescriptions in compliance with his authority and scope of practice and the provisions of this section to a Board agent for use pursuant to subsection G of § **18.2-258.1**. Such prescriptions issued by such prescriber shall be deemed to be valid prescriptions.

S. Nothing in this title shall prevent or interfere with dialysis care technicians or dialysis patient care technicians who are certified by an organization approved by the Board of Health Professions or persons authorized for provisional practice pursuant to Chapter 27.01 (§ **54.1-2729.1** et seq.), in the ordinary course of their duties in a Medicare-certified renal dialysis facility, from administering heparin, topical needle site anesthetics, dialysis solutions, sterile normal saline solution, and blood volumizers, for the purpose of facilitating renal dialysis treatment, when such administration of medications occurs under the orders of a licensed physician, nurse practitioner, or physician assistant and under the immediate and direct supervision of a licensed registered nurse. Nothing in this chapter shall be construed to prohibit a patient care dialysis technician trainee from performing dialysis care as part of and within the scope of the clinical skills instruction segment of a supervised dialysis technician training program, provided such trainee is identified as a "trainee" while working in a renal dialysis facility.

The dialysis care technician or dialysis patient care technician administering the medications shall have demonstrated competency as evidenced by holding current valid certification from an organization approved by the Board of Health Professions pursuant to Chapter 27.01 (§ **54.1-2729.1** et seq.).

T. Persons who are otherwise authorized to administer controlled substances in hospitals shall be authorized to administer influenza or pneumococcal vaccines pursuant to § **32.1-126.4**.

U. Pursuant to a specific order for a patient and under his direct and immediate supervision, a prescriber may authorize the administration of controlled substances by personnel who have been properly trained to assist a doctor of medicine or osteopathic medicine, provided the method does not include intravenous, intrathecal, or epidural administration and the prescriber remains responsible for such administration.

V. A physician assistant, nurse, dental hygienist, or authorized agent of a doctor of medicine, osteopathic medicine, or dentistry may possess and administer topical fluoride varnish pursuant to an oral or written order or a standing protocol issued by a doctor of medicine, osteopathic medicine, or dentistry.

W. A prescriber, acting in accordance with guidelines developed pursuant to § **32.1-46.02**, may authorize the administration of influenza vaccine to minors by a licensed pharmacist, registered nurse, licensed practical nurse under the direction and immediate supervision of a registered nurse, or emergency medical services provider who holds an advanced life support certificate issued by the Commissioner of Health when the prescriber is not physically present.

X. Notwithstanding the provisions of § **54.1-3303**, pursuant to an oral, written, or standing order issued by a prescriber or a standing order issued by the Commissioner of Health or his designee authorizing the dispensing of naloxone or other opioid antagonist used for overdose reversal in the absence of an oral or written order for a specific patient issued by a prescriber, and in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health, a pharmacist, a health care provider providing services in a hospital emergency department, and emergency medical services personnel, as that term is defined in § **32.1-111.1**, may dispense naloxone or other opioid antagonist used for overdose reversal and a person to whom naloxone or other opioid antagonist has been dispensed pursuant to this subsection may possess and administer naloxone or other opioid antagonist used for overdose reversal to a person who is believed to be experiencing or about to experience a life-threatening opioid overdose. Law-enforcement officers as defined in § **9.1-101**, employees of the Department of Forensic Science, employees of the Office of the Chief Medical Examiner, employees of the Department of General Services Division of Consolidated Laboratory Services, employees of the Department of Corrections designated as probation and parole officers or as correctional officers as defined in § **53.1-1**, employees of regional jails, school nurses, local health department employees that are assigned to a public school pursuant to an agreement between the local health department and the school board, other school board employees or individuals contracted by a school board to provide school health services, and firefighters who have completed a training program may also possess and administer naloxone or other opioid antagonist used for overdose reversal and may dispense naloxone or other opioid antagonist used for overdose reversal pursuant to an oral, written, or standing order issued by a prescriber or a standing order issued by the Commissioner of Health or his designee in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health.

Notwithstanding the provisions of § **54.1-3303**, pursuant to an oral, written, or standing order issued by a prescriber or a standing order issued by the Commissioner of Health or his designee authorizing the dispensing of naloxone or other opioid antagonist used for overdose reversal in the absence of an oral or written order for a specific patient issued by a prescriber, and in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health, an employee or other person acting on behalf of a public place who has completed a training program may also possess and administer naloxone or other opioid antagonist used for overdose reversal other than naloxone in an injectable formulation with a hypodermic needle or syringe in

accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health.

Notwithstanding any other law or regulation to the contrary, an employee or other person acting on behalf of a public place may possess and administer naloxone or other opioid antagonist, other than naloxone in an injectable formulation with a hypodermic needle or syringe, to a person who is believed to be experiencing or about to experience a life-threatening opioid overdose if he has completed a training program on the administration of such naloxone and administers naloxone in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health.

For the purposes of this subsection, "public place" means any enclosed area that is used or held out for use by the public, whether owned or operated by a public or private interest.

Y. Notwithstanding any other law or regulation to the contrary, a person who is acting on behalf of an organization that provides services to individuals at risk of experiencing an opioid overdose or training in the administration of naloxone for overdose reversal may dispense naloxone to a person who has received instruction on the administration of naloxone for opioid overdose reversal, provided that such dispensing is (i) pursuant to a standing order issued by a prescriber and (ii) in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health. If the person acting on behalf of an organization dispenses naloxone in an injectable formulation with a hypodermic needle or syringe, he shall first obtain authorization from the Department of Behavioral Health and Developmental Services to train individuals on the proper administration of naloxone by and proper disposal of a hypodermic needle or syringe, and he shall obtain a controlled substance registration from the Board of Pharmacy. The Board of Pharmacy shall not charge a fee for the issuance of such controlled substance registration. The dispensing may occur at a site other than that of the controlled substance registration provided the entity possessing the controlled substances registration maintains records in accordance with regulations of the Board of Pharmacy. No person who dispenses naloxone on behalf of an organization pursuant to this subsection shall charge a fee for the dispensing of naloxone that is greater than the cost to the organization of obtaining the naloxone dispensed. A person to whom naloxone has been dispensed pursuant to this subsection may possess naloxone and may administer naloxone to a person who is believed to be experiencing or about to experience a life-threatening opioid overdose.

Z. A person who is not otherwise authorized to administer naloxone or other opioid antagonist used for overdose reversal may administer naloxone or other opioid antagonist used for overdose reversal to a person who is believed to be experiencing or about to experience a life-threatening opioid overdose.

AA. Pursuant to a written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize, with the consent of the parents as defined in § **22.1-1**, an employee of (i) a school board, (ii) a school for students with disabilities as defined in § **22.1-319** licensed by the Board of Education, or (iii) a private school accredited pursuant to § **22.1-19** as administered by the Virginia Council for Private Education who is trained in the administration of injected medications for the treatment of adrenal crisis resulting from a condition causing adrenal insufficiency to administer such medication to a student diagnosed with a condition causing adrenal insufficiency when the student is believed to be experiencing or about to experience an adrenal crisis. Such authorization shall be effective only when a licensed nurse, nurse practitioner, physician, or physician assistant is not present to perform the administration of the medication.

2. That the Department of Health Professions (the Department) shall convene a work group to study the licensure and regulation of certified nurse midwives, certified midwives, and certified professional midwives to determine the

appropriate licensing entity for such professionals. The Department shall report its findings and conclusions to the Governor and the General Assembly by November 1, 2021.

Agenda Item: Adoption of Final Regulation for Waiver of Electronic Prescribing

Included in agenda package:

Amendments to 18VAC90-40, Regulations Governing Prescriptive Authority for Nurse Practitioners

Staff note:

Proposed amendments are identical to the emergency regulations that became effective on 12/23/19. There were no comments on the proposed regulations to replace emergency regulations.

Board action:

Motion to adopt the final regulations for nurse practitioners that replace emergency regulations for a temporary waiver for e-prescribing of opioids

Virginia.gov Agencies | Governor

VIRGINIA REGULATORY TOWN HALL

Emergency Text

highlight

Action: Waiver for electronic prescribing

Stage: Emergency/NOIRA 1/3/20 8:23 AM [latest]

18VAC90-40-122
18VAC90-40-122. Waiver for electronic prescribing.

A. Beginning July 1, 2020, a prescription for a controlled substance that contains an opioid shall be issued as an electronic prescription consistent with § 54.1-3408.02 of the Code of Virginia.

B. Upon written request, the boards may grant a one-time waiver of the requirement of subsection A of this section, 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.

Agenda Item: Guidance document – Revision of 90-56 (Practice Agreements for Nurse Practitioners)

Staff note:

The guidance document on practice agreement has been substantially revised to conform the guidance to statutory provisions as amended in the 2021 Session of the General Assembly.

The Board of Nursing adopted the revised document on July 20, 2021, and it must be jointly adopted by the Board of Medicine.

Action:

To adopt the revised guidance document 90-56 as included in the agenda package

Guidance document: 90-56

Practice Agreement Requirements for Licensed Nurse Practitioners (Advanced Practice Registered Nurses)

Revised by the Board of Nursing – July 20, 2021
Adopted by the Board of Medicine –

KEY POINTS:

- Certified Registered Nurse Anesthetist ("CRNA") – A practice agreement is **not** required for nurse practitioners licensed in the category of CRNA. The CRNA practices under the supervision of a licensed doctor of medicine, osteopathy, podiatry, or dentistry.
- Certified Nurse Midwife ("CNM") - A practice agreement is required with either a CNM who has practiced for at least two years or a licensed physician for nurse practitioners licensed in the category of CNM prior to completion of 1,000 practice hours.
- Clinical Nurse Specialist ("CNS") – A practice agreement with a licensed physician is required for nurse practitioners licensed in the category of CNS.
- Nurse Practitioner ("NP") – A practice agreement with a patient care team physician is required for nurse practitioners with less than 2 years of clinical experience; this does not apply for NPs in the categories of CNM, CRNA, or CNS.
- Nurse practitioners who are required to have a practice agreement are responsible for maintaining the practice agreement and making it available for review by the Board of Nursing upon request.
- Practice agreements do **not** need to be submitted to the Board of Nursing to obtain or renew the professional license.

FURTHER STATUTORY DETAILS :

CNM - §§ 54.1-2957(H) and 54.1-2957.01(G)

A CNM who has practiced fewer than 1,000 hours shall practice in consultation through a practice agreement with a CNM who has practiced for at least two years prior to entering into the practice agreement or a licensed physician.

- The practice agreement shall address the availability of the consulting CNM or the licensed physician for routine and urgent consultation on patient care.
- If the CNM will prescribe, the practice agreement shall include the parameters of such prescribing of Schedules II through VI controlled substances.

Requirements for CNM autonomous practice can be found in **§ 54.1-2957(H)**

CNS - §§ 54.1-2957(J) and 54.1-2957.01(G)

A CNS shall practice in consultation with a licensed physician in accordance with a practice agreement

- The practice agreement shall address the availability of the physician for routine and urgent consultation on patient care.
- If the CNS will prescribe, the practice agreement shall include the parameters of such prescribing of Schedules II through V controlled substances.
- Inclusion of the prescribing of Schedule VI controlled substances is not required in the practice agreement.

NOTE: There are no conditions in Virginia Code under which a CNS may practice without a practice agreement

NP - §§ 54.1-2957(C) & (D) and 54.1-2957.01(B)

An NP not qualified for autonomous practice shall maintain appropriate collaboration and consultation with at least one patient care team physician, as evidenced in a written or electronic practice agreement which is periodically reviewed and revised. The practice agreement shall include:

- Provisions for the periodic review of health records by the patient care team physician and may include provisions for visits to the site where health care is delivered in the manner and at the frequency determined by the patient care team;
- Provisions for appropriate input from health care providers in complex clinical cases and patient emergencies and for referrals;
- Categories of drugs and devices that may be prescribed;
- Guidelines for availability and ongoing communications that provide for and define consultation among the collaborating parties and the patient;
- Provisions for periodic joint evaluation of services provided;
- Provisions for periodic review and revision of the practice agreement; and
- The signature of the patient care team physician or the name of the patient care team physician clearly stated.

Requirements for NP autonomous practice can be found in **§ 54.1-2957(I)**

Agenda Item: Report on the Implementation of HB 793 (2018)

Staff Note: HB793 was passed in 2018 and established a pathway to autonomous practice for nurse practitioners. The Enactment Clause in HB793 requires the Boards of Medicine and Nursing to report certain data to the Chairmen of the House Committee on Health, Welfare and Institutions, the Senate Committee on Education and Health, and the Joint Commission on Health Care by November 1, 2021. Here is the text of the Enactment Clause.

Enactment Clause from H.B. 793

4. That the Boards of Medicine and Nursing shall report on data on the implementation of this act, including the number of nurse practitioners who have been authorized to practice without a practice agreement, the geographic and specialty areas in which nurse practitioners are practicing without a practice agreement, and any complaints or disciplinary actions taken against such nurse practitioners, along with any recommended modifications to the requirements of this act including any modifications to the clinical experience requirements for practicing without a practice agreement, 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.

In the following pages, you will find a draft report and comments from the Medical Society of Virginia, Virginia Academy of Family Physicians, Virginia Orthopedic Society, Virginia Society of Eye Physicians and Surgeons, Virginia College of Emergency Physicians, Virginia Society of Anesthesiologists, Psychiatric Society of Virginia, Virginia Chapter of the American Academy of Pediatrics, Virginia Chapter of the American College of Surgeons, and the Richmond Academy of Medicine.

Action: To discuss the draft report and accept as written or suggest amendments.

VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS

Boards of Medicine and Nursing

Report on the Implementation of House Bill 793 (2018)[1]

Background

House Bill 793 (2018) eliminated the practice agreement requirement for a Licensed Nurse Practitioner (LNP) who applies for authorization to practice autonomously and has at least five years of full-time clinical practice attested by the patient care team physician. HB793 also requires a report from the boards of Medicine and Nursing as set forth in the enactment clause below:

> ***Enactment Clause from H.B. 793 (2018)***
> ***4. That the Boards of Medicine and Nursing shall report on data on the implementation of this act, including the number of nurse practitioners who have been authorized to practice without a practice agreement, the geographic and specialty areas in which nurse practitioners are practicing without a practice agreement, and any complaints or disciplinary actions taken against such nurse practitioners, along with any recommended modifications to the requirements of this act including any modifications to the clinical experience requirements for practicing without a practice agreement, 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.***

The current draft report provides the most recent responsive data and recommended modification language available as of this writing.

Number of Autonomous Licensed Nurse Practitioners and Specialty Areas

The first Autonomous LNP professional designation was issued on February 6, 2019. As of June 30, 2021, there were 1,257 Autonomous LNPs with 1,290 professional designations. Professional designations are classified according to specialty area(s); 33 practitioners have two specialty areas.

The table below lists the various specialty areas and the percentage of the overall professional designations each constituted as of June 30, 2021.

Adult/Geriatric Acute (7.7%)	Pediatric Acute (<1%)
Adult/Geriatric Primary (11.5%)	Pediatric Primary (4.5%)
Family (61.3%)	Psychiatric/Mental (11.5%)
Neonatal (<1%)	Women's Health (2.5%)

Note that the largest proportion is "Family," followed by "Psychiatric/Mental," and "Adult/Geriatric Acute." The smallest proportions are in "Pediatric Acute" and "Neonatal."

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[1] The legislative summary, text, and history of the bill are accessible through Virginia's Legislative Information System at: https://lis.virginia.gov/cgi-bin/legp604.exe?ses=181&typ=bil&val=hb793.

Geographic Distribution of Specialty Areas

A Tableau® interactive data visualization was created to provide insight into the geographic practice specialty distributions of Virginia's Autonomous LNPs. It is posted online and is accessible at: https://public.tableau.com/app/profile/rajana.siva/viz/npspecialtycounts/Dashboard2

The user has access to a drop-down menu that enables selection of all or specific specialty areas. As of June 30, 2021, there were 1,132 practices with geographic locations denoted. The map and accompanying table automatically populate with data based upon the specialty selection.[2]

For the remaining 125 Autonomous LNPs, there was no geographic location indicated; these are presumed to be telehealth practices.

For the final written report, an appendix will include all maps and tables in hardcopy form.

Complaints and Disciplinary Actions

To provide information and context on the volume and types of complaints received for the Joint Board's meeting on June 17, 2021, the staff analyzed the agency's disciplinary case tracking data,[3] referencing "Cases Received" in the system from the February 6, 2019 to April 30, 2021 period. The complaints received per 1,000 licensees' rates for the agency overall, board, and profession levels follow.

Additionally, because complaints do not necessarily equate to substantiated misconduct, staff also determined the rate of cases closed with a final disposition of violations per 1,000 licensees. This measure provides additional insight into boards' assessments of actual harm to the public. Here, too, the results are at the agency, board, and profession level.

Staff also analyzed the categories of cases with a violation final disposition to provide additional information on the types of cases involved. The Appendix provides a listing and description of the case categories.

Finally, this section provides a brief summary of the founded cases against Autonomous LNPs.

AGENCY

[2]This visualization is similar to the Department of Health Professions Healthcare Workforce Data Center's "Virginia Physician Board Certification Dashboard" accessible at: https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/Dashboards/VirginiaPhysicianBoardCertificationDashboard/

[3] Data are from the agency's standard monthly download of internal disciplinary case processing data from the MLO system. The final report will extend the analysis to cover data on cases received up until **June 30, 2021**, end of fiscal year.

As indicated in the table below, the agency received 15,510 complaints within the jurisdiction of a licensing board. As of April 30, 2021, the majority (73.5%) had been resolved.

Received (within Jurisdiction only)	Closed	Violation	Complaint [4] Rate/1k Lic	Violation Rate/ 1k Lic	Licensees [5]
15,510	11,400 (73.5% of received)	1,571 (14% of closed)	35.27	3.57	439,644

The rate of **all** complaints received per 1,000 licensees within boards' jurisdiction was 38.32, and the overall violation rate was 3.90.

The following provides a breakout by Board of the respective rates per 1,000 licensees.

BOARD

Complaints Received Rate per 1,000 Licensees by Board

Board	Rate/1k	Board	Rate/1k
ASLP	5.46	**Optometry**	42.55
Counseling	22.78	**Pharmacy**	38.57
Dentistry	70.06	**Physical Therapy**	8.40
FD&E	58.30	**Psychology**	54.47
LTCA	83.11	**Social Work**	20.67
Medicine	60.79	**Veterinary Medicine**	97.9
Nursing	25.10		

The complaint rate ranged from a low of 5.46 for the Board of Audiology and Speech-Language Pathology to a high of 97.9 for the Board of Veterinary Medicine. For the Board of Nursing, the rate was 25.10. The average (mean) was 45.24.

As noted earlier, board findings of violation constitute substantiated evidence of harm to the public due to professional misconduct. A board renders its final disposition when the investigation is complete, evidence reviewed, and adjudication processes completed. A violation final disposition confirms that the licensee has engaged in professional misconduct.

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[4] The Rate of Complaints Received per 1,000 Licensees and Rate of Violations per 1,000 Licensees are similar to the standard measures tracked in the DHP Biennial Report under Appendix B – Complaints Against Licensees and C – Violations. They are calculated, respectively, as follows: (#Cases Received/#Licensees) x 1,000 and (#Cases with Violation final disposition/#Licensees) x 1,000. Note: Here, the #Licensees refers to the count of licensees as of March 31, 2021 rather than June 30, 2021 due to the timing of the review.

[5] The number of licensees is from March 31, 2021, the latest full quarter for which there are agency standard quarterly data.

The table below shows rate of violation per 1,000 licensees by board for those cases received and closed during the period.

Violation Rate per 1000 Licensees by Board

Board	Rate/1k	Board	Rate/1k
ASLP	0.88	**Optometry**	1.93
Counseling	0.87	**Pharmacy**	16.7
Dentistry	2.62	**Physical Therapy**	0.96
FD&E	5.64	**Psychology**	1.02
LTCA	3.96	**Social Work**	0.25
Medicine	2.83	**Veterinary Medicine**	0.12
Nursing	2.42		

The violation rates were much lower than the complaint rates, and range from a low for Veterinary Medicine of 0.12 to a high for Pharmacy (includes facility violations). The Board of Nursing's rate is a 2.42. The average (mean) across all boards is 3.02.

PROFESSIONS

Within the agency, there are over 60 regulated professions in addition to a number of facility types. The following tables provide a rank ordering of the rate of complaints and of violations per 1,000 licensees for 51 professions.[6] [7]

Profession	Complaint Rate/1KLic	Profession	Violation Rate/1KLic
Ltd Radiologic Technologist	1.84	Ltd Radiologic Technologist	0
Clinical Nurse Specialist	2.45	Lic. Clinical Social Worker	0.37
Speech-Language Pathologist	4.27	Dental Hygienist	0.49
Dental Hygienist	4.76	Sub Abuse Tx Practitioner	0.51
Occupational Therapist	5.36	Occupational Therapy Asst	0.59
Physician Selling CS	5.38	Intern & Resident	0.59
Occupational Therapy Asst	5.87	Behavioral Analyst	0.6
Sub Abuse Tx Practitioner	7.11	Physician Assistant	0.6
Radiologic Technologist	8.32	Speech-Language Pathologist	0.85
Physical Therapist	8.95	Physical Therapist	0.95
Physical Therapist Asst	10.16	Lic Clinical Psychologist	0.96
Athletic Trainer	10.27	QMHP-Child	0.99
QMHP-Child	11.22	Lic Professional Counselor	0.99
Respiratory Therapist	12.46	Lic Marriage & Family Therapist	1.05
Behavioral Analyst	13.24	Occupational Therapist	1.07
Intern & Resident	13.82	QMHP-Adult	1.32
School Speech-Language Pathologist	14.74	Physical Therapist Asst	1.37
Restricted Volunteer	15.15	Respiratory Therapist	1.44
Registered Nurse	15.35	Veterinary Technician	1.69
QMHP-Adult	18.58	Athletic Trainer	1.71
Polysomnographic Technologist	20.28	Lic. Nurse Practitioner	1.71
Veterinary Technician	20.3	Registered Nurse	1.72
Lic Massage Therapist	20.49	Physician Selling CS	1.79
Pharmacy Technician	20.78	Certified Nurse Aide	2.29
Pharmacist	21.7	TPA Optometrist	2.33
Lic Acupuncturist	24.39	Clinical Nurse Specialist	2.45
Lic. Clinical Social Worker	26.48	School Speech-Language Pathologist	2.46
Certified Nurse Aide	30.6	Doctor of Osteopathy	2.64

[6] Facility cases are excluded.

[7] A profession was included if there was at least one case during the period. Note that only closed cases applied to the violation rate.

Profession	Complaint Rate/1KLic	Profession	Violation Rate/1KLic
Physician Selling Drugs	30.67	Assisted Living Facility Administrator	2.9
Lic. Marriage & Family Therapist	31.41	Nursing Home Administrator	3.01
Lic. Practical Nurse	37.18	Medicine & Surgery	3.33
Physician Assistant	37.78	Autonomous Lic Nurse Practitioner	3.35
Lic Nurse Practitioner	39.76	Lic. Practical Nurse	3.77
Lic Professional Counselor	44.03	Radiologic Technologist	4.05
Medication Aide	45.59	Pharmacist	4.27
TPA Optometrist	48.83	Sex Offender Tx Provider	4.47
Lic. Clinical Psychologist	59.56	Genetic Counselor Temp	4.68
Funeral Service Intern	70.18	Dentist	4.76
Doctor of Osteopathy	70.96	Lic Massage Therapist	4.95
Chiropractor	71.47	Lic Acupuncturist	5.22
Funeral Service Licensee	71.93	Medication Aide	6.32
Sex Offender Tx Provider	76.06	Funeral Service Licensee	6.37
Autonomous Lic Nurse Practitioner	89.69	Chiropractor	6.81
Medicine & Surgery	92.85	Veterinarian	7.59
Assisted Living Facility Administrator – Administrator-in-Training	93.02	Pharmacy Technician	10.12
Assisted Living Administrator	97.1	Polysomnographic Technologist	12.17
Nursing Home Administrator	107.54	Physician Selling Drugs	12.27
Veterinarian	125.06	Podiatrist	12.64
Dentist	131.41	Restricted Volunteer	15.15
Podiatrist	158.84	Funeral Service Intern	17.54
Genetic Counselor Temp	222.2	Assisted Living Facility Administrator—Administrator-in-Training	46.51

The complaint rate per 1,000 licensees ranges from 1.87 for Limited Radiologic Technologist to 222.2 for Genetic Counselor Temporary. Note that the violation rate is lower, with a range of near 0 for Limited Radiologic Technologist to 46.51 for Assisted Living Administrator – Administrator-in-Training. The respective average (mean)[8] for each measure is 43.68 and 4.66. Note the arrows indicating the approximate locations of these means in the rankings above.

For Autonomous Licensed Nurse Practitioner, the complaint rate was 89.84 and violation rate was 3.36. This is higher than average complaint rate but lower than average violation rate.

[8] The complaint rate median was 24.39; the standard deviation was 110.18. The violation rate median was 2.45 and standard deviation was 23.26

These rates are similar to Medicine & Surgery (M.D.s) where the complaint rate is 92.85 and violation rate is 3.33.

SPECIAL NOTE: On July 1, 2021, staff received professional designation, complaint and violation data as of June 30, 2021 pertaining to Autonomous LNPs, only. The Complaint /1k Licensees Rate will be revised to 87.50 and Violation/1k Licensee to 3.98 in the next draft. All other professions will be similarly revised to coincide with June 30, 2021 data.

Case Categories

As indicated earlier, staff also analyzed the categories of cases with a finding of violation.

For details on Autonomous LNP founded cases, see the summary "Disciplinary Actions Pertaining to Autonomous LNPs as of June 30, 2021" in the box below.

Disciplinary Actions Pertaining to LNPs as of June 30, 2021

A search of License Lookup for the period January 1, 2019 to June 30, 2021 revealed public disciplinary records on five (5) individuals hereinafter referred to a Respondent A, B, C, D and E. The following is a brief summary of the founded cases. [9]

Respondent A - Family Practice and Authorization to Prescribe. An Order issued December 3, 2020 required participation in the Health Practitioners Monitoring Program.

Respondent A - Family Practice and Authorization to Prescribe. An Order issued December 3, 2020 required participation in the Health Practitioners Monitoring Program.

Respondent B – Adult Acute Geriatric and Authorization to Prescribe. An order issued December 11, 2020 required participation in the Health Practitioners Monitoring Program.

Respondent C – Family Practice and Authorization to Prescribe. An order issued September 13, 2019 rendered a Reprimand for prescribing outside of a bona-fide practitioner-patient relationship and outside of an emergency and failing to document the rationale in the patient's record.

Respondent D – Family Practice and Authorization to Prescribe. An order issued November 20, 2020 rendered a Reprimand and approved course in opiate prescribing regarding a case of continued opiate prescribing for a patient with a history of opioid addiction and noncompliance with pain management. On February 22, 20201, the Board notified the Respondent of compliance with the order.

Respondent E[10] – Family Practice (out of state). Mandatory suspension issued July 21, 2020 for felony criminal conviction for conspiracy to commit Medicaid fraud.

[9] NOTE: The data for the analyses in this section of the report covers the period February 6, 2019 to June 30, 2021 to coincide with the first designation issued and to allow sufficient time for analysis and reporting prior to the boards' meetings. Results may differ with other timeframes.

[10] Respondent E's license was mandatorily suspended under the authority of the Department of Health Professions Director. For further information on mandatory suspension, reference *Code of Virginia* §54.1-2409 (accessible at https://law.lis.virginia.gov/vacode/title54.1/chapter24/section54.1-2409/.

The founded Autonomous LNP cases involved Inability to Safely Practice and Drug-Related, Patient Care.

The following information enables comparison at the agency, board, and profession level. For the sake of simplicity, the board and profession levels narrow to the Board of Nursing, Board of Medicine, Licensed Nurse Practitioner (with collaborative practice), Registered Nurses and Medicine & Surgery (MDs). Other boards and professions can be included in subsequent reports if desired.

SPECIAL NOTE: The following results cover the period February 6, 2019 to ***April 30, 2021.*** *The next report will extend the analysis period to June 30, 2021 and update rankings if needed.*

AGENCY

The top ten (10) categories across all boards are ranked below. Those that respectively constitute 5% or more are highlighted. It is important to note that only three (3) are considered "complaints" in that the licensing boards, themselves, docket cases with categories related to license issuance or renewal (i.e., continuing education, reinstatement, and eligibility) and compliance cases in follow up to previous orders.

1. **Business Practice Issues**
2. **Inability to Safely Practice**
3. ~~**Continuing Education**~~
4. ~~**Reinstatement**~~
5. **Drug-Related, Patient Care**
6. ~~**Eligibility**~~
7. Abuse, Abandonment & Neglect
8. Criminal Activity
9. Unlicensed Activity
10. Standard of Care – Diagnosis/Treatment

NOTE: The remaining lists only include the categories that constitute 5% or more of the cases.

BOARD OF NURSING (excluding CNAs)

1. **Inability to Safely Practice**
2. ~~**Reinstatement**~~
3. ~~**Eligibility**~~
4. **Drug-Related, Patient Care**
5. **Abuse, Abandonment & Neglect**
6. **Criminal Activity**
7. **Action by Another Board – Patient Care**
8. ~~**Compliance**~~

BOARD OF MEDICINE

1. **Unlicensed Activity**
2. **Inability to Safely Practice**
3. **Drug-Related-Patient Care**
4. **Standard of Care-Diagnosis/Treatment**
5. **Abuse, Abandonment & Neglect**
6. ~~**Reinstatement**~~
7. **Criminal Activity**

LICENSED NURSE PRACTITIONER (COLLABORATIVE ONLY)

1. **Drug-Related-Patient Care**
2. **Inability to Safely Practice**
3. ~~**Reinstatement**~~
4. **Action-by-Another Board, Patient Care**
5. **Criminal Activity**
6. ~~**Eligibility**~~

REGISTERED NURSES

1. **Inability to Safely Practice**
2. ~~**Reinstatement**~~
3. **Action by Another Board, Patient Care**
4. **Criminal Activity**
5. **Abuse, Abandonment & Neglect**
6. ~~**Eligibility**~~

MEDICINE & SURGERY (M.D.)

1. **Inability to Safely Practice**
2. **Drug-Related, Patient Care**
3. **Standard of Care, Diagnosis/Treatment**
4. **Criminal Activity**
5. ~~**Reinstatement**~~
6. **Abuse/Abandonment/Neglect**
7. **Standard of Care, Surgery**

The following section provides modifications to the statutory requirements recommended by the Joint Boards of Nursing and Medicine at their June 16, 2021 and are included for further feedback from the Board of Nursing and Board of Medicine

Recommended Modifications of Act to amend and reenact select sections of the Code of Virginia, relating to nurse practitioners; practice agreements

Enactment Clause - [H 793] Approved April 4, 2018 - That the Boards of Medicine and Nursing shall report on data on the implementation of this act, including the number of nurse practitioners who have been authorized to practice without a practice agreement, the geographic and specialty areas in which nurse practitioners are practicing without a practice agreement, and any complaints or disciplinary actions taken against such nurse practitioners, along with any recommended modifications to the requirements of this act including any modifications to the clinical experience requirements for practicing without a practice agreement, 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.

The following recommendations were discussed by the Committee of the Joint Boards of Nursing and Medicine ("Committee") at its meeting on June 16, 2021:

- Apply existing national data and data to be collected during the DHP study (Budget Amendment – SB1100) on Advanced Practice Registered Nurses ("APRNs") to decisions regarding amending of this Act.
- Adopt the criteria for APRN practice as outlined in the National Council of State Boards of Nursing APRN compact in order to better respond to healthcare needs by increasing access to nurse practitioners across state lines through standardizing APRN scope of practice.
- Amend the Act to enable nurse practitioners who hold licenses in both Virginia and another jurisdiction to use attestation of clinical experience in the other jurisdiction for the requisite years to practice without a practice agreement.
- Follow the precedent that was set in 2021 legislation regarding licensed nurse practitioners in the category of certified nurse midwives (see §54.1-2957(H)) by providing the option for experienced nurse practitioners to enter into a practice agreement with less experienced nurse practitioners.
- Permit a licensed nurse practitioner to provide documentary evidence of completion of two years of clinical experience directly to the Boards in lieu of the patient care team physician attestation in order to practice without a practice agreement.
- Collect data on nurse practitioners who have completed two years of clinical experience prior to being permitted to practice without a practice agreement for comparison to the data on those who have completed five years of experience.
- Permanently modify the Act to require two years of clinical experience prior to practicing without a practice agreement.
- Eliminate the practice agreement requirement from the Act because 1) a core competency of nurse practitioner education includes collaboration with the patient care team to achieve optimal care outcomes, and 2) disciplinary actions against nurse practitioners who have practiced without a practice agreement identified in this Report did not reveal a greater safety risk to the public.

APPENDIX

Applying DISCIPLINE Complaint Types in MLO

Every disciplinary case entered in MLO must be assigned at least one *Complaint Type*. Most cases will require only one, but others will need several types to accurately reflect all aspects of the case. There is no limit on the number of complaint types that can be entered. Users entering the complaint types in MLO should include as many of the **Patient Care Complaint Types** and **Non-Patient Care Complaint Types** as are active concerns. Many of the numbered complaint types have one or more subtypes which are identified by a + symbol. Users should also include as many of the subtypes that are active concerns. Complaint types and subtypes must be reviewed and changed when needed to accurately address the current issues in each case as it proceeds through *Intake, Investigation, Probable Cause Review, Administrative Proceedings* and *Closure*.

Follow these rules for entering multiple case types:

1. Enter all applicable Patient Care Complaint Types. Enter the types in numerical order.
2. When + symbols and subtypes are shown, use one or more of the sub-types as applicable to the case.
3. Enter any Non-Patient Care Complaint Types and subtypes. Enter the types in numerical order.

PATIENT CARE Complaint types: #1-14

1. **INABILITY TO SAFELY PRACTICE:** Impairment due to use of alcohol, illegal substances, or prescription drugs or incapacitation due to mental, physical or medical conditions.
   - + Death associated

2. **DRUG RELATED – PATIENT CARE:** Dispensing in violation of DCA (to include dispensing for non-medicinal purposes, excessive prescribing, not in accordance with dosage, filling an invalid prescription, or dispensing without a relationship), prescription forgery, drug adulteration, patient deprivation, stealing drugs from patients, or personal use.
   - + Improper compounding or MDR (mixing/diluting/reconstituting formulation)
   - + Death associated

3. **ABUSE/ABANDONMENT/NEGLECT:** Any sexual assault, mistreatment of a patient, inappropriate termination of provider/patient relationship, leaving a patient unattended in a health-care environment, failure to do what a reasonable person would do in a similar situation.
   - + Sexual misconduct involved
   - + Death associated

4. **STANDARD OF CARE – SURGERY:** Improper/unnecessary performance of surgery, improper patient management, and other surgery-related issues.
   - + Death associated
   - + Sedation/Anesthesia associated

5. **STANDARD OF CARE – DIAGNOSIS/TREATMENT:** Instances in which the diagnosis/treatment was improper, delayed, or unsatisfactory. Also includes failure to diagnose/treat as well as other diagnosis/treatment related issues.
   - + Death associated

6. **STANDARD OF CARE – MEDICATION/PRESCRIPTION:** Prescribing, labeling, dispensing, and administration errors. Also includes improper management of patient regimen and failure to provide counseling as well as other medication/prescription related issues.
   - + Death associated

7. **STANDARD OF CARE – MALPRACTICE REPORTS:** a judgment or settlement as well as other malpractice related issues.
   - + Death associated

8. **STANDARD OF CARE – EXCEEDING SCOPE:** practicing outside the permitted functions of license granted.
   - + Death associated

9. **STANDARD OF CARE – OTHER:** cases involving patient care that cannot fit adequately into any other standard of care case type. *Must have supervisor's approval before using this code.*
   - + Sexual misconduct involved

10. **INAPPROPRIATE RELATIONSHIP:** Dual, sexual or other boundary issue. Including inappropriate touching and written or oral communications.

11. **UNLICENSED ACTIVITY:** Practicing a profession or occupation without holding a valid license as required by statute or regulation to include: practicing on a revoked, suspended, lapsed, non-existent or expired license, as well as aiding and abetting the practice of unlicensed activity.
    - + Expired license
    - + Suspended/revoked license
    - + No license
    - + Delegation to unlicensed staff

12. **MISAPPROPRIATION OF PATIENT PROPERTY:** stealing or use of patient property without authorization.

+ **Fraudulent documentation**

13. **FRAUD – PATIENT CARE:** Performing unwarranted/unjust services or the falsification/alteration of patient records.

+ **Fraudulent documentation**

14. **ACTION BY ANOTHER BOARD – PATIENT CARE:** Disciplinary action by another state or jurisdiction when the underlying act is a patient care case as defined above. This code must be accompanied by another patient care case code that best describes the underlying offense.

+ **Death associated**

NON-PATIENT CARE Complaint types: #50-64

50. **CRIMINAL ACTIVITY:** Felony or misdemeanor arrest, charges pending, or conviction.

+ **Death associated**

51. **HPMP:** Dismissal, vacated stay and non-compliance.

52. **DRUG RELATED- NON-PATIENT CARE:** Theft or diversion of drugs when a patient is not involved (e.g., pharmacies, hospitals, or facilities).

53. **FRAUD – NON-PATIENT CARE:** Improper patient billing, mishandling of pre-need funds, fee splitting, and falsification of licensing/renewal documents.

+ **Fraudulent documentation**

54. **BUSINESS PRACTICE ISSUES:** Advertising, default on guaranteed student loan, solicitation, records, inspections, audits, self-referral of patients, required report not filed, prescription blanks, or disclosure. Using a VA protected title such as MD, without a license, but not practicing in VA.

+ **Failure to address sexual misconduct**
+ **Failure to report patient events**
+ **Failure to supervise patient care**
+ **Hospital failure to report**
+ **Nursing home failure to report**
+ **ALF failure to report (Assisted Living Facility)**
+ **Other institution failure to report**
+ **Licensee failure to report**

55. **DRUG RELATED – SECURITY:** Failure to maintain security of controlled substances.

56. **COMPLIANCE:** Violation of a board order term or probation violation.

57. **MISAPPROPRIATION OF PROPERTY – NON-PATIENT CARE:** stealing or use of property that does not belong to a patient without authorization.

58. **CONFIDENTIALITY BREACH:** disclosing unauthorized client information without permission or necessity.

59. **CONTINUING COMPETENCY REQUIREMENT NOT MET:** Failure to obtain or document CE requirements.

60. **DISHONORED CHECK:** Check with insufficient funds submitted to agency.

61. **RECORDS RELEASE:** Failure or delay in the release of patient records. Charging excessive fees for records requests.

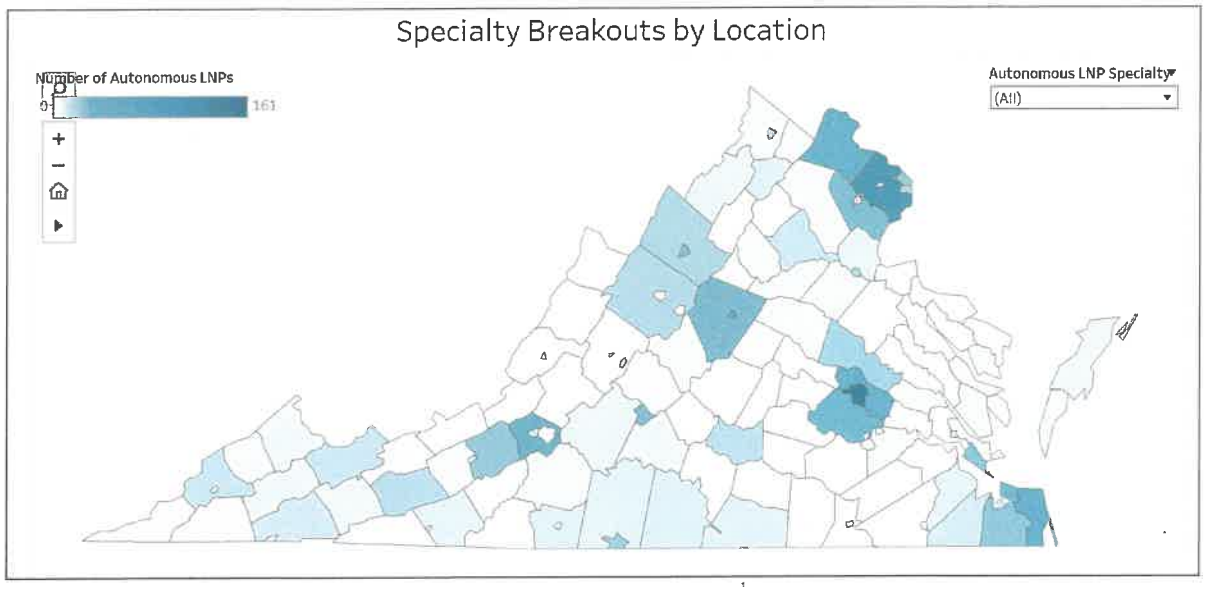
62. **ACTION BY ANOTHER BOARD – NON-PATIENT CARE:** Disciplinary action by another state or jurisdiction when the underlying act is a non-patient care case. This code must be accompanied by another non-patient care Complaint Type code that best describes the underlying offense.

Autonomous Licensed Nurse Practitioner Practice Locations, Overall and by Specialty

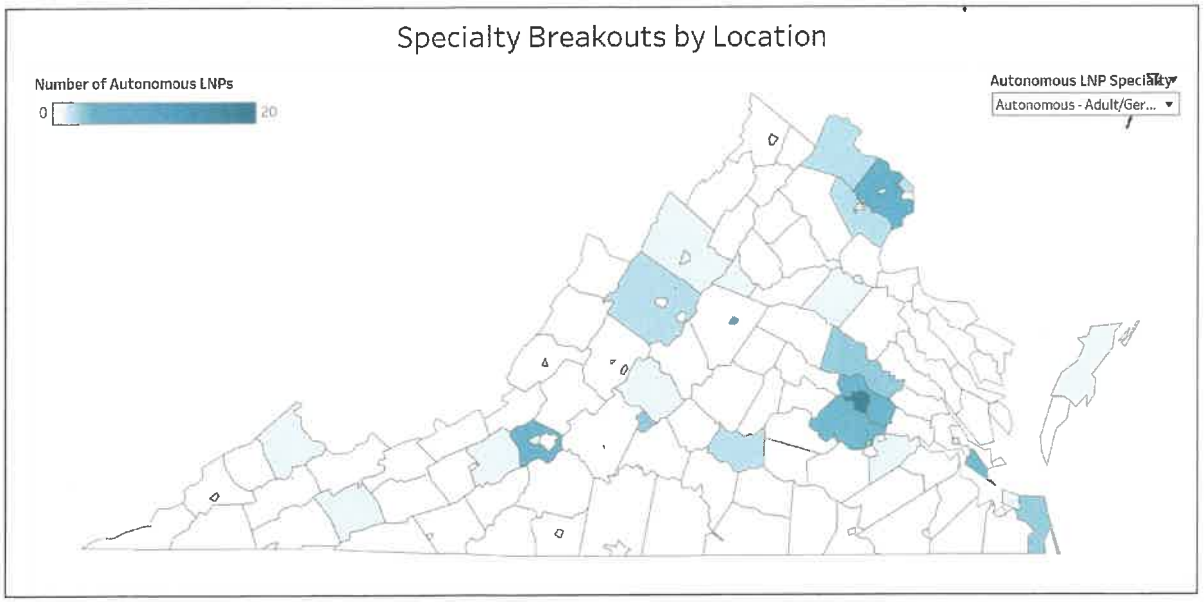
Map Extracts from the online Tableau®

https://public.tableau.com/app/profile/rajana.siva/viz/npspecialtycounts/Dashboard2

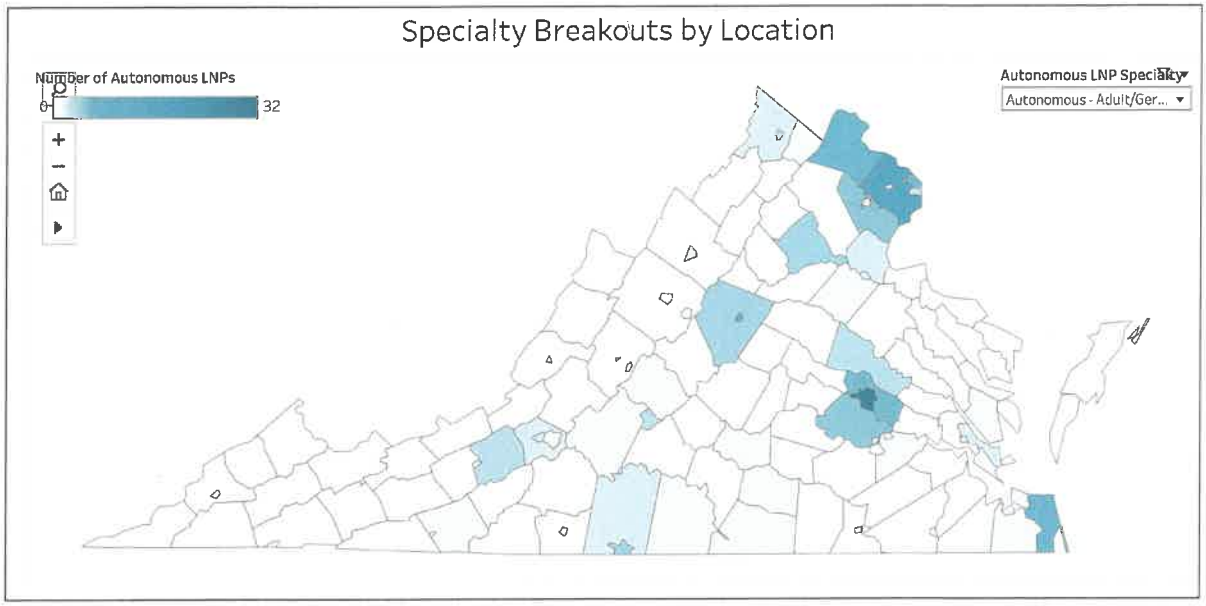
All



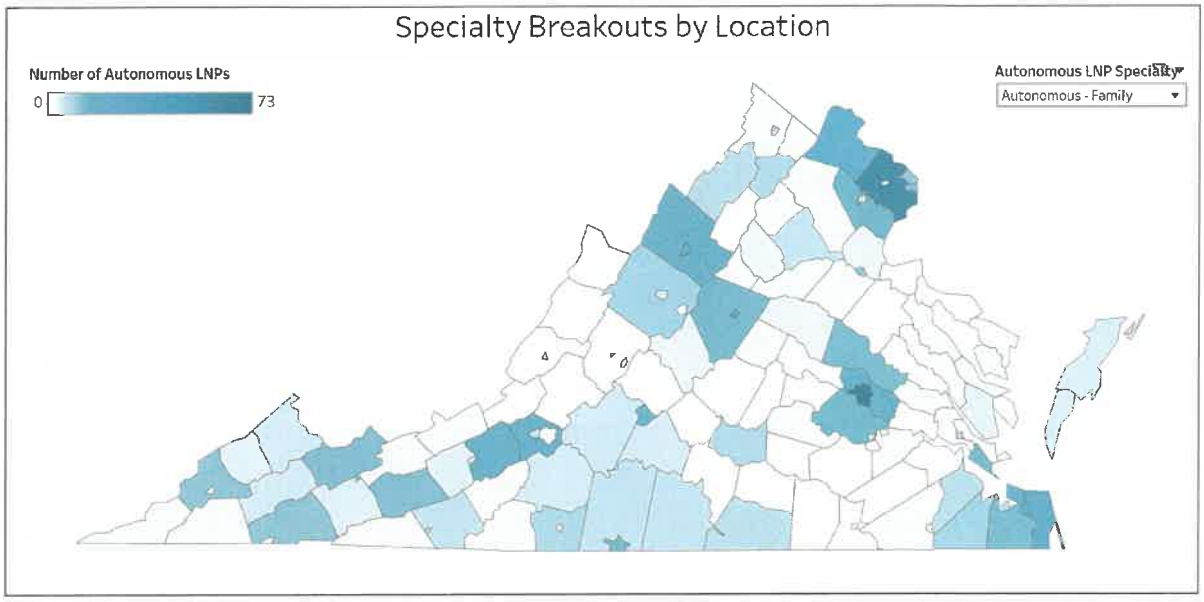
Adult/Geriatric Acute



Adult/Geriatric Primary



Family



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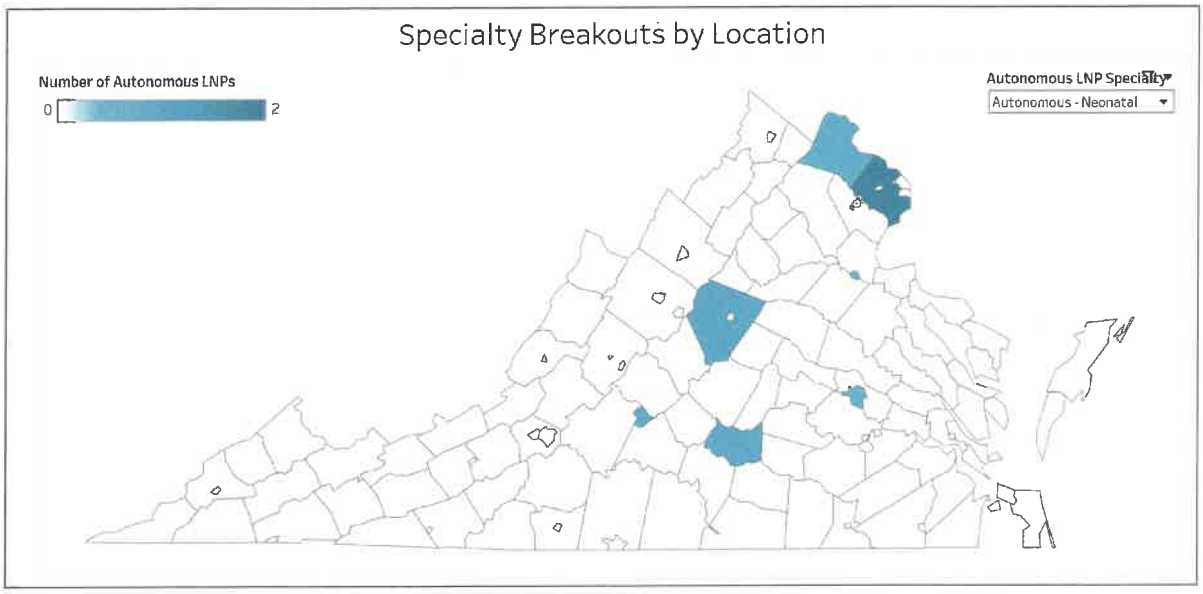
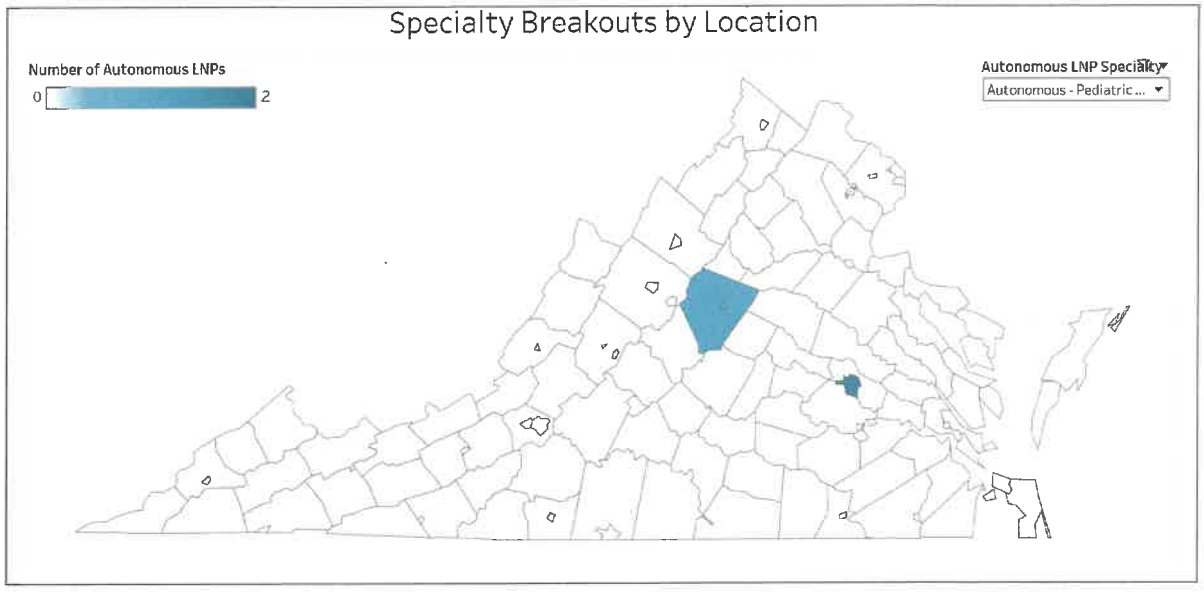
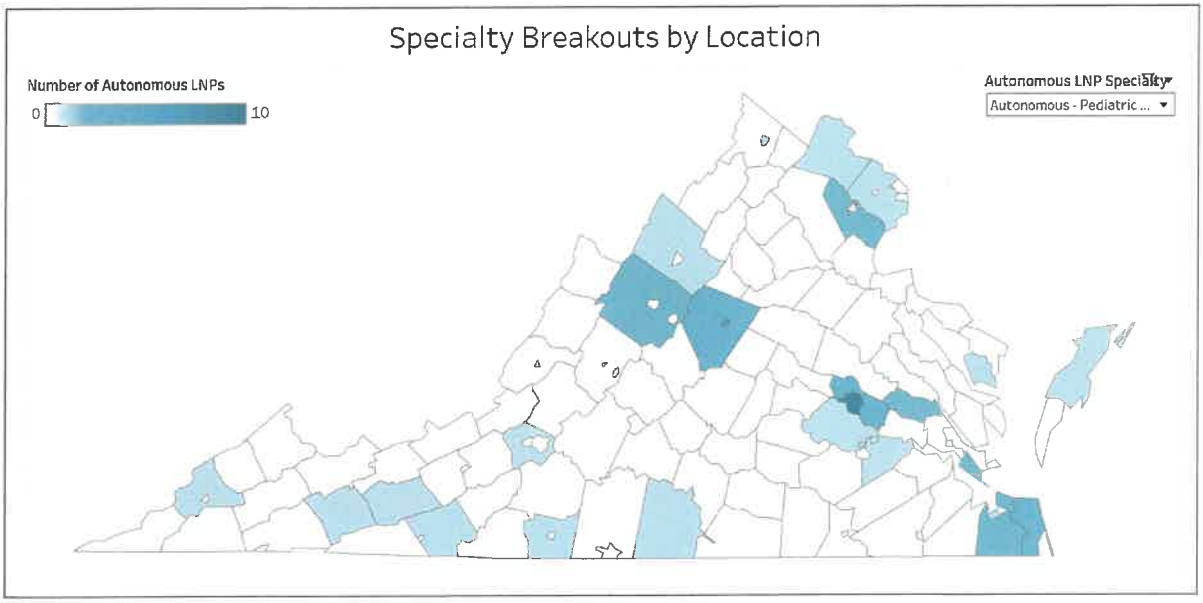


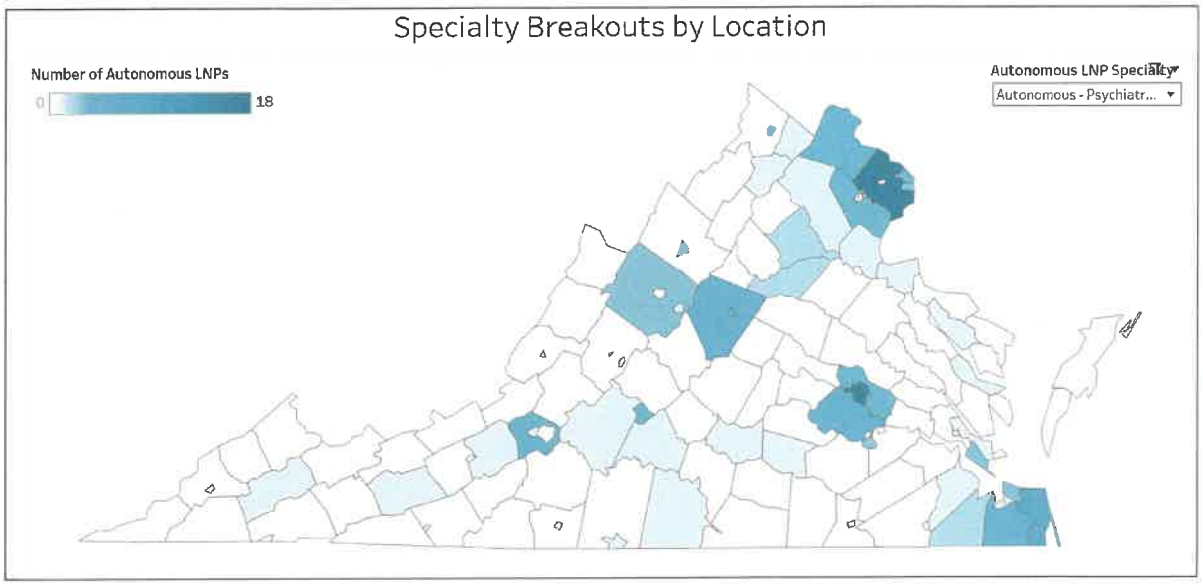
Pediatric Acute



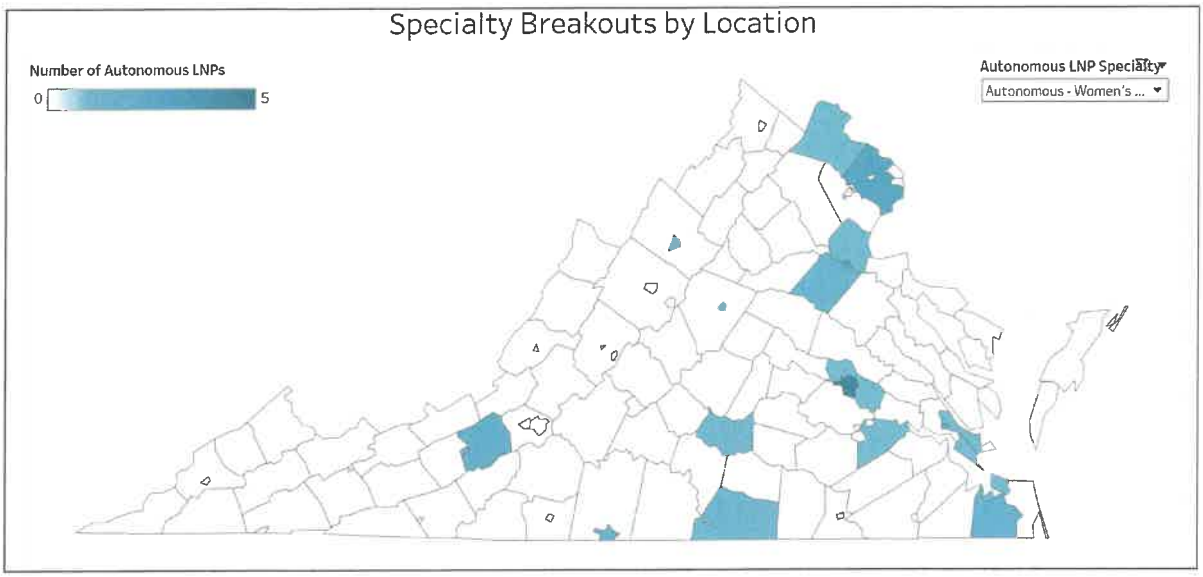
Pediatric Primary



Psychiatric/Mental



Women's Health



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July 16, 2021

Jay P. Douglas, MSM, RN, CSAC, FRE, Executive Director
Via Electronic Mail: Jay.Douglas@dhp.virginia.gov
cc: Marie Gerardo, MS, RN, ANP-BC, President
Huong Vu, EA for the Board and Executive Director, huong.vu@dhp.virginia.gov

Re: MSV Comments Regarding House Bill 793 and Draft Report

Dear Executive Director Douglas and Ms. Gerardo:

On behalf of the PAs, medical students, and physicians of the Commonwealth, thank you for your unwavering support of Virginia's healthcare workforce and for your leadership on the Board of Nursing. As the President of the MSV, I would like to offer the following written comment for consideration of the Boards of Nursing and Medicine regarding a recommendation on HB 793.

Just three years ago, the General Assembly passed Del. Robinson's HB 793 hoping to increase access to healthcare by reducing the full-time clinical requirement needed for independent practice of Nurse Practitioners to 5 years. The bill also requested data and an informed recommendation after consideration of geographic, workforce, and disciplinary data in 2021. During the 2021 Session, Del. Dawn Adams introduced HB 1737 that preemptively reduced the clinical requirement prior to the reporting of that data. With HB 793 in mind, HB 1737 passed with the addition of a sunset clause that would allow the Joint Boards an opportunity to review the pending data request from 2018 and see if autonomous practice of NPs with 5 years of clinical experience allowed more patients access to care, and if a further reduction was warranted.

Upon review of the preliminary report, **the data does not indicate that NP autonomous practice with 5 years of full-time clinical experience expanded access geographically or increased access to medical care by nurse practitioners**. Healthcare access issues in Health Professional Shortage Areas (HPSAs) and rural communities across the Commonwealth should be met with evidence-based legislative and regulatory solutions that prove to make a real difference in the lives of Virginians. The reduction of clinical experience required for NP independent practice did not prove successful in expanding access in these areas. Based on the results from the 2020 Nurse Practitioner Workforce survey from the Department of Health Professions, 53% of NPs in Virginia live or work in areas like Northern and Central Virginia where there are a surplus of other healthcare providers, hospitals, and practices. HPSAs such as the Southwest and the Eastern region account for less than 10% of the population of NPs. These

are the areas where patients need expanded access most.[1] **There is therefore no Virginia-specific evidence to suggest a further reduction from 5 years to 2 years will increase access.**

Supervised training before practicing independently is a proven method to protect patients by ensuring that clinicians see the most expansive scope of complex cases with the support of a more experienced provider.[2] Continuing to pursue policy to reduce the required hours of supervised full-time clinical experience needed by a healthcare provider for autonomous practice is ill considered, and such resources and legislation could be better expended on proven, data-driven policy options to expand access to care for more patients.

We humbly ask that the clinicians on the Board of Nursing and the Board of Medicine consider recommending maintenance of 5 years of clinical experience for autonomous practice for NPs. This recommendation will help legislators and stakeholders at the General Assembly evaluate and consider other legislative, regulatory, and budgetary options to increase access that maintain the importance of hands-on clinical experience. The Medical Society of Virginia and Virginia's physician specialties are invested in expanding access to healthcare but are concerned that doing so by reducing years of clinical experience without supportive data is not the answer.

Thank you for your consideration and for your time. To discuss this matter further, please contact Clark Barrineau, Assistant Vice President of Government Affairs and Health Policy, at Cbarrineau@msv.org or 704-609-4948.

Sincerely,

Arthur J. Vayer Jr., MD, FACS
President, The Medical Society of Virginia

CC:
Scott Johnson, Esquire/Hancock, Daniel & Johnson, General Counsel/MSV
Ben H. Traynham, Esquire/Hancock, Daniel & Johnson
Tyler S. Cox, Government Affairs Manager/Hancock, Daniel & Johnson
Clark Barrineau, Assistant Vice President of Government Affairs and Health Policy/ MSV
Kelsey Wilkinson, Government Affairs Manager/MSV

[1] Virginia's Licensed Nurse Practitioner Workforce: 2020
[2] Scope of Practice Policy, Nurse Practitioners Overview

VAFP

VIRGINIA'S FAMILY PHYSICIANS

July 16, 2021

Jay P. Douglas, MSM, RN, CSAC, FRE, Executive Director
Via Electronic Mail: Jay.Douglas@dhp.virginia.gov
cc: Marie Gerardo, MS, RN, ANP-BC, President
Huong Vu, EA for the Board and Executive Director, huong.vu@dhp.virginia.gov

Re: Virginia Primary Care Physicians' Public Comment Concerning House Bill 793

Dear Executive Director Douglas and Ms. Gerardo:

On behalf of the over 3,000 family physicians, family medicine residents and medical student members of the Virginia Academy of Family Physicians, thank you for your unwavering support of the Commonwealth's healthcare workforce and for your leadership on the Board of Nursing. The VAFP offers the following written comment for consideration of the Boards of Nursing and Medicine regarding your recommendation on HB 793.

The VAFP believes that health professionals should work collaboratively as clinically integrated teams in the best interest and medical care of patients. Physician-led team-based care addresses patients' needs for high quality, accessible health care and reflects the skills, training, and abilities of each of the health care team members to the full extent of their licenses.

While current licensing standards may hold out the practice of nurse practitioners as the practice of nursing, the VAFP views nurse practitioners as practicing medicine. They are not practicing nursing. Short of performing surgery, nurse practitioners are indeed attempting to fulfill the duties of a physician. Allowing APRNs the ability to independently practice medicine, after just two years in practice, with no physician collaboration further splinters the health care team and places patients at risk. APRNs do not have the medical education and training to provide full coordination of a patient's medical care. The VAFP recognizes that nurses are an integral and valuable part of a physician-led team. However, we believe that rushing the independent practice of medicine by autonomous nurse practitioners and prescribing is not the answer. Physicians offer an unmatched service to patients, and, without their skills, patients' safety is at risk.

Healthcare access issues are felt most in health professional shortage areas (HPSAs) and rural communities across the Commonwealth. Based on the preliminary data, the 2018 bill setting NP independent practice to 5 years was not successful in expanding access in these areas. Licensed NPs of medicine have continued to practice in areas such as Northern Virginia, the greater Richmond area, and the Virginia Beach region where prominent health systems and small medical practices are already located.

The VAFP knows the importance of access to primary care physician as we are the most trusted clinician to our patients. States with a higher ratio of primary care physicians to patients have lower Medicare expenditures and lower total and disease-specific mortality.[1] While proponents of independent

[1] Starfield B, Shi L, Macinko J. Contribution of primary care to health system and health. Milbank Q. 2005;83(3):457–502.

diagnosis and prescriptive authority for APRNs frequently argue that APRNs can alleviate the lack of access to primary medical care services, in reality nurse practitioners across the country are choosing to enter into more lucrative subspecialties rather than remaining in primary medical care. Since 2004, the number of nurse practitioners entering primary medical care has dropped by 40 percent[2].

This legislation undermines the physician-led team-based care models that have proven to be most effective in improving patient health and lowering health care costs. VAFP strongly urges you to support physician-led health care teams by opposing the proposed legislation on expanding APRN scope of practice-to-practice medicine without clinical physician collaboration after just two years in the practice of medicine. The significantly variable education, training and clinical experiences of APRNs, poses a significant challenge to the delivery of consistent medical care to our citizens. We respectfully ask the Board of Nursing and the Board of Medicine to consider a recommendation to maintain 5 years of clinical experience before autonomous medical practice of NPs. The intent of HB 793 was to discuss the viability and longevity of NP autonomous medical practice after the first several years. As the members of this Board can see, while NPs are essential members of Virginia's healthcare system, the data does not support that autonomous medical practice has significantly increased access to medical care in the Commonwealth. Reducing the years of clinical experience for any provider without clear and proven data is not the answer.

Thank you for your consideration and for your time. To discuss this matter further, please contact the VAFP's General Counsel and Legislative Consultant Hunter Jamerson, JD, MBA at hunter@macjamlaw.com

Sincerely,

Neeta Goel

Neeta Goel, MD
President

Jesus Lizarzaburu, MD, FAAFP
Chair, Legislative Committee

CC:
Hunter Jamerson, JD, MBA, Macaulay & Jamerson, PC, VAFP General Counsel
Scott Johnson, Esquire/Hancock, Daniel & Johnson, General Counsel/MSV
Ben H. Traynham, Esquire/Hancock, Daniel & Johnson
Tyler S. Cox, Government Affairs Manager/Hancock, Daniel & Johnson
Clark Barrineau, Assistant Vice President of Government Affairs and Health Policy/ MSV
Kelsey Wilkinson, Government Affairs Manager/MSV

[2] Agency for Healthcare Research and Quality. Primary Care Workforce Facts and Stats No. 2. AHRQ Pub. No. 12-P001-3-EF. October 2011.

July 16, 2021

Jay P. Douglas, MSM, RN, CSAC, FRE, Executive Director
Via Electronic Mail: Jay.Douglas@dhp.virginia.gov
cc: Marie Gerardo, MS, RN, ANP-BC, President
Huong Vu, EA for the Board and Executive Director, huong.vu@dhp.virginia.gov

Re: Virginia's Physicians Specialty Comment Concerning House Bill 793

Dear Executive Director Douglas and Ms. Gerardo:

The undersigned thank you for your unwavering support of the Commonwealth's healthcare workforce and for your leadership on the Board of Nursing. On behalf of the undersigned specialty societies, we offer the following written comment for consideration of the Boards of Nursing and Medicine regarding your recommendation on HB 793.

Based on the findings of the HB 793 preliminary report, reducing the clinical experience required for NP independent practice in 2018 **did not prove successful in expanding access to care** in Health Professional Shortage Areas (HPSA) and rural areas in Virginia. HPSAs in the Commonwealth account for less than 10% of the population of NPs, but these are the areas where patients need expanded access most.[1] The 2020 DHP Workforce report indicates NPs have continued to practice in areas such as Northern Virginia, the greater Richmond area, and the Hampton Roads region—all where prominent health systems and small practices are already located.

Additionally, decreasing the amount of clinical experience required for NPs to practice independently **does not address the increasing need for specialists in Virginia**. The single largest employer of Virginia's NPs is the inpatient department of hospitals, not specialty offices, private practices, or research centers.[2]

We respectfully ask that the clinicians on the Board of Nursing and the Board of Medicine consider recommending maintenance of 5 years of clinical experience before autonomous practice of NPs. The intent of HB 793 was, after a period of time, to let the data suggest whether a further reduction was supported. Plainly, the data does not support such a change.

Virginia's physician specialty representatives hope the Joint Boards and the General Assembly consider other legislative, budgetary, and regulatory policy that would better address the growing access issues in the Commonwealth. We are committed to expanding access to healthcare but are concerned that doing so by reducing years of clinical experience for any provider without supportive data.

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[1] Virginia's Licensed Nurse Practitioner Workforce: 2020
[2] ibid

Thank you for your consideration and for your time. To discuss this matter further, please contact Aimee Perron Seibert at aimee@commonwealthstrategy.net or 804-647-3140.

Sincerely,

Virginia Orthopaedic Society
Virginia Society of Eye Physicians and Surgeons
Virginia College of Emergency Physicians
Virginia Society of Anesthesiologists
Psychiatrics Society of Virginia
Virginia Chapter, American Academy of Pediatrics
Virginia Chapter, American College of Surgeons
Richmond Academy of Medicine

Virginia Society of Eye Physicians and Surgeons

Virginia College of Emergency Physicians

PSYCHIATRIC SOCIETY OF VIRGINIA PSV

vsa virginiasociety of anesthesiologists

Virginia Chapter
INCORPORATED IN VIRGINIA

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

RICHMOND ACADEMY OF MEDICINE 1810 20

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CC:
Scott Johnson, Esquire/Hancock, Daniel & Johnson, General Counsel/MSV
Ben H. Traynham, Esquire/Hancock, Daniel & Johnson
Tyler S. Cox, Government Affairs Manager/Hancock, Daniel & Johnson
Clark Barrineau, Assistant Vice President of Government Affairs and Health Policy/ MSV
Kelsey Wilkinson, Government Affairs Manager/MSV

Next Meeting Date of the Executive Committee is

December 3, 2021

Please check your calendars and advise staff of any known conflicts that may affect your attendance.

The travel regulations require that "travelers must submit the Travel Expense Reimbursement Voucher **within 30 days after completion of their trip"**. (CAPP Topic 20335, State Travel Regulations, p.7). If you submit your reimbursement after the 30 day deadline, please provide a justification for the late submission.

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

Septmber 3, 2021