Executive Committee Meeting

Virginia Board of Medicine
August 4, 2023
8:30 a.m.

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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Board Room 4

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Executive Committee

Friday, August 4, 2023 @ 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..... i

Approval of Minutes from December 2, 2022 1

Adoption of Agenda

Public Comment on Agenda Items

DHP Director's Report – Arne Owens

Reports of President and Acting Executive Director

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

New Business

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4. Amendment of Guidance Document 85-10 regarding midwife disclosures..... 33
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10. Adoption of revised policy on meetings held with electronic participation pursuant to statutory changes..... 185
11. Announcements/Reminders
12. Adjourn

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

—DRAFT UNAPPROVED—

VIRGINIA BOARD OF MEDICINE
EXECUTIVE COMMITTEE MINUTES

Friday, December 2, 2022 Department of Health Professions Henrico, VA

CALL TO ORDER: Mr. Marchese called the meeting of the Executive Committee to order at 8:30 a.m.

ROLL CALL: Ms. Brown called the roll; a quorum was declared.

MEMBERS PRESENT:
Blanton Marchese – President & Chair
Alvin Edwards, MDiv, PhD
Jane Hickey, JD
Jacob Miller, DO
Joel Silverman, MD
Ryan Williams, MD

MEMBERS ABSENT:
David Archer, MD
Karen Ransone, MD

STAFF PRESENT:
William L. Harp, MD - Executive Director
Jennifer Deschenes, JD - Deputy Exec. Director for Discipline
Michael Sobowale, LLM - Deputy Exec. Director for Licensure
Arne Owens, LTC, USA Retired, MS – DHP Director
Jim Jenkins, BSN, RN, SCRN – DHP Deputy Director
Barbara Matusiak, MD - Medical Review Coordinator
Deirdre C. Brown - Executive Assistant
Erin Barrett, JD – DHP Senior Policy Analyst
M. Brent Saunders, JD – OAG Board Counsel

OTHERS PRESENT:
Jennie Wood – Discipline Case Manager
Matt Novak – DHP Policy Analyst
W. Scott Johnson, JD – Medical Society of Virginia
Clark Barrineau – Medical Society of Virginia

EMERGENCY EGRESS INSTRUCTIONS

Mr. Marchese provided the emergency egress instructions for Board Room 3.

APPROVAL OF MINUTES OF AUGUST 5, 2022

Dr. Edwards moved to approve the minutes from August 5, 2022 with one correction on page 2. The motion was seconded by Dr. Miller and carried unanimously.

ADOPTION OF AGENDA

Dr. Edwards moved to adopt the agenda with the revision that New Business items 1 & 2 be presented by Erin Barrett immediately after Public Comment. The motion was seconded by Dr. Miller and carried unanimously.

PUBLIC COMMENT

Mr. Marchese opened the floor for public comment. Scott Johnson, JD shared with the Committee that Dr. Harp was recognized by the MSV Foundation for "Service to the Profession" at the end of October 2022. Dr. Harp was nominated for the award by his peers. Mr. Johnson thanked Dr. Harp for his service to the medical community. Dr. Harp said he was honored and humbled by the recognition and thanked Mr. Johnson and MSV for their collegial coordination over the years.

Next, Clark Barrineau took the podium and asked the Committee to turn their attention to page 20 in the agenda packet. He asked that question #4 in the application be removed from the application. Question #4 is focused on mental health, and Mr. Barrineau stated that Virginia should trend with other states that are removing mental health questions from their applications.

NEW BUSINESS ITEMS 1 AND 2

Before going into New Business, Ms. Barrett introduced Matt Novak to the Committee as the newly hired DHP Policy Analyst. She stated that Mr. Novak will be attending the Board's meetings, and at times will be covering meetings in her absence.

1. Regulatory Actions as of October 5, 2022 – Erin Barrett

Ms. Barrett asked the Committee members to turn to page 10 of the agenda packet, the Board of Medicine's "Current Regulatory Actions" as of October 5, 2022. Ms. Barrett commented that at this time there were no actions in the Governor's office. The actions listed as being at the Secretary's level were expected to move on soon. The actions listed at DPB or OAG are currently at 41 days in those offices. Lastly, there are no actions that recently became effective or are awaiting publication. There was no action to be taken on this item.

2. Adoption of Revisions to Guidance Document 90-56 – Erin Barrett

Ms. Barrett presented proposed revisions to Guidance Document 90-56 related to practice agreements for nurse practitioners, as seen on page 14 of the agenda packet. This guidance document pertains to licensees who are jointly regulated by both the Board of Medicine and the Board of Nursing. Ms. Barrett shared that the Board of Nursing has already approved this document at its November Board meeting. Therefore if any changes are made, it will need to

return to the Board of Nursing for review. After discussion, Ms. Barrett shared that most Clinical Nurse Specialists are not required to have a practice agreement with a physician, since most do not prescribe. The statutory changes have been reflected in the proposed language of the Guidance Document.

MOTION: Dr. Williams moved to revise Guidance Document 90-56 as presented. The motion was properly seconded by Dr. Miller and carried unanimously.

DHP DIRECTOR'S REPORT

Mr. Marchese introduced DHP's newly appointed Director, Arne Owens, and shared his previous positions and past accomplishments. Mr. Owens then took the floor.

He said that what he found rewarding here is the people, the DHP staff, and said that he looks forward to working with everyone at DHP. He congratulated Dr. Harp on the MSV recognition and then introduced Jim Jenkins, the newly appointed DHP Deputy Director, who comes from VCU Health. Mr. Jenkins served as a member of the Board of Medicine and more recently as a member of the Board of Pharmacy. He mentioned his previous positions and past accomplishments. Mr. Jenkins congratulated Dr. Harp on his award and thanked everyone for the warm welcome to DHP. He said that he enjoys the education that came from being a part of the Board, and he was looking forward to the future at DHP.

PRESIDENT'S REPORT

Mr. Marchese shared with the Board that he attended the 2022 Tri-Regulators' meeting in October in Washington, DC. Jay Douglas from the Board of Nursing and Caroline Juran from the Board of Pharmacy also attended. He mentioned that overdose deaths from prescription opioids have not changed significantly in the last 15 years, and that now illicit fentanyl is responsible for the greatest number of overdose deaths.

Mr. Marchese then gave an update on the Physician Assistant Compact, stating that it now has model legislation that can be submitted in state legislatures. Virginia will probably not see this is in the 2023 Session, but perhaps in a subsequent year. The structure of the Compact will allow PA's to cross state lines with practice privileges and will not require licensure as does the Interstate Medical Licensure Compact. The PA Compact has some similarities to the Nurse Compact.

Dr. Harp then informed all that Michael Sobowale is Chair of the Rules Committee for the OT Compact, which gives Virginia considerable influence in how the OT Compact will be administered.

EXECUTIVE DIRECTOR'S REPORT

Dr. Harp shared with the Committee that FSMB sends out an annual board survey on board concerns and resources that FSMB might provide. This year's survey was completed by 52 of the 70 state boards (74%) between July and September of 2022. The boards reported the following top three issues on a 0-10 importance scale: Physician Sexual Misconduct (8.9),

Physician Impairment (8.8), and Opioid Prescribing (8.4). Jennifer Deschenes added that FSMB's Disciplinary Alert Service is very useful because it notifies all state boards of disciplinary actions in which a physician is licensed.

Dr. Harp added that the Board and its entities can no longer meet virtually. An individual Board member can petition to attend virtually if statutory good cause is shown.

3. Reciprocal Licensing Process and Application – Dr. Harp and Michael Sobowale

Dr. Harp stated that the first step is to establish a Memorandum of Agreement (MOA), which DC's Board Counsel put together this summer. The 3 jurisdictions made suggestions on the draft MOA to DC Counsel, who incorporated them into the document. Board Counsel Brent Saunders stated that the MOA is currently under review at OAG. Dr. Harp then described generally the process that would be involved and the application that is going to be used. The process anticipates an online application that goes to a dedicated email box. There will be a dedicated phone line for staff handling reciprocal licensing to field questions. The only supporting documents required will be license verification from the other jurisdiction and a NPDB report. If all questions on the application are answered, "no", then the licensing specialist will be able to issue the license. If any of the questions are answered, "yes", then the application will be switched over to the traditional pathway. If a Virginia licensee applies to DC or Maryland, Board staff will email a verification to the requesting Board. Jennifer Deschenes and her staff will verify any pending disciplinary actions or current investigations for the other jurisdiction.

Dr. Harp asked the Committee to weigh in on the 7 questions in the draft application. Question #1 drew comment from Ms. Hickey asking if this included a reprimand. Dr. Harp stated that it would not include a reprimand, which is a cross-sectional sanction. The question only asks about a restriction on the license which encumbers it going forward. The NPDB report would capture those with prior discipline. The Committee agreed to the question as written.

Question #2 was agreed to as well, given that either a pending disciplinary matter or an ongoing investigation would be disqualifying for reciprocal licensing.

Dr. Harp moved to question #3. Dr. Silverman noted that if the word "physical" was removed from question #3, it might obviate the need for questions #4 and #5. Dr. Harp said that these 3 questions are to protect the public, and he liked Dr. Silverman's suggestion very much. Dr. Miller and Dr. Silverman agreed that the questions should be asked, but applicants may not answer truthfully. Question #4 is currently at OAG to consider revised language. If there is revised language, it will be used by all boards in DHP.

Dr. Harp then reviewed question #6. He said that the process in licensing now requires an applicant that is currently in another state's physician health program to join Virginia's HPMP in order to be licensed. A "yes" answer to this question moves the application over to the traditional pathway.

Lastly, Dr. Harp asked the Committee for its input on question #7 on the application. The Board members agreed with 3 or more malpractice paid claims, but suggested to take out the $75,000 amount. The Committee thought that 3 or more paid claims are significant, regardless of the

amounts. A "yes" answer to this question will cause the application to be placed in the traditional pathway.

MOTION: Dr. Miller moved to adopt the draft application as discussed. The motion was properly seconded and carried unanimously.

Break at 9:51 a.m., resumed meeting at 10:03 a.m.

4. Greater Delegation to Licensing Staff for Non-Routine Applications – Dr. Harp

Dr. Harp shared with the Committee that on October 20, 2022, a Zoom meeting was held with Mr. Marchese, Dr. Miller, and Michael during which non-routine information was discussed. Mr. Marchese then shared with the Committee that there are about twenty non-routine applications a week, some of which Ms. Hickey has reviewed as well. Dr. Miller and he have made suggestions about the non-routine information that staff could be delegated for review. Dr. Miller, Mr. Marchese, and Ms. Hickey all agree that these suggestions will help reduce the number of days it takes to process applications.

Dr. Miller then asked Mr. Sobowale to describe the qualifications of a licensing specialist. Mr. Sobowale responded that the licensing specialists go through an interview process, and that they all come from different professional backgrounds. Once on staff, they are trained about their specific professions, applications, and required supporting documentation.

Mr. Marchese then suggested for the Committee to review all 18 of the suggestions to see if anyone had any questions or concerns. The Committee agreed to most of the changes, but would like the wording of all suggestions be changed from "5 years prior…" to "5 years of active practice prior to application."

MOTION: Dr. Edwards moved greater delegation to licensing staff for review of non-routine applications as discussed. The motion was properly seconded by Dr. Miller and carried unanimously.

5. Regulatory Advisory Panel for Updating the Board of Medicine Regulations Governing Prescribing of Opioids and Buprenorphine – Blanton Marchese

Mr. Marchese shared that the CDC published its 2022 Clinical Practice Guideline for Prescribing Opioids for Pain in November. He suggested to the Committee the need to convene a regulatory advisory panel (RAP) to perform a periodic review of the Board's opioid regulations and consider including revisions from the updated CDC guideline. He said the RAP should include a diversity of stakeholders. Dr. Harp underscored that the Board's regulations became effective in March 2017, and now that the CDC has published its new guideline, the Board can move forward with its periodic review. Stakeholders in this process should include those in academia, the community, and other state agencies. Dr. Miller suggested full-time community pain management doctors be included, since they treat 80% of pain patients. Ms. Hickey suggested recovering patients, who are consumers, would also

be good to add to the RAP. Mr. Marchese also suggested someone from the CDC could perhaps be on the panel. In closing, Mr. Owens stated that it was really good that the Board of Medicine was doing this.

MOTION: Dr. Edwards moved to form a Regulatory Advisory Panel to perform periodic review of the Board's opioid regulations and incorporate significant changes from the new CDC guideline. The motion was properly seconded by Dr. Miller and carried unanimously.

ANNOUNCEMENTS

All were reminded to submit their Travel Expense Reimbursement Vouchers within 30 days after completion of their trip (CAPP Topic 20335, State Travel Regulations, p. 7).

The next meeting of the Executive Committee will be April 7, 2023 @ 8:30 a.m.

ADJOURNMENT

With no additional business, the meeting adjourned at 10:58 a.m.

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William L. Harp, MD
Executive Director

Board of Medicine
Current Regulatory Actions
As of July 10, 2023

In the Governor's Office

None.

In the Secretary's Office

VAC	Stage	Subject Matter	Date submitted*	Time in office	Notes
18VAC85-150	NOIRA	Conforming licensure requirements to Code	7/1/2022	327 days	Amendment to 18VAC85-150-60, which sets out requirements for licensure as a behavior analyst or assistant behavior analyst, to conform to Virginia Code § 54.1-2957.16(B)(1). **Note:** This action on agenda for withdrawal pursuant to HB1946/SB1406.
18VAC85-160	Final	Changes consistent with a licensed profession	7/5/2022	370 days	Proposed regulations consistent with surgical assistants changing from certification to licensure
18VAC85-160	Fast-track	Reinstatement as a surgical technologist	8/30/2022	314 days	Action to allow certified surgical technologists to voluntarily request inactive status, and for surgical technologists to reinstate certification from inactive status or from suspension or revocation

					following disciplinary action.
18VAC85-130	Fast-track	Implementation of changes following 2022 periodic review of Chapter	5/30/2023	Secretary 41 days	Implements changes following 2022 periodic review
18VAC85-140	Fast-track	Implementation of changes following 2022 periodic review of Chapter	6/2/2023	Secretary 38 days	Implements changes following 2022 periodic review
18VAC85-150	Fast-track	Implementation of changes following 2022 periodic review of Chapter	6/5/2023	Secretary 35 days	Implements changes following 2022 periodic review
18VAC85-170	Fast-track	Implementation of changes following 2022 periodic review of Chapter	6/5/2023	Secretary 35 days	Implements changes following 2022 periodic review
18VAC85-15	Fast-Track	Implementation of Periodic Review	7/10/2023	0 days	Implements changes following 2022 periodic review

* Date submitted to current location

At DPB or OAG

VAC	Stage	Subject Matter	Date submitted*	Time in office	Notes
18VAC85-40	Fast-track	Implementation of changes following 2022 periodic review of Chapter	6/22/2023	DPB 18 days	Implements changes following 2022 periodic review
18VAC85-80	Fast-track	Implementation of changes following 2022 periodic review of Chapter	6/30/2023	DPB 10 days	Implements changes following 2022 periodic review
18VAC85-101	Fast-track	Implementation of changes following 2022 periodic review of Chapter	6/30/2023	DPB 10 days	Implements changes following 2022 periodic review

18VAC85-50	Fast-track	Implementation of changes following 2022 periodic review of Chapter	7/5/2023	DPB 5 days	Implements changes following 2022 periodic review
18VAC85-120	Fast-track	Implementation of changes following 2022 periodic review of Chapter	7/5/2023	DPB 5 days	Implements changes following 2022 periodic review
18VAC85-110	Fast-track	Implementation of changes following 2022 periodic review of Chapter	7/10/2023	DPB 0 days	Implements changes following 2022 periodic review
18VAC85-20	Fast-track	Implementation of changes following 2022 periodic review of Chapter	7/14/2023	DPB 0 days	Implements changes following 2022 periodic review
18VAC85-160	Exempt	Exempt regulatory change pursuant to HB2222	7/2/2023	OAG 8 days	Implements changes to certification of surgical technologists

Soon to be filed

VAC	Stage	Subject Matter
18VAC85-21	Fast-track	Amendments to opioid and buprenorphine prescribing regulations

Recently effective/awaiting publication

VAC	Stage	Subject Matter	Publication date	Effective date
18VAC85-80	Proposed	Implementation of OT Compact	6/5/2023	Executive Committee to vote on final amendments today.

Agenda Item: Withdrawal of NOIRA regarding behavior analyst training

Included in your agenda package:

- Agency background document in support of Notice of Intended Regulatory Action, filed June 2022 to conform to Code requirements for licensure;

- Chapter 693 of the 2023 Acts of Assembly, which required the Board to accept only certification by the Behavior Analyst Certification Board or its successor, making the NOIRA unnecessary; and

- 18VAC85-150-60.

Staff Note: Existing regulations currently conform to 2023 legislation. The only action the Board must take to be in compliance with the 2023 legislation is to withdraw the regulatory action.

Action needed:

- Motion to withdraw the NOIRA regarding behavior analyst and behavior analyst assistant training filed in June 2022.

Form: TH-01
April 2020

VIRGINIA
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townhall.virginia.gov

Notice of Intended Regulatory Action (NOIRA) Agency Background Document

Agency name	Board of Medicine, Department of Health Professions
Virginia Administrative Code (VAC) Chapter citation(s)	18VAC85-150-60
VAC Chapter title(s)	Regulations Governing the Practice of Behavior Analysis
Action title	Conforming licensure requirements to Code
Date this document prepared	June 17, 2022

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 14 (as amended, July 16, 2018), the Regulations for Filing and Publishing Agency Regulations (1VAC7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code.*

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of the subject matter, intent, and goals of this this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation.

The Board intends to amend 18VAC85-150-60, which sets out requirements for licensure as a behavior analyst or assistant behavior analyst, to conform to Virginia Code § 54.1-2957.16(B)(1).

Acronyms and Definitions

Define all acronyms or technical definitions used in this form.

BACB = Behavior Analyst Certification Board

Mandate and Impetus

Identify the mandate for this regulatory change and any other impetus that specifically prompted its initiation (e.g., new or modified mandate, petition for rulemaking, periodic review, or board decision). For purposes of executive branch review, "mandate" has the same meaning as defined in Executive Order 14 (as amended, July 16, 2018), "a directive from the General Assembly, the federal government, or a court that requires that a regulation be promulgated, amended, or repealed in whole or part."

There is no mandate for this change. The impetus comes from a petition for rulemaking filed with the Board in February 2022 which pointed out that the regulatory requirement for the certification needed for licensure was impermissibly more restrictive than the statutory language requiring such certification.

Legal Basis

Identify (1) the promulgating agency, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia and Acts of Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

Regulations of the Board of Medicine are promulgated under the general authority of Chapter 24 of Title 54.1 of the Code of Virginia. Virginia Code § 54.1-2400(6) specifically states that the general powers and duties of health regulatory boards shall be "[t]o promulgate regulations in accordance with the Administrative Process Act (§ 2.2-4000 et seq.) that are reasonable and necessary to administer effectively the regulatory system."

Additionally, Virginia Code § 54.1-2957.16(D) requires the Board to promulgate regulations necessary for the issuance of licenses to behavior analysts and assistant behavior analysts.

Purpose

Describe the specific reasons why the agency has determined that this regulation is essential to protect the health, safety, or welfare of citizens. In addition, explain any potential issues that may need to be addressed as the regulation is developed.

The purpose of this amendment will be to correctly license all individuals entitled to licensure under Virginia Code § 54.1-2957.16.

Substance

Briefly identify and explain the new substantive provisions that are being considered, the substantive changes to existing sections that are being considered, or both.

18VAC85-150-60 currently requires an applicant for licensure as a behavior analyst or assistant behavior analyst hold current certification from the BACB. Virginia Code § 54.1-2957.16(B)(1), however, requires a current certification from the BACB "or any other entity that is nationally accredited to certify practitioners of behavior analysis." The regulatory change will be to amend 18VAC85-150-60 to include "or any other entity that is nationally accredited to certify practitioners of behavior analysis."

Alternatives to Regulation

Describe any viable alternatives to the regulatory change that were considered, and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the regulatory change. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulatory change.

The Board is required by statute to promulgate regulations for the licensure of behavior analysts and assistant behavior analysts. There is no alternative to amending the current regulation.

Periodic Review and Small Business Impact Review Announcement

This NOIRA is not being used to announce a periodic review or a small business impact review.

Public Participation

Indicate how the public should contact the agency to submit comments on this regulation, and whether a public hearing will be held, by completing the text below. In addition, as required by § 2.2-4007.02 of the Code of Virginia describe any other means that will be used to identify and notify interested parties and seek their input, such as regulatory advisory panels or general notices.

The Board of Medicine is providing an opportunity for comments on this regulatory proposal, including but not limited to (i) the costs and benefits of the regulatory proposal, (ii) any alternative approaches, and (iii) the potential impacts of the regulation.

Anyone wishing to submit written comments for the public comment file may do so through the Public Comment Forums feature of the Virginia Regulatory Town Hall web site at: https://townhall.virginia.gov. Comments may also be submitted by mail, email or fax to Erin Barrett, Agency Regulatory Coordinator, 9960 Mayland Drive, Henrico, VA 23233 or erin.barrett@dhp.virginia.gov or by fax to (804) 915-0382. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

A public hearing will be held following the publication of the proposed stage, and notice of the hearing will be posted on the Virginia Regulatory Town Hall website (https://townhall.virginia.gov) and on the Commonwealth Calendar website (https://commonwealthcalendar.virginia.gov/). Both oral and written comments may be submitted at that time.

VIRGINIA ACTS OF ASSEMBLY -- 2023 SESSION

CHAPTER 693

An Act to amend and reenact § 54.1-2957.16 of the Code of Virginia, relating to behavior analysts; assistant behavior analysts; licensure criteria; certifying entities.

[H 1946]

Approved March 27, 2023

Be it enacted by the General Assembly of Virginia:

1. That § 54.1-2957.16 of the Code of Virginia is amended and reenacted as follows:

§ 54.1-2957.16. Licensure of behavior analysts and assistant behavior analysts; requirements; powers of the Board.

A. It ~~shall be~~ *is* unlawful for any person to practice or to hold himself out as practicing as a behavior analyst or to use the title "Licensed Behavior Analyst" unless he holds a license as a behavior analyst issued by the Board. It ~~shall be~~ *is* unlawful for any person to practice or to hold himself out as practicing as an assistant behavior analyst or to use the title "Licensed Assistant Behavior Analyst" unless he holds a license as an assistant behavior analyst issued by the Board. The Board shall issue licenses to practice as a behavior analyst or an assistant behavior analyst to applicants for licensure who meet the requirements of this chapter and the Board's regulations.

B. The Board shall establish criteria for licensure as a behavior analyst, which shall include, but not be limited to, the following:

1. Documentation that the applicant is currently certified as a Board Certified Behavior Analyst by the Behavior Analyst Certification Board or ~~any other entity that is nationally accredited to certify practitioners of behavior analysis~~ *its successor*;

2. Documentation that the applicant conducts his professional practice in accordance with the Behavior Analyst Certification Board ~~Guidelines for Responsible Conduct and Professional Ethical and Disciplinary Standards~~ *ethics code for behavior analysts* and any other accepted professional and ethical standards the Board deems necessary; and

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

C. The Board shall establish criteria for licensure as an assistant behavior analyst, which shall include, but not be limited to, the following:

1. Documentation that the applicant is currently certified as a Board Certified Assistant Behavior Analyst by the Behavior Analyst Certification Board or ~~any other entity that is nationally accredited to certify practitioners of behavior analysis~~ *its successor*;

2. Documentation that the applicant conducts his professional practice in accordance with the Behavior Analyst Certification Board ~~Guidelines for Responsible Conduct and Professional Ethical and Disciplinary Standards~~ *ethics code for behavior analysts* and any other accepted professional and ethical standards the Board deems necessary;

3. Documentation that the applicant for licensure has not had his license or certification as an assistant behavior analyst suspended or revoked and is not the subject of any disciplinary proceedings by the certifying board or in another jurisdiction; and

4. Documentation that the applicant's work is supervised by a licensed behavior analyst in accordance with the supervision requirements and procedures established by the Board.

D. The Board shall promulgate such regulations as may be necessary to implement the provisions of this chapter related to (i) application for and issuance of licenses to behavior analysts or assistant behavior analysts, (ii) requirements for licensure as a behavior analyst or an assistant behavior analyst, (iii) standards of practice for licensed behavior analysts or licensed assistant behavior analysts, (iv) requirements and procedures for the supervision of a licensed assistant behavior analyst by a licensed behavior analyst, and (v) requirements and procedures for supervision by licensed behavior analysts and licensed assistant behavior analysts of unlicensed individuals who assist in the provision of applied behavior analysis services.

E. The Board shall establish a fee, determined in accordance with methods used to establish fees for other health professionals licensed by the Board of Medicine, to be paid by all applicants for licensure as a behavior analyst or assistant behavior analyst.

Virginia Administrative Code
Title 18. Professional And Occupational Licensing
Agency 85. Board of Medicine
Chapter 150. Regulations Governing the Practice of Behavior Analysis

Part II. Requirements for Licensure as a Behavior Analyst or an Assistant Behavior Analyst

18VAC85-150-60. Licensure requirement.

An applicant for a license to practice as a behavior analyst or an assistant behavior analyst shall hold current certification as a BCBA® or a BCaBA® obtained by meeting qualifications and passage of the examination required for certification as a BCBA® or a BCaBA® by the BACB.

Statutory Authority
§§ 54.1-2400 and 54.1-2957.16 of the Code of Virginia.

Historical Notes
Derived from Virginia Register Volume 30, Issue 16, eff. May 7, 2014.

Agenda Item: Adoption of final regulations for implementation of the Occupational Therapy Interjurisdictional Compact

Included in your agenda package:

- Proposed regulations implementing the OT Compact in Virginia;
- Chapter 242 of the 2021 Special Session I, which entered Virginia into the OT Compact.

Staff notes: A handout of public comment received on Town Hall will be included as a handout at your place.

Action needed:

- Motion to adopt final regulations implementing the OT Compact.

Project 6878 - Proposed

Board of Medicine

Implementation of the OT 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"

"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.

"Compact" means the Occupational Therapy Interjurisdictional Licensure Compact.

"Compact privilege" means the same as the definition of the term in § 54.1-2956.7:1 of the Code of Virginia.

"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~~ 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~~ 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~~ the licensee's 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.

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.

Agenda Item: Amendment of Guidance Document 85-10 regarding midwife disclosures

Included in your agenda package:

- An amended version of Guidance Document 85-10 following recommended changes by an ad hoc committee specifically convened for this purpose and approval of the Midwifery Advisory Board.

Staff Note: The previous version of Guidance Document 85-10 was created using an old Word version and could not be updated properly. This document therefore does not show track changes. However, the following major changes were made:

- Preamble was limited to the all-inclusive disclosure that every patient receives;
- Advanced maternal age added for disclosure;
- Assisted reproductive technologies added for disclosure;
- Group B strep added for disclosure;
- Opioid use disorder during pregnancy addressed;
- Recommendations for HIV positive status or AIDS and breastfeeding updated according to existing scientific literature; and
- Footnotes throughout the document were removed due to lack of necessity.

Action needed:

- Motion to accept amendments to Guidance Document 85-10 as recommended by the ad hoc committee and Advisory Board on Midwifery.

Guidance Document: 85-10

Revised: August 4, 2023
Effective Date: TBD

Virginia Board of Medicine

Disclosures by Licensed Professional Midwives for High-Risk Pregnancy Conditions

Regulations which govern licensed professional midwives require that midwives disclose to patients, when appropriate, options for consultation and referral to a physician, as well as information on health risks associated with the birth of a child outside of a hospital or birthing center. *See* 18VAC85-130-81(A). Regulations of the Board, specifically 18VAC85-130-81(B), list the risk factors and conditions that require disclosure, as well as steps the midwife must take if the risk factors or conditions are presented. 18VAC85-130-81(C) contains requirements for communication and record-keeping if risk factors or conditions are identified.

This guidance document provides evidence-based information and a format to record the disclosure of information and options for consultation and referral in the patient's record for each risk factor or condition included in 18VAC85-130-81(B). Use the table of contents links below to access forms for particular risk factors or conditions.

**** The disclosure for intrapartum risk factors should be given to a client at the first prenatal visit. ****

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Intrapartum Risk Factors

The Midwives Model of Care recognizes the client/patient as the primary decision-maker in all aspects of her care and respects her autonomy. This is supported within a model of well-informed, shared decision-making in order to achieve optimal clinical outcomes. Disclosure of risks is an integral part of the informed consent process, as outlined by the North American Registry of Midwives ("NARM").

> If a midwife supports a client's choices that are outside of her [plan of care], she must be prepared to give evidence of informed consent. The midwife must also be able to document the process that led to the decision and show that the client was fully informed of the potential risks and benefits of proceeding with the new care plan. It is the responsibility of the midwife to provide evidence-based information, clinical expertise, and when appropriate, consultation or referral to other providers to aid the client in the decision-making process.

Informed Consent for Waiver of Midwife's Plan of Care, NARM.

Licensed professional midwives are trained experts in the management of low-risk pregnancy and birth outside of the hospital. Certain conditions may present increased risk to the mother and baby. The risks listed below apply to birth in any setting and are not all-inclusive. The condition or risk factor listed may require medication and treatment outside of the scope of practice of licensed professional midwives in Virginia and therefore may necessitate consultation with a physician, additional testing, and careful consideration of the appropriateness of birth in an out-of-hospital setting. Some conditions in pregnancy are optimally managed and supported by a multidisciplinary team that may include midwives, obstetricians, perinatologists, family physicians, psychologists, social workers, and spiritual advisors.

Conditions requiring on-going medical supervision or on-going use of medications.

Clients with chronic medical conditions, clients on prescribed medications, or clients under medical care for a time-limited problem that coincides with pregnancy should be advised to consult with their treating healthcare providers regarding the impact of these conditions and medications on pregnancy, as well as any impact pregnancy may have on their other diagnosed conditions. Women who choose not to disclose information regarding any existing medical conditions or existing medications may increase their risk of complications.

Current substance abuse (including alcohol and tobacco).

Obstetrical complications of cigarette smoking include:

- Growth restriction (IUGR)
- Spontaneous abortion (miscarriage)
- Sudden infant death syndrome (SIDS)

Alcohol abuse leads to:

- Nutritional deficiencies
- Fetal alcohol syndrome

In addition to increased risk of preterm labor and baby being small for gestational age, complications resulting from using other drugs are listed below:

- Heroin and cocaine consumption result in medical, nutritional, and social neglect
- Cocaine and amphetamine use causes hypertension and placental abruption
- Intravenous drug use increases the risk of contracting infectious diseases
- Maternal substance use of opioids, benzodiazepines, barbiturates, and alcohol can cause neonatal abstinence syndrome ("NAS"). NAS is a set of drug withdrawal symptoms that affect the central nervous, gastrointestinal, and respiratory systems in the newborn when separated from the placenta at birth.

Opioid use disorder.

Opioid use disorder during pregnancy may contribute to:

- Preterm birth
- Stillbirth
- Maternal mortality
- Neonatal abstinence syndrome

Documented intrauterine grown retardation (IUGR)/small for gestational age (SGA) at term.

Complications for the growth-restricted fetus include:

- Prematurity
- Perinatal morbidity
- Stillbirth

Reviewing evidence-based information, the Board has determined that IUGR is a serious problem, regardless of why the baby is small. About 20% of stillborn babies are IUGR, and perinatal mortality for growth-restricted infants may be 6 to 10 times higher than for those of normal size. Most IUGR stillbirths occur after the 36th week of pregnancy and before labor begins.

Suspected uterine rupture.

The Board determines the following based on evidence-based information regarding uterine rupture:

- There have been no reported maternal deaths due to uterine rupture

- Overall, 14% - 33% of women will require a hysterectomy when the uterus ruptures
- Approximately 6% of uterine ruptures will result in perinatal death, which is an overall risk of intrapartum fetal death of 20 per 100,000 women undergoing trial of labor after previous cesarean section
- For term pregnancies, the reported risk of fetal death with uterine rupture is less than 3%. Although the risk is similarly low, there is insufficient evidence to quantify the neonatal morbidity directly related to uterine rupture.

Prolapsed cord or presentation.

Prolapsed cord is a term describing a cord that is passing through the cervix at the same time or in advance of the fetal presenting part. This occurs in approximately 1.4-6.2 per 1,000 pregnancies. Although uncommon, it is considered a true obstetrical emergency most often necessitating a cesarean delivery. Prolapsed cord is also associated with other complications of pregnancy and delivery. Fetal risks include:

- Hypoxia
- Stillbirth/death

Suspected complete or partial placental abruption.

Placental abruption results from a cascade of pathophysiologic processes ultimately leading to the separation of the placenta prior to delivery. Pregnancies complicated by abruption result in increased frequency of:

- Low birth weight
- Preterm delivery
- Stillbirth
- Perinatal death

Suspected placental previa.

Pregnancies complicated with placenta previa have significantly higher rates of:

- Second-trimester bleeding
- Pathological presentations
- Placental abruption
- Congenital malformations
- Perinatal mortality
- Cesarean delivery
- Apgar scores at 5 minutes lower than 7
- Placenta accreta
- Postpartum hemorrhage
- Postpartum anemia
- Delayed maternal and infant discharge from the hospital

Suspected chorioamnionitis.

Chorioamnionitis is a potentially serious complication, as described below:

- Chorioamnionitis is a major risk factor in the event of preterm birth, especially at earlier gestational ages, contributing to prematurity-associated mortality and morbidity
- Increased susceptibility of the lung for postnatal injury, which predisposes for bronchopulmonary dysplasia.
- Chorioamnionitis is associated with cystic periventricular leukomalacia, intraventricular hemorrhage and cerebral palsy in preterm infants
- Prenatal inflammation/infection has been shown a risk factor for neonatal sepsis

Preeclampsia/eclampsia.

Complications of preeclampsia include:

- Eclampsia
- HELLP (hemolysis, elevated liver enzymes, low platelets) syndrome
- Liver rupture
- Pulmonary edema
- Renal failure
- Disseminated intravascular coagulopathy (DIC)
- Hypertensive emergency
- Hypertensive encephalopathy
- Cortical blindness

Maternal complications occur in up to 70% of women with eclampsia and include:

- DIC (disseminated intravascular coagulation)
- Acute renal failure
- Hepatocellular injury
- Liver rupture
- Intracerebral hemorrhage
- Cardiopulmonary arrest
- Aspiration pneumonitis
- Acute pulmonary edema
- Postpartum hemorrhage
- Maternal death. Rates of 0-13.9% have been reported.

Fetal complications in preeclampsia are directly related to gestational age and the severity of maternal disease and include increased rates of:

- Preterm delivery
- Intrauterine growth restriction
- Placental abruption

- Perinatal death

Thick meconium stained amniotic fluid without reassuring fetal heart tones and birth is not imminent.

Meconium staining of the amniotic fluid is a common occurrence during labor. Although a large proportion of these pregnancies will have a normal neonatal outcome, its presence may be an indicator of fetal hypoxia and has been linked to the development of:

- Cerebral palsy
- Seizures
- Meconium aspiration syndrome

Abnormal auscultated fetal heart rate pattern unresponsive to treatment or inability to auscultate fetal heart tones.

Sustained abnormal fetal heart rate patterns include bradycardia (abnormally low heart rate) and decelerations in the baby's heart rate. Additionally, tachycardia (abnormally high heart rate) is abnormal, and can also be an indication for the need for further evaluation. Historically, a 30-minute rule from decision-to-incision time for emergent cesarean delivery in the setting of abnormal FHR pattern has existed; however, the scientific evidence to support this threshold is lacking.

Excessive vomiting, dehydration, or exhaustion unresponsive to treatment.

- Sufficient fluid intake during labor may prevent hemoconcentration, starvation, and activation of the thrombogenic and fibrinolytic system
- With extreme exhaustion, the chances of fetal distress and non-progressive labor are greatly increased
- Bleeding during or after the placental birth, followed by shock, are much more likely to occur when the woman and her uterus are exhausted
- Maternal exhaustion is diagnosed with a combination of ketonuria, elevated temperature, and elevated pulse. This condition is also known as ketoacidosis, in that the mother's blood becomes abnormally acidic and less able to carry oxygen. Unless this condition is reversed, fetal distress will result.

Blood pressure greater than 140/90 which persists or rises and birth is not imminent.

Women with chronic hypertension are at increased risk of:

- Superimposed preeclampsia (25% risk)
- Preterm delivery
- Fetal growth restriction or demise
- Placental abruption
- Congestive heart failure
- Acute renal failure

- Seizures
- Stroke
- Death

Maternal fever equal to or greater than 100.4°.

Fever can indicate infection. Fever in labor is associated with:

- Early neonatal and infant death
- Hypoxia
- Infection-related death. These associations were stronger among term than preterm infants
- Meconium aspiration syndrome
- Hyaline membrane disease
- Neonatal seizures
- Assisted ventilation

Labor or premature rupture of membrane (PROM) less than 37 weeks according to due date.

Premature rupture of membranes before 37 weeks' gestation (and where there is at least an hour between membrane rupture and the onset of contractions and labor) can have consequences for both the mother and the baby.

Risks to baby:

- Neurologic injury
- Infection
- Respiratory Distress
- Death
- Increased need for neonatal intensive care services

Maternal risks:

- Infection
- Prolonged Labor
- C-Section
- Death

Because the out-of-hospital birth setting does not provide for immediate access to some medications, surgery, and consultation with a physician, there may be increased risks to mother and/or baby if any of these conditions present during the birth. In some communities, the lack of availability of a seamless, cooperative hospital transfer process adds additional risk during intrapartum transfer.

I understand that the intrapartum risks may not be apparent until labor, and my opportunity for referral to a physician, should I choose that, would be limited to hospital transfer and transfer of care to the physician on call at that facility.

I have received and read this document, discussed it with my midwife, and my midwife has answered my questions to my satisfaction.

Client _____ Date _____

Midwife _____ Date _____

Abnormal Fetal Cardiac Rate or Rhythm

Disclosure of risks related to abnormal fetal cardiac rate or rhythm

Fetal rhythm abnormalities (fetal heart rates that are irregular, too fast or too slow):

- occur in up to 2% of pregnancies
- are usually identified by the obstetrical clinician who detects an abnormal fetal heart rate or rhythm using a Doppler or stethoscope
- majority have isolated premature atrial contractions which may spontaneously resolve
- sustained tachyarrhythmia (rapid) or bradyarrhythmia (slow) may be of clinical significance
    - may indicate severe systemic disease
    - may have the potential to compromise the fetal circulation
    - May require intensive antepartum and/or neonatal care

As required by the regulations for practice as a licensed professional midwife in Virginia, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me.

I have decided to:

□ Consult with a physician regarding my risk factors.
□ Decline consultation with a physician regarding my risk factors.

Client _____ Date _____

Midwife _____ Date _____

Active Cancer

Maternal risks:

- maternal infection due to immune suppression
- deep vein thrombosis and pulmonary embolism during pregnancy and especially after delivery
- hemorrhage at delivery

Fetal risks:

- Intrauterine growth restriction
- Preterm birth
- Fetal health effects from exposure to maternal medications

As required by the regulations for practice as a licensed professional midwife in Virginia, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me.

I have decided to:

□ Consult with a physician regarding my risk factors.
□ Decline consultation with a physician regarding my risk factors.

Client _____ Date _____

Midwife _____ Date _____

Acute or Chronic Thrombophlebitis

Deep vein thrombosis (DVT) and pulmonary embolism (PE) are collectively known as venous thromboembolism (VTE). VTE occurs more frequently in pregnant women, with an incidence of 0.5 to 2.0 per 1000 pregnancies, four to five times higher than in the nonpregnant population. The risk for VTE is further elevated in the postpartum period.

Risk for VTE in pregnancy in increased in women with:

- Prior history of VTE
- Advanced maternal age
- Collagen-vascular disease, especially antiphospholipid antibody syndrome
- Obesity (BMI > 30)
- Multiparity
- Hypercoaguable state
- Nephrotic syndrome
- Operative delivery
- Prolonged bed rest
- Hematologic disorders (hemoglobin SS and SC disease, polycythemia, thrombotic thrombocytopenic purpura, paroxysmal nocturnal hemoglobinuria, and some dysfibrinogenemias)
- Maternal medical conditions (diabetes, heart disease, inflammatory bowel disease)
- Smoking
- Preeclampsia

Maternal complications:

- hypoxemia
- post-phlebitic syndrome
- pulmonary infarction
- death

As required by the regulations for practice as a licensed professional midwife in Virginia, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me.

I have decided to:

□ Consult with a physician regarding my risk factors.
□ Decline consultation with a physician regarding my risk factors.

Client _____ Date _____

Midwife _____ Date _____

Advanced Maternal Age

The "age cutoff" for advanced maternal age is not uniformly defined in literature. Generally, as birthing persons approach and pass age 40, the following risks may increase:

- Pregnancy loss, including beyond first trimester
- Fetal aneuploidy and other congenital fetal anomalies
- Health concerns which may contribute to obstetric complications such as preeclampsia, postpartum hemorrhage, and gestational diabetes
- Stillbirth
- Multiple gestation

As required by the regulations for practice as a licensed professional midwife in Virginia, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me.

I have decided to:

□ Consult with a physician regarding my risk factors.
□ Decline consultation with a physician regarding my risk factors.

Client _____ Date _____

Midwife _____ Date _____

Anemia (Hematocrit less than 30 or hemoglobin less than 10 at term)

The World Health Organization (WHO) estimates that worldwide, 42% of pregnant women are anemic. Current knowledge indicates that iron deficiency anemia in pregnancy is a risk factor for preterm delivery and subsequent low birth weight, and possibly for inferior neonatal health. Data are inadequate to determine the extent to which maternal anemia might contribute to maternal mortality. A woman who is already anemic is unable to tolerate blood loss that a healthy woman can.

Maternal risks related to severe or untreated anemia:

- need for blood transfusion(s), resulting from a hemorrhage (significant blood loss) during delivery
- postpartum depression
- difficulty breastfeeding

Fetal/Neonatal risks related to maternal severe or untreated anemia:

- prematurity
- low-birthweight
- anemia
- developmental delays
- difficulty breastfeeding

As required by the regulations for practice as a licensed professional midwife in Virginia, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me.

I have decided to:

□ Consult with a physician regarding my risk factors.
□ Decline consultation with a physician regarding my risk factors.

Client _____ Date _____

Midwife _____ Date _____

Any Pregnancy with Abnormal Fetal Surveillance Tests

There is no benefit in continuing a pregnancy at or post term after fetal surveillance is found to be non-reassuring. The recommendation is delivery. Abnormal stress tests at any point in pregnancy are associated with an increased risk of poor outcomes in pregnancy and during labor and delivery. Babies with diagnosed or undiagnosed anomalies are more likely to have abnormal test results requiring specialized care before or after delivery. Antepartum testing results, with regard to the overall clinical picture, should be taken seriously.

Risks to fetus:

- Stillbirth
- Asphyxia
- Fetal Acidosis
- Low Apgar scores
- Respiratory distress
- Surgical delivery
- Meconium Aspiration
- Death

As required by the regulations for practice as a licensed professional midwife in Virginia, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me.

I have decided to:

□ Consult with a physician regarding my risk factors.
□ Decline consultation with a physician regarding my risk factors.

Client _____ Date _____

Midwife _____ Date _____

Assisted Reproductive Technologies (ART/IVF)

Assisted reproductive technologies may lead to the following increased risks:

- Multifetal gestations
- Prematurity
- Small for gestational age and perinatal mortality
- Cesarean section
- Placental issues, such as previa and abruption
- Preeclampsia
- Birth defects

As required by the regulations for practice as a licensed professional midwife in Virginia, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me.

I have decided to:

□ Consult with a physician regarding my risk factors.
□ Decline consultation with a physician regarding my risk factors.

Client _____ Date _____

Midwife _____ Date _____

Blood Coagulation Defect

Hereditary thrombophilia, or predisposition to thrombosis, ranges from the common (Factor V Leiden heterozygosity, present in 1- 15% of pregnant women) to the rare (antithrombin deficiency occurring in 0.02%). The risk of deep vein thrombosis or pulmonary embolism (collectively known as venous thromboembolism or VTE) ranges from 0.1-7% of pregnancies. The maternal medical history determines the management during pregnancy, which can include anticoagulation with injections of heparin throughout the pregnancy and post-partum period.

The presence of one of these disorders may contribute to the risk of obstetric complications as well, including:

- IUGR
- preeclampsia
- stillbirth
- Frequent fetal surveillance is recommended in most cases, as well as timed delivery in the last week before the estimated date of delivery.

Alternatively, disorders of maternal hemostasis (such as von Willebrand disease) increase the risk of blood loss at delivery, and as hereditary disorders also increase the risk for abnormal bleeding in the newborn.

As required by the regulations for practice as a licensed professional midwife in Virginia, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me.

I have decided to:

□ Consult with a physician regarding my risk factors.
□ Decline consultation with a physician regarding my risk factors.

Client _____ Date _____

Midwife _____ Date _____

Body Mass Index (BMI) Equal to or Greater Than 30

Obesity is defined as having a BMI of 30 or higher. The number of obese women in the United States has increased greatly during the past 25 years. Obesity has also become a major health concern for pregnant women. More than one half of pregnant women are overweight or obese.

Risks of obesity include:

- Birth defects – Babies born to obese mothers have an increased risk of having birth defects, such as heart defects and neural tube defects.
- Macrosomia – In this condition, the baby is larger than normal. This can increase the risk of the baby being injured during birth. For example, the baby's shoulder can become entrapped after the head is delivered. Macrosomia also increases the risk of cesarean birth.
- Preterm Birth – Problems associated with a mother's obesity may mean that the baby will need to be delivered early. Preterm infants have an increased risk of health problems, including breathing problems, eating problems, and developmental and learning difficulties later in life.
- Stillbirth – The risk of stillbirth increases the higher the mother's BMI.
- High Blood Pressure
- Preeclampsia – Preeclampsia is a serious illness for both the woman and her baby. Although gestational hypertension is the most common sign of preeclampsia, this condition affects all organs of the body. The kidneys and liver may fail. In rare cases, stroke can occur. The fetus is at risk of growth problems and problems with the placenta. It may require early delivery, even if the baby is not fully grown. In severe cases, the woman, baby, or both may die.
- Gestational Diabetes – High blood glucose (sugar) levels during pregnancy increase the risk of having a very large baby and a cesarean delivery. Women who have had gestational diabetes have a higher risk of having diabetes in the future, as do their children.
- Challenges in Prenatal Care – Obesity can make it more difficult for the midwife to assess fetal position and fetal growth.
- Challenges in Labor Management – Obesity can create challenges in moving the woman quickly in the event of an emergency during the birth, and can make auscultation of fetal heart tones more difficult.

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Cardiac Disease

Most women tolerate the cardiovascular changes of pregnancy without difficulty. Pregnancy in a patient with significant cardiac disease is associated with significant risk. Despite occurring in only 0.2-4% of pregnancies, cardiac disease is associated with up to 30% of maternal deaths. A pregnant patient with cardiac disease will benefit from the coordinated care of a multidisciplinary team including perinatologists, cardiologists, and anesthesiologists. In particular, adults with repaired congenital heart disease may pose complex management scenarios. They may require specialized cardiac monitoring during labor and birth, and some cardiac conditions are associated with a high enough risk of labor complications that cesarean is recommended.

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Chronic Obstructive Pulmonary Disease or Other Pulmonary Disorders

Chronic Obstructive Pulmonary Disease (COPD) or other pulmonary disorders affect approximately 4% to 6% of adults of all ages and is one of the most common medical conditions complicating pregnancy.

Risks:

- Preterm birth
- Decreased birth weight
- Increased neonatal and maternal death

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Ectopic Pregnancy

Today, about 1 in 50 pregnancies is ectopic. An ectopic pregnancy occurs when a fertilized egg grows outside of the uterus most commonly in the tube. As the pregnancy grows, it can rupture (burst). If this occurs, it can cause major internal bleeding. This can be life threatening and needs to be treated. If there is evidence of ectopic pregnancy, medical and surgical interventions are available, and a referral should be made to an appropriate health provider. If there is a positive pregnancy test with follow-up ultrasound showing no intrauterine pregnancy, then referral should be made to an appropriate healthcare provider.

Risks:

- Fallopian tube damaged, leading to an increased likelihood of having another ectopic pregnancy in the future
- Ruptured ectopic pregnancy (when the fallopian tube splits) and severe internal bleeding, which can lead to shock
- Death

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Essential Chronic Hypertension

Elevated blood pressure, systolic >140 or diastolic >90 or both, that predates conception or is diagnosed before 20 weeks of gestation.

Maternal risks:

- Preterm delivery
- Difficulty breastfeeding
- Placental abruption
- Preeclampsia
- Eclampsia
- Seizures
- Maternal congestive heart failure
- Acute renal failure
- Stroke
- Death

Fetal/neonatal risks:

- Fetal growth restriction
- Fetal death
- Difficulty breastfeeding

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Genital Herpes or Partner with Genital Herpes

Because of its serious and potentially lethal risks to the fetus and neonate, pregnant women and their partners should be tested for HSV - Herpes Simplex Virus (HSV1 & HSV2).

In women with a previous diagnosis of genital herpes, cesarean delivery to prevent neonatal HSV infection is not indicated if there are NO genital lesions at the time of labor. To reduce cesarean deliveries performed for the indication of genital herpes, the use of oral acyclovir or valacyclovir near the end of pregnancy to suppress genital HSV recurrences has become increasingly common in obstetric practice. Several studies with small sample sizes suggest that suppressive acyclovir therapy during the last weeks of pregnancy decreases the occurrence of clinically apparent genital HSV disease at the time of delivery, with an associated decrease in cesarean delivery rates for the indication of genital HSV. However, because viral shedding still occurs (albeit with reduced frequency), the potential for neonatal infection is not avoided completely, and cases of neonatal HSV disease in newborn infants of women who were receiving antiviral suppression recently have been reported.

Genital HSV, especially in primary infections, may be dangerous to the neonate if infected during delivery, as it can cause a severe neonatal disease.

The frequency of neonatal infection ranged from 31% to 44% for primary first-episode, and 1 to 3% in recurrent.

Risks of HSV infection to the fetus include:

- intrauterine fetal demise (the death of the fetus while in the uterus)
- skin scars (cutaneous manifestations)
- ophthalmologic findings (chorioretinitis, microphtalmia)
- neurological involvement (causing brain damage)

The clinical presentation of infants with neonatal HSV infection, that is almost invariably symptomatic and frequently lethal, is a direct reflection of the site and extent of viral replication.

Risks of HSV infection to the newborn include:

- death
- neurologic (brain) damage (intracranial calcifications, microcephaly, seizures, encephalomacia)
- growth restriction
- psychomotor development impairment
- skin vesicles or scarring
- eye lesions resulting in vision loss and/or blindness (chorioretinitis, microphthalmia, cataracts)
- hearing loss and/or deafness

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Group B Strep (GBS)

The following risks are related to group B strep.

Maternal risks:

- Minimal to none

Fetal/infant risk:

- Increased in context of chorioamnionitis, GBS bacteriuria in current pregnancy, labor or birth at less than 37 weeks gestation, previous delivery with early onset of GBS sepsis, prolonged interval (18 hours or more) between rupture of membranes and delivery.
- Sepsis
- Pneumonia
- Meningitis
- Death

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History of Hemoglobinopathies

Hemoglobinopathies include sickle cell disease and its variants as well as alpha and beta thalassemia. The involvement of a multidisciplinary team including perinatologists, hematologists and anesthesiologists can allow for development of a plan to screen for and manage complications.

Maternal risks:

- cerebral vein or deep vein thrombosis
- anemia and vaso-occlusive crisis
- pneumonia
- pyelonephritis
- transfusion
- pregnancy induced hypertension
- postpartum infection, sepsis, and systemic inflammatory response syndrome
- cesarean delivery

Fetal risks:

- preterm birth and its consequences including low birth weight
- intrauterine growth restriction
- abruption placentae
- stillbirth
- genetic risk assessment is also recommended for individuals identified as carriers for hemoglobinopathy, as they may be at risk to have affected offspring.

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HIV Positive Status or AIDS

HIV transmission from mother to child during pregnancy, labor and delivery, or breastfeeding is known as perinatal transmission and is the most common route of HIV infection in children. When HIV is diagnosed before or during pregnancy, perinatal transmission can be reduced to less than 1% if appropriate medical treatment is given and the virus becomes undetectable. In such situations the risk of transmitting to the baby through breastfeeding is decreased.

Recommended medical treatment includes antiretroviral medication taken throughout pregnancy and during labor, regular monitoring of the maternal viral load, cesarean delivery for viral load > 1000 copies/mL, and initiation of antiretroviral medication for the newborn shortly after birth.

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Inappropriate Fetal Size for Gestation – Macrosomia (Large for Gestational Age)

Macrosomia (meaning big body), is arbitrarily defined as a birth weight of more than 4,000 g (8 lb, 13 oz). Also known as "large for gestational age," fetal macrosomia complicates more than 10 percent of all pregnancies in the United States.

Risks to the mother:

- increased risk of uterine rupture after previous cesarean section or other uterine surgery;
- increased likelihood of induction at or before 40 weeks;
- increased likelihood of an operative delivery: forceps, vacuum, or cesarean section;
- trauma to vagina and/or perineum; including perineal and/or vulvar lacerations, 3rd or 4th degree episiotomy, short or long-term urinary or fecal incontinence;
- increased blood loss and/or postpartum hemorrhage,
- damage to the coccyx (tailbone)

Risks to the baby at the time of birth:

- shoulder dystocia (the baby gets stuck at the shoulders after the delivery of the head), which may result in trauma to the baby including:
    - broken clavicle (collar) bone(s);
    - brachial plexus injury, temporary or permanent nerve damage (sensory and motor) to either one or both shoulders, arms, and hands;
    - cerebral palsy;
    - hypoxia, resulting in permanent brain damage;
    - death.
- injuries related to operative delivery (forceps, vacuum, or cesarean section) including:
    - bruising and/or injury to the scalp, head and/or face;
    - temporary weakness in the facial muscles (facial palsy);
    - external eye and/or ear trauma;
    - broken clavicle (collar) bone(s);
    - brachial plexus injury (see description above);
    - cerebral palsy;
    - skull fracture;
    - bleeding within the skull;
    - seizures; lacerations (during cesarean section) to the baby's presenting part
- immature lungs and breathing problems, if the due date has been miscalculated and the infant is delivered before 39 weeks of gestation;
- need for special care in the neonatal intensive care unit (NICU)

Risks to the newborn and later childhood risks:

- higher than normal blood sugar level (impaired glucose tolerance);
- childhood obesity (research suggests that the risk of childhood obesity increases as birth weight increases);

- metabolic syndrome (a group of conditions: increased blood pressure, a high blood sugar level, excess body fat, abnormal cholesterol levels; that occur together, increasing the risk of heart disease, stroke and diabetes later in life

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Inappropriate Fetal Size for Gestation – IUGR (Small for Gestational Age)

IUGR (Intrauterine Growth Restriction) is a serious problem, regardless of why the baby is small. About 20% of stillborn babies are IUGR, and perinatal mortality for growth-restricted infants may be 6 to 10 times higher than for those of normal size. Most IUGR stillbirths occur after the 36th week of pregnancy and before labor begins.

Risks to the baby:

- low birth weight (LBW);
- difficulty handling the stresses of vaginal delivery;
- decreased oxygen levels (hypoxia);
- hypoglycemia (low blood sugar);
- low resistance to infection;
- low APGAR scores (a test given immediately after birth to evaluate the newborn's physical condition and determine need for special medical care);
- meconium aspiration (inhalation of stools passed while in the uterus), which can lead to breathing problems, lung surfactant dysfunction, chemical pneumonitis, and persistent pulmonary hypertension;
- trouble maintaining body temperature (hypothermia);
- abnormally high red blood cell count;
- admission to NICU;
- long-term growth problems;
- intrauterine fetal demise (fetal death prior to labor);
- stillbirth (fetal death during labor or birth).

Risks to the mother:

- increased stress related to fetal monitoring and surveillance (serial ultrasounds and non-stress testing);
- premature labor;
- premature birth (delivery of the fetus before 37 weeks gestation);
- induction and early delivery, before 40 weeks;
- cesarean section.

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Incomplete Spontaneous Abortion or Incomplete Miscarriage

Spontaneous abortion also known as early pregnancy loss refers to a miscarriage that happens before 20 weeks of gestation and is seen in 13% to 20% of all diagnosed pregnancies. Incomplete spontaneous abortion occurs when some tissue is retained in the uterus. Medication or a procedure may be needed to remove the tissue.

Stillbirth or intrauterine fetal demise (IUFD):

Fetal death that happens after 20 weeks of gestational age is called stillbirth and has a rate of 3.2 per 1000 births. Medical intervention is needed for delivery.

Maternal fetal risks of early or late fetal loss:

- Infection
- Hemorrhage
- Maternal coagulopathy
- Gestational trophoblastic disease
- Rh isoimmunization

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Isoimmunization to Blood Factors

Pregnant women with a negative Rh blood type (O-, A-, B-, AB-) or with other atypical antibodies have significant fetal and neonatal risk factors. Clinical manifestations of RhD haemolytic disease (HDN) range from asymptomatic mild anemia to hydrops fetalis or stillbirth associated with severe anemia and jaundice.

Use of anti-D immune globulin for prevention of D has decreased the risk of isoimmunization. Routine treatment includes prophylactic dosage at 28 weeks of gestation, after delivery of a D-positive newborn and at any significant bleeding. Testing for Rh typing should be performed with every pregnancy because revisions in lab procedures may present as a change in the Rh blood type.

Risks to the baby:

- destruction of fetal red blood cells (hemolysis);
    - mild to moderate hemolysis manifests as increased indirect bilirubin (red cell pigment)
    - severe hemolysis leads to red blood cell production by the spleen and liver
- severe anemia;
- hepatic circulatory obstruction (portal hypertension);
- placental edema, interfering with placental perfusion;
- ascites (accumulation of fluid in the abdominal cavity);
- hepatomegaly (swelling of the liver);
- increased placental thickness;
- polyhydramnios (increased amniotic fluid);
- hydrops (fetal heart failure);
- anasarca (extreme generalized edema);
- effusions (abnormal accumulation of fluid);
- intrauterine fetal demise (fetal death);
- stillbirth

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Multiple Gestation

Maternal risks:

- Anemia
- Hemorrhage
- Preeclampsia
- Gestational diabetes
- Cesarean delivery

Fetal risks:

- Twin-to-twin transfusion syndrome (TTTS) in monochorionic twins
- Vanishing twin/death of one fetus
- Congenital anomalies
- Hydramnios
- Preterm birth
- Malpresentation
- Small for gestational age
- Umbilical cord prolapse
- Neonatal intensive care unit admission

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Persistent Severe Abnormal Quantity of Amniotic Fluid (Oligohydramnios and Polyhydramnios)

Oligohydramnios (decreased amniotic fluid) may be caused by fetal anomalies (bladder outlet obstruction, renal agenesis), premature rupture of the membranes, or placental insufficiency occurring de novo or as a consequence of maternal conditions such as hypertension.

Maternal risks:

- Antepartum hospitalization
- Induction of labor
- Cesarean delivery

Fetal risks:

- Pulmonary hypoplasia (underdevelopment of the lungs)
- Limb contractures
- Abnormal fetal heart rate patterns
- Acidosis
- Neonatal intensive care unit admission
- Need for surgical intervention if anomalies present
- Stillbirth or neonatal death

Polyhydramnios (increased amniotic fluid) is most commonly idiopathic (no identifiable cause) but may be seen in maternal diabetes (especially uncontrolled or with large for gestational age fetus) and with fetal anomalies (diaphragmatic hernia, intestinal obstruction).

Maternal risks:

- Cesarean delivery
- Post-partum hemorrhage

Fetal risks:

- malpresentation
- neonatal intensive care unit admission
- need for surgical intervention if anomalies present
- neonatal hypoglycemia
- stillbirth and neonatal death

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Platelet Count Less than 120,000

Platelet disorders in pregnancy include those that are time-limited to pregnancy (gestational thrombocytopenia, HELLP syndrome) and those that may pre-date or be newly diagnosed during the pregnancy (idiopathic thrombocytopenic purpura (ITP), thrombotic thrombocytopenic purpura (TTP)). Except for gestational thrombocytopenia, all of these platelet disorders place the mother at increased risk for blood loss and need for transfusion.

Gestational thrombocytopenia: occurs in 7-8% of pregnancies and accounts for 70-80% of cases of thrombocytopenia in pregnancy, typically diagnosed in the third trimester, rarely associated with platelet counts below 70,000, not associated with increased risks of bleeding in the mother or fetus, platelet counts return to normal after delivery.

It is important to differentiate gestational thrombocytopenia from more serious platelet disorders.

ITP: chronic disorder associated with:

- Fluctuating platelet counts that may be lower than 50,000
- Need for steroid or immune globulin treatment and platelet transfusion to avoid excess blood loss at delivery, particularly surgical delivery.

TTP: acute or chronic disorder generally associated with:

- severe thrombocytopenia of 20,000 or less
- hepatic impairment
- renal impairment
- CNS impairment
- increased risk of death for both mother and fetus

HELLP syndrome: an acute condition occurring in up to 2% of pregnancies, usually seen in the setting of preeclampsia, and characterized by:

- thrombocytopenia
- elevated liver enzymes
- hemolytic anemia
- potential for severe maternal illness including:
    - liver failure
    - hepatic subcapsular hematoma
    - excess maternal blood loss
    - seizure
    - maternal death
    - preterm birth
    - intrauterine growth restriction
    - fetal death

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Position Presentation Other Than Cephalic at Term or While in Labor

Non-cephalic presentations occur in less than 4% of all pregnancies. This would include breech, transverse lie, and compound presentations. Non-cephalic presentations are associated with congenital abnormalities of the baby, multiple pregnancies, placenta previa, and uterine abnormalities. These associations may increase risk to the mother/baby in addition to the actual risks associated with non-cephalic delivery.

C-section has become the standard mode of delivery for babies in non-cephalic positions. Physicians and midwives may not have adequate training in the vaginal delivery of non-cephalic presentations further increasing the risk of injury or death to both mother and baby. A transverse presentation is considered incompatible with vaginal delivery. Posterior, Brow, and Face presentations are associated with complicated delivery and increased maternal and/or fetal complications and may require C-section if the fetal malpresentation does not resolve.

Risks to babies:

- Low APGAR scores
- Ruptured organs (kidney, liver)
- Neck Trauma
- Genital edema
- Prematurity
- Cord Prolapse
- Respiratory distress
- Stillbirth
- Head entrapment
- Edema to face and skull
- Tracheal damage
- Increased NICU admission rates
- Shoulder/arm trauma
- Hip and leg trauma
- Intracranial hemorrhage
- Death

Maternal risks:

- C-section
- Prolonged/Dysfunctional labor
- Placenta abruption
- Increased risk of deep lacerations

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Preeclampsia/Eclampsia

Preeclampsia is a leading cause of death in pregnant women and occurs in 5% of all pregnancies. The management of preeclampsia may require medication and monitoring unavailable in an out of hospital setting.

Maternal risks:

- Hypertension leading to brain injury
- Liver Failure
- Kidney Failure
- HELLP Syndrome: an acute condition occurring in up to 2% of pregnancies, usually seen in the setting of preeclampsia and characterized by:
    - Thrombocytopenia
    - elevated liver enzymes
    - hemolytic anemia
    - potential for severe maternal illness including: liver failure, hepatic supscapular hematoma, excess maternal blood loss, seizure, maternal death, preterm birth, intrauterine growth restriction, fetal death.
- Clotting problems (DIC)
- Pulmonary edema
- Seizure (Eclampsia)
- Stroke
- Placental Abruption
- C-section
- Death

Fetal risks:

- Small for gestational age (IUGR)
- Premature birth
- Stillbirth

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Midwife _____ Date _____

Guidance Document: 85-10

Revised: August 4, 2023
Effective Date: TBD

Pregnancy Lasting Longer Than 42 Completed Weeks with an Abnormal Stress Test

Pregnancy is considered to be post term at 42 weeks of gestation. There is limited research available to outline the risks of a pregnancy continuing beyond 42 weeks with an abnormal stress test. Current medical standard of practice is that beginning at 41 weeks, a non-stress test (NST) be combined with other indicators of fetal well-being, i.e., amniotic fluid index (AFI) or biophysical profile (BPP). There is no benefit in continuing a pregnancy at or post term after fetal surveillance is found to be non-reassuring. The recommendation is delivery.

Maternal risks:

- Oligohydramnios
- Medical induction
- C-section
- Prolonged labor
- Complicated delivery such as: Shoulder dystocia

Fetal risks:

- Large size leading to risks associated with macrosomia
- uteroplacental insufficiency
- Asphyxia
- Infection
- Neonatal acidemia
- Low Apgar
- Birth Injury
- Stillbirth
- Postmaturity/Dysmaturity syndrome
- Fetal distress
- Meconium Aspirtation
- Death

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VBAC (Vaginal Birth after Cesarean) Previous Uterine Incision or Myomectomy

Because the uterine scar for most caesarian sections is low on the uterus, women who undergo TOLAC (trial of labor after cesarean), are able to give birth vaginally 60–80% of the time. If problems arise during TOLAC, the baby may need to be born by emergency cesarean delivery (uterine rupture can be sudden and unexpected labor outside of a hospital can delay delivery and increase the risk of injury and death for both mother and baby in an emergency). Some surgery for fibroids can result in a similar risk for uterine rupture. An unknown type of prior uterine scar is a contraindication for TOLAC outside of the hospital setting so review of prior surgical records is essential part of the evaluation.

Maternal risks:

- Maternal hemorrhage
- Infection
- Thromboembolism
- Placenta accreta
- Death
- Emergency hysterectomy

Fetal risks:

- Hypoxic Ischemic Encephalopathy
- Stillbirth
- Perinatal death
- Neonatal death
- Respiratory morbidity
- Transient tachypnea
- Hyperbillirubinemia

The probability that a woman attempting TOLAC will achieve VBAC depends on her individual combination of factors.

Selected Clinical Factors Associated with Trial of Labor after Previous Cesarean Delivery Success:

Increased probability of success

- Prior vaginal birth
- Spontaneous labor

Decreased probability of success

- Recurrent indication for initial cesarean delivery (labor dystocia)
- Increased maternal age
- Maternal obesity
- Preeclampsia

- Short interpregnancy interval
- Increased neonatal birth weight

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Midwife _____ Date _____

Mental Health Issues

Clients with clinically-diagnosed and self-reported mental health issues such as:

- Depression
- Panic/anxiety
- Obsessive-compulsive traits
- Schizophrenia

should be counseled about the stresses of pregnancy and the postpartum period. Clients who are taking psychiatric medication should be made aware that some potential for birth defects may exist and are advised to discuss the risks and benefits of continuing their drugs during pregnancy with their provider.

Risks associated with pregnancy and psychiatric disorders include:

- Poor maternal health
- Poor outcomes for babies including poor fetal growth and development
- Maternal psychiatric medication side effects
- Increased potential for some birth defects

Clients who are taking psychiatric medication are advised to discuss the risks and benefits of continuing their drugs during pregnancy with their mental health provider.

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Rupture of Membranes 24 Hours Before the Onset of Labor

The risk of prolonged rupture of membranes is chorioamnionitis. The risk increases with the delay between rupture of membranes and delivery.

Maternal complications:

- cesarean delivery
- endomyometritis
- wound infection
- pelvic abscess
- postpartum hemorrhage
- bacteremia, most commonly involving GBS
- Rarely:
    - septic shock
    - disseminated intravascular coagulation
    - adult respiratory distress syndrome
    - maternal death

Fetal complications:

- fetal death
- neonatal sepsis

Neonatal complications:

- perinatal death
- asphyxia
- early onset neonatal sepsis
- septic shock
- pneumonia
- intraventricular hemorrhage
- cerebral palsy

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- □ Consult with a physician regarding my risk factors.
- □ Decline consultation with a physician regarding my risk factors.

Client _____ Date _____

Midwife _____ Date _____

Guidance Document: 85-10

Revised: August 4, 2023
Effective Date: TBD

Seizure Disorder Requiring Prescriptive Medication

Most pregnancies are uneventful in women with epilepsy, and most babies are delivered healthy with no increased risk of obstetric complications in women. When controlled, there does not appear to be an increased risk for intrauterine growth restriction, preeclampsia, preterm birth or stillbirth compared to women without seizure disorder.

Fetal risks:

- With uncontrolled seizures:
  - Intrauterine growth restriction (IUGR)
  - Preterm birth
  - Stillbirth
- Some medications are associated with an increased risk of birth defects

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As required by the regulations for practice as a licensed professional midwife in Virginia, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me.

I have decided to:

□ Consult with a physician regarding my risk factors.
□ Decline consultation with a physician regarding my risk factors.

Client _____ Date _____

Midwife _____ Date _____

Severe Liver Disease – Active or Chronic

Liver disease occurs in approximately 3% of pregnancies. It may be chronic or occurring coincident with pregnancy, such as viral hepatitis or drug-induced hepatotoxicity, or pregnancy specific such as HELLP syndrome, intrahepatic cholestasis of pregnancy or acute fatty liver of pregnancy.

Severe liver disease:

- Is usually acute in onset
- Can be life-threatening to the mother
- Associated with a high risk of stillbirth
- If hypertension has preceded the onset of HELLP syndrome, fetal growth restriction may also be present.

As required by the regulations for practice as a licensed professional midwife in Virginia, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me.

I have decided to:

□ Consult with a physician regarding my risk factors.
□ Decline consultation with a physician regarding my risk factors.

Client _____ Date _____

Midwife _____ Date _____

Severe Renal Disease – Active or Chronic

Renal disease is associated with increased risks of both maternal and fetal adverse outcomes. These risks, which rise with the severity of preexisting renal disease, include:

Maternal risks:

- Hypertension
- Placental abruption
- Deterioration of renal function including permanent, end-stage renal failure

Fetal risks:

- Intrauterine growth restriction (IUGR)
- Placental abruption
- Stillbirth

As required by the regulations for practice as a licensed professional midwife in Virginia, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me.

I have decided to:

□ Consult with a physician regarding my risk factors.
□ Decline consultation with a physician regarding my risk factors.

Client _____ Date _____

Midwife _____ Date _____

Guidance Document: 85-10

Revised: August 4, 2023
Effective Date: TBD

Significant 2nd or 3rd Trimester Bleeding

Significant 2nd or 3rd trimester bleeding is often associated with potentially serious conditions, including placenta previa, placental abruption, and vasa previa.

Medical management and ultrasound is indicated to rule out and/or monitor potentially serious conditions associated with significant bleeding.

Maternal risk factors:

- Cesarean section
- Hemorrhage
- Anemia
- Hypovolemic shock
- Death
- Coagulation defects (DIC)
- Damage to kidneys and brain

Fetal risk factors:

- Poor fetal growth (IUGR)
- Birth defects
- Premature birth
- Anemia
- Hypovolemic shock
- Stillbirth

As required by the regulations for practice as a licensed professional midwife in Virginia, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me.

I have decided to:

□ Consult with a physician regarding my risk factors.
□ Decline consultation with a physician regarding my risk factors.

Client _____ Date _____

Midwife _____ Date _____

Significant Glucose Intolerance (Preexisting Diabetes, Gestational Diabetes, PCOS)

Pre-gestational diabetes mellitus (Type 1 or Type 2) affects approximately 1% of pregnancies, with an incidence rising with the incidence of type 2 diabetes in younger adults. Gestational diabetes is diagnosed in 5-7% of pregnancies.

Risk factors for GDM: occurs more commonly in women with a family history of diabetes, prior personal history of glucose intolerance including prior gestational diabetes, obesity, and maternal age over 25.

Maternal risks:

- Hypertension
- Antepartum hospitalization
- Induction of labor
- Cesarean delivery
- Uncontrolled diabetes may result in:
    - kidney damage
    - retinopathy resulting in vision loss
    - peripheral nerve damage.

Fetal risks:

- Even when controlled, pre-gestational diabetes is associated with an increased risk of miscarriage and major congenital anomalies. This risk rises with poorer control around the time of conception.
- Throughout pregnancy, diabetes is associated with increased risks of:
    - hypertensive disorders
    - large for gestational age babies
    - stillbirth
    - abnormal progression of labor
    - cesarean delivery
    - shoulder dystocia with resultant brachial plexus injury

- Due to these risks, more frequent ultrasound examinations and antepartum testing of fetal well-being may be indicated in the newborn period:
    - hypoglycemia
    - hyperbilirubinemia
    - polycythemia

Timing of delivery:

- Pre-gestational diabetes, and uncontrolled gestational diabetes: between 37 and 39 weeks, individualized
- Controlled gestational diabetes: between 39 and 41 weeks, individualized

As required by the regulations for practice as a licensed professional midwife in Virginia, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me.

I have decided to:

- □ Consult with a physician regarding my risk factors.
- □ Decline consultation with a physician regarding my risk factors.

Client _____ Date _____

Midwife _____ Date _____

Uncontrolled Hyperthyroidism

Hyperthyroidism occurs in 0.2% of pregnancies; Graves' disease accounts for 95% of these cases. The signs and symptoms of hyperthyroidism include nervousness, tremors, tachycardia, frequent stools, excessive sweating, heat intolerance, weight loss, goiter, insomnia, palpitations, and hypertension.

Risks

- Premature delivery
- Severe preeclampsia
- Heart failure
- Maternal death
- Low birth weight
- Fetal death
- Abnormal thyroid function in the newborn

Thyroid storm is a medical emergency and occurs in 1% of pregnant patients with hyperthyroidism and can be triggered by infection, labor, or delivery.

Risks

- Shock
- Stupor
- Coma

As required by the regulations for practice as a licensed professional midwife in Virginia, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me.

I have decided to:

□ Consult with a physician regarding my risk factors.
□ Decline consultation with a physician regarding my risk factors.

Client _____ Date _____

Midwife _____ Date _____

Guidance Document: 85-10

Revised: August 4, 2023
Effective Date: TBD

Uterine Ablation (Endometrial Ablation)

Endometrial ablation is a procedure accompanied by sterilization or the strong recommendation for continuous contraception. Pregnancy after ablation is rare and therefore there is little research, and the maternal and fetal complications are poorly defined. The general recommendation is that pregnancy is contra-indicated once endometrial ablation has been performed.

Maternal risks:

- Miscarriage
- Ectopic pregnancy
- Placenta accreta
- Manual/Surgical removal of placenta
- Hemorrhage
- Uterine rupture
- C-section
- Hysterectomy
- Death

Fetal risks:

- Prematurity
- Death
- Possible increase in anomalies
- Malpresentation

As required by the regulations for practice as a licensed professional midwife in Virginia, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me.

I have decided to:

□ Consult with a physician regarding my risk factors.
□ Decline consultation with a physician regarding my risk factors.

Client _____ Date _____

Midwife _____ Date _____

Uterine Anomaly

Women with a uterine anomaly (uterine septum, unicornuate uterus, bicornuate uterus, uterine didelphys) are at risk for:

- PTB (preterm birth)
- Fetal presentation other than cephalic
- Hemorrhage
- Retained placenta
- Maternal urinary tract malformation
- Miscarriage
- Restricted fetal growth
- Cesarean delivery
- Pregnancy-associated hypertension

As required by the regulations for practice as a licensed professional midwife in Virginia, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me.

I have decided to:

□ Consult with a physician regarding my risk factors.
□ Decline consultation with a physician regarding my risk factors.

Client _____ Date _____

Midwife _____ Date _____

Agenda Item: Adoption of formulary and best practice/standards of care protocol

Staff Note: Information regarding the formulary and best practice/standards of care protocol recommended by the ad hoc committee convened to address this issue will be provided as a handout.

Action needed:

- Motion to adopt formulary and best practice/standards of care protocol.

Agenda Item: Adoption of final regulations for licensure of Licensed Certified Midwives

Included in your agenda package:

- Proposed regulations governing licensure of LCMs approved by the Boards of Medicine and Nursing;

- Chapter 200 of the 2021 Special Session I, which required that the Boards of Nursing and Medicine promulgate regulations for licensure of a new category of practitioner, licensed certified midwives.

Staff notes: The public comment period for this stage ended on July 21, 2023. A handout of public comment received on Town Hall will be included as a handout at your place.

Following action at this meeting, the Board of Nursing will vote on final regulations at its September 2023 meeting.

Action needed:

- Motion to adopt final regulations regarding licensure of licensed certified midwives.

Project 7056 - Proposed

Board of Nursing

New regulations for licensed certified midwives

Chapter 70

Regulations Governing the Practice of Licensed Certified Midwives

Part I

General Provisions

18VAC90-70-10. 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.

"Approved program" means a midwifery education program that is accredited by the Accreditation Commission for Midwifery Education or its successor.

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

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

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

"Licensed certified midwife" means an advanced practice midwife who is jointly licensed by the Boards of Nursing and Medicine pursuant to § 54.1-2957.04 of the Code of Virginia.

"MME" means morphine milligram equivalent.

"Practice agreement" means a written or electronic statement, jointly developed by the consulting licensed physician and the licensed certified midwife, that describes the availability of the physician for routine and urgent consultation on patient care.

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

18VAC90-70-20. Delegation of authority.

A. The boards hereby delegate to the Executive Director of the Virginia Board of Nursing the authority to issue the initial licensure and the biennial renewal of such licensure to those persons who meet the requirements set forth in this chapter and to grant extensions or exemptions for compliance with continuing competency requirements as set forth in 18VAC90-70-90 E and F. Questions of eligibility shall be referred to the Committee of the Joint Boards of Nursing and Medicine.

B. All records and files related to the licensure of licensed certified midwives shall be maintained in the office of the Virginia Board of Nursing.

18VAC90-70-30. Committee of the Joint Boards of Nursing and Medicine.

A. The Committee of the Joint Boards of Nursing and Medicine, appointed pursuant to 18VAC90-30-30 and consisting of three members appointed from the Board of Medicine and three members appointed from the Board of Nursing, shall administer this chapter.

B. In accordance with 18VAC90-30-30, the committee may, in its discretion, appoint an advisory committee. The advisory committee shall include practitioners specified in 18VAC90-30-30.

18VAC90-70-40. Fees.

Fees required in connection with the licensure of certified midwives are:

1. Application	$125
2. Biennial licensure renewal	$80
3. Late renewal	$25
4. Reinstatement of licensure	$150
5. Verification of licensure to another jurisdiction	$35
6. Duplicate license	$15
7. Duplicate wall certificate	$25
8. Handling fee for returned check or dishonored credit card or debit card	$50
9. Reinstatement of suspended or revoked license	$200

Part II

Licensure

18VAC90-70-50. Licensure generally.

A. No person shall perform services as a certified midwife in the Commonwealth of Virginia except as prescribed in this chapter and when licensed by the Boards of Nursing and Medicine.

B. The boards shall license applicants who meet the qualifications for licensure as set forth in 18VAC90-70-60 or 18VAC90-70-70.

18VAC90-70-60. Qualifications for initial licensure.

An applicant for initial licensure as a licensed certified midwife shall:

1. Submit evidence of a graduate degree in midwifery from an approved program;

2. Submit evidence of current certification as a certified midwife by the American Midwifery Certification Board;

3. File the required application; and

4. Pay the application fee prescribed in 18VAC90-70-40.

18VAC90-70-70. Qualifications for licensure by endorsement.

An applicant for licensure by endorsement as a licensed certified midwife shall:

1. Provide verification of a license as a certified midwife in another United States jurisdiction with a license in good standing or, if lapsed, eligible for reinstatement;

2. Submit evidence of current certification as a certified midwife by the American Midwifery Certification Board;

3. File the required application; and

4. Pay the application fee prescribed in 18VAC90-70-40.

18VAC90-70-80. Renewal of licensure.

A. Licensure of a licensed certified midwife shall be renewed biennially.

B. The renewal notice of the license shall be sent to the last known address of record of each licensed certified midwife. Failure to receive the renewal notice shall not relieve the licensee of the responsibility for renewing the license by the expiration date.

C. The licensed certified midwife shall attest to current certification as a certified midwife by the American Midwifery Certification Board and submit the license renewal fee prescribed in 18VAC90-70-40.

D. The license shall automatically lapse if the licensee fails to renew by the expiration date. Any person practicing as a certified midwife during the time a license has lapsed shall be subject to disciplinary actions by the boards.

18VAC90-70-90. Continuing competency requirements.

A. In order to renew a license biennially, a licensed certified midwife shall hold a current certification as a certified midwife by the American Midwifery Certification Board.

B. A licensed certified midwife shall obtain a total of eight hours of continuing education in pharmacology or pharmacotherapeutics for each biennium.

C. The licensed certified midwife shall retain evidence of compliance with this section 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 at least 1.0% of their licensed certified midwives to determine compliance. The licensed certified midwives 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 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 submitted prior to the renewal date.

F. The boards may delegate to the committee the authority to grant an exemption for all or part of the continuing education requirements in subsection B of this section for circumstances

beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters.

18VAC90-70-100. Reinstatement of license.

A. A licensed certified midwife whose license has lapsed may be reinstated within one renewal period by payment of the current renewal fee and the late renewal fee.

B. An applicant for reinstatement of license lapsed for more than one renewal period shall:

1. File the required application and reinstatement fee; and

2. Provide evidence of current professional competency consisting of:

a. Current certification by the American Midwifery Certification Board;

b. Continuing education hours completed during the period in which the license was lapsed, equal to the number required for licensure renewal during that period, not to exceed 120 hours; or

c. If applicable, a current, unrestricted license as a certified midwife in another jurisdiction.

C. An applicant for reinstatement of a license following suspension or revocation shall:

1. Petition for reinstatement and pay the reinstatement fee; and

2. Present evidence that he is competent to resume practice as a licensed certified midwife in Virginia, to include:

a. Current certification by the American Midwifery Certification Board; and

b. Continuing education hours taken during the period in which the license was suspended or revoked, equal to the number required for licensure during that period, not to exceed 120 hours.

The committee shall act on the petition pursuant to the Administrative Process Act (§ 2.2-4000, et seq. of the Code of Virginia).

Part III

Practice of Licensed Certified Midwives

18VAC90-70-110. Practice of licensed certified midwives.

A. All licensed certified midwives shall practice in accordance with a written or electronic practice agreement as defined in 18VAC90-70-10.

B. The written or electronic practice agreement shall include provisions for the availability of the physician for routine and urgent consultation on patient care.

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

D. The practice of licensed certified midwives shall be consistent with the standards of care for the profession.

E. The licensed certified midwife shall include on each prescription issued or dispensed the licensed certified midwife's signature and Drug Enforcement Administration (DEA) number, when applicable.

F. The licensed certified midwife shall disclose to patients at the initial encounter that the licensed certified midwife is a licensed certified midwife. Such disclosure may be included on a prescription or may be given in writing to the patient.

G. 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 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.

H. The licensed certified midwife shall disclose, upon request of a patient or a patient's legal representative, the name of the consulting physician, and information regarding how to contact the consulting physician.

Part IV

Prescribing

18VAC90-70-120. Prescribing for self or family.

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

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

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

18VAC90-70-130. Waiver for electronic prescribing.

A. 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, unless the prescription qualifies for an exemption as set forth in § 54.1-3408.02 C.

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.

Part V

Management of Acute Pain

18VAC90-70-140. Evaluation of the patient for acute pain.

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

1. The treatment of acute pain related to (i) cancer, (ii) sickle cell, (iii) a patient in hospice care, or (iv) a patient in palliative care;

2. The treatment of acute pain during an inpatient hospital admission or in a nursing home or an assisted living facility that uses a sole source pharmacy; or

3. A patient enrolled in a clinical trial as authorized by state or federal law.

B. Nonpharmacologic and non-opioid treatment for pain shall be given consideration prior to treatment with opioids. If an opioid is considered necessary for the treatment of acute pain, the practitioner shall give a short-acting opioid in the lowest effective dose for the fewest possible days.

C. Prior to initiating treatment with a controlled substance containing an opioid for a complaint of acute pain, the prescriber shall perform a history and physical examination appropriate to the

complaint, query the Prescription Monitoring Program as set forth in § 54.1-2522.1 of the Code of Virginia, and conduct an assessment of the patient's history and risk of substance misuse as a part of the initial evaluation.

18VAC90-70-150. Treatment of acute pain with opioids.

A. Initiation of opioid treatment for patients with acute pain shall be with short-acting opioids.

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

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

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

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

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

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

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

D. Buprenorphine is not indicated for acute pain in the outpatient setting, except when a prescriber who has obtained a U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) waiver is treating pain in a patient whose primary diagnosis is the disease of addiction.

18VAC90-70-160. Medical records for acute pain.

The medical record shall include a description of the pain, a presumptive diagnosis for the origin of the pain, an examination appropriate to the complaint, a treatment plan, and the medication prescribed or administered to include the date, type, dosage, and quantity prescribed or administered.

Part VI

Management of Chronic Pain

18VAC90-70-170. Evaluation of the chronic pain patient.

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

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

2. The treatment of chronic pain during an inpatient hospital admission or in a nursing home or an assisted living facility that uses a sole source pharmacy; or

3. A patient enrolled in a clinical trial as authorized by state or federal law.

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

1. The nature and intensity of the pain;

2. Current and past treatments for pain;

3. Underlying or coexisting diseases or conditions;

4. The effect of the pain on physical and psychological function, quality of life, and activities of daily living;

5. Psychiatric, addiction, and substance misuse histories of the patient and any family history of addiction or substance misuse;

6. A urine drug screen or serum medication level;

7. A query of the Prescription Monitoring Program as set forth in § 54.1-2522.1 of the Code of Virginia;

8. An assessment of the patient's history and risk of substance misuse; and

9. A request for prior applicable records.

C. Prior to initiating opioid analgesia for chronic pain, the practitioner shall discuss with the patient the known risks and benefits of opioid therapy and the responsibilities of the patient during treatment to include securely storing the drug and properly disposing of any unwanted or unused drugs. The practitioner shall also discuss with the patient an exit strategy for the discontinuation of opioids in the event they are not effective.

18VAC90-70-180. Treatment of chronic pain with opioids.

A. Nonpharmacologic and non-opioid treatment for pain shall be given consideration prior to treatment with opioids.

B. In initiating opioid treatment for all patients, the practitioner shall:

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

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

3. Prescribe naloxone for any patient when risk factors of prior overdose, substance misuse, doses in excess of 120 MME per day, or concomitant benzodiazepine are present; and

4. Document the rationale to continue opioid therapy every three months.

C. Buprenorphine mono-product in tablet form shall not be prescribed for chronic pain.

D. Due to a higher risk of fatal overdose when opioids, including buprenorphine, are given with other opioids, benzodiazepines, sedative hypnotics, carisoprodol, and tramadol (an atypical opioid), the prescriber shall only co-prescribe these substances when there are extenuating circumstances and shall document in the medical record a tapering plan to achieve the lowest possible effective doses if these medications are prescribed.

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

18VAC90-70-190. Treatment plan for chronic pain.

A. The medical record shall include a treatment plan that states measures to be used to determine progress in treatment, including pain relief and improved physical and psychosocial function, quality of life, and daily activities.

B. The treatment plan shall include further diagnostic evaluations and other treatment modalities or rehabilitation that may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

C. The prescriber shall record in the medical records the presence or absence of any indicators for medication misuse or diversion and take appropriate action.

18VAC90-70-200. Informed consent and agreement to treatment of chronic pain.

A. The practitioner shall document in the medical record informed consent, to include risks, benefits, and alternative approaches, prior to the initiation of opioids for chronic pain.

B. There shall be a written treatment agreement, signed by the patient, in the medical record that addresses the parameters of treatment, including those behaviors that will result in referral to a higher level of care, cessation of treatment, or dismissal from care.

C. The treatment agreement shall include notice that the practitioner will query and receive reports from the Prescription Monitoring Program and permission for the practitioner to:

1. Obtain urine drug screen or serum medication levels, when requested; and

2. Consult with other prescribers or dispensing pharmacists for the patient.

D. Expected outcomes shall be documented in the medical record, including improvement in pain relief and function or simply in pain relief. Limitations and side effects of chronic opioid therapy shall be documented in the medical record.

18VAC90-70-210. Opioid therapy for chronic pain.

A. The practitioner shall review the course of pain treatment and any new information about the etiology of the pain or the patient's state of health at least every three months.

B. Continuation of treatment with opioids shall be supported by documentation of continued benefit from the prescribing. If the patient's progress is unsatisfactory, the practitioner shall assess

the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

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

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

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

18VAC90-70-220. Additional consultation.

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

B. When a practitioner makes the diagnosis of opioid use disorder, treatment for opioid use disorder shall be initiated or the patient shall be referred for evaluation and treatment.

18VAC90-70-230. Medical records.

The prescriber shall keep current, accurate, and complete records in an accessible manner and readily available for review to include:

1. The medical history and physical examination;

2. Past medical history;

3. Applicable records from prior treatment providers or any documentation of attempts to obtain those records;

4. Diagnostic, therapeutic, and laboratory results;

5. Evaluations and consultations;

6. Treatment goals;

7. Discussion of risks and benefits;

8. Informed consent and agreement for treatment;

9. Treatments;

10. Medications, including date, type, dosage and quantity prescribed, and refills;

11. Patient instructions; and

12. Periodic reviews.

Part VII

Disciplinary Provisions

18VAC90-70-240. Grounds for disciplinary action against the license of a certified midwife.

The boards may deny licensure or relicensure, revoke or suspend the license, or place on probation, censure, reprimand, or impose a monetary penalty on a licensed certified midwife for the following unprofessional conduct:

1. Has had licensure to practice midwifery in this Commonwealth or in another jurisdiction revoked or suspended or otherwise disciplined;

2. Has directly or indirectly held himself out or represented himself to the public as a physician or is able to, or will practice independently of a physician;

3. Has performed procedures or techniques that are outside the scope of practice as a licensed certified midwife and for which the licensed certified midwife is not trained and individually competent;

4. Has violated or cooperated in the violation of the laws or regulations governing the practice of medicine, nursing, or certified midwifery;

5. Has become unable to practice with reasonable skill and safety as the result of physical or mental illness or the excessive use of alcohol, drugs, narcotics, chemicals, or any other type of material;

6. Has violated or cooperated with others in violating or attempting to violate any law or regulation, state or federal, relating to the possession, use, dispensing, administration, or distribution of drugs;

7. Has failed to comply with continuing competency requirements as set forth in 18VAC90-70-90;

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

9. Has engaged in unauthorized use or disclosure of confidential information received from the Prescription Monitoring Program; or

10. Has practiced as a licensed certified midwife during a time when the practitioner's certification as a certified midwife by the American Midwifery Certification Board has lapsed.

18VAC90-70-250. Hearings.

A. The provisions of the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) shall govern proceedings on questions of violation of 18VAC90-70-240.

B. The Committee of the Joint Boards of Nursing and Medicine shall conduct all proceedings prescribed in this chapter and shall take action on behalf of the boards.

18VAC90-70-260. Delegation of proceedings.

A. Decision to delegate. In accordance with subdivision 10 of § 54.1-2400 of the Code of Virginia, the committee may delegate an informal fact-finding proceeding to an agency subordinate upon determination that probable cause exists that a licensed certified midwife may be subject to a disciplinary action.

B. Criteria for delegation. Cases that involve intentional or negligent conduct that caused serious injury or harm to a patient may not be delegated to an agency subordinate, except as may be approved by the chair of the committee.

C. Criteria for an agency subordinate.

1. An agency subordinate authorized by the committee to conduct an informal fact-finding proceeding may include current or past board members, professional staff, or other persons deemed knowledgeable by virtue of their training and experience in administrative proceedings involving the regulation and discipline of health professionals.

2. The Executive Director of the Board of Nursing shall maintain a list of appropriately qualified persons to whom an informal fact-finding proceeding may be delegated.

3. The committee may delegate to the executive director the selection of the agency subordinate who is deemed appropriately qualified to conduct a proceeding based on the qualifications of the subordinate and the type of case being heard.

Documents Incorporated by Reference (18VAC90-70)

Standards for the Practice of Midwifery, revised 2011, American College of Nurse-Midwives

VIRGINIA ACTS OF ASSEMBLY -- 2021 SPECIAL SESSION I

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: Consideration of Petition for Rulemaking regarding supervision of radiologist assistants

Included in your agenda package:

- Petition for Rulemaking filed by Jeffrey LaPole to amend 18VAC85-101-92 to allow off-site supervision by radiolgists for minimally invasive and diagnostic procedures;
- Public comments filed on Town Hall during the public comment period;
- 18VAC85-101-92.

Staff note: Six comments were submitted during the public comment period. Four were supportive of the petition, while two were in opposition.

Action needed:

- Motion to either:
    - Take no action on the petition, clearly stating the reason; or
    - Accept the petition and initiate rulemaking.

COMMONWEALTH OF VIRGINIA
Board of Medicine

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Petition for Rule-making

The Code of Virginia (§ 2.2-4007) and the Public Participation Guidelines of this board require a person who wishes to petition the board to develop a new regulation or amend an existing regulation to provide certain information. Within 14 days of receiving a valid petition, the board will notify the petitioner and send a notice to the Register of Regulations identifying the petitioner, the nature of the request and the plan for responding to the petition. Following publication of the petition in the Register, a 21-day comment period will begin to allow written comment on the petition. Within 90 days after the comment period, the board will issue a written decision on the petition. If the board has not met within that 90-day period, the decision will be issued no later than 14 days after it next meets.

Please provide the information requested below. (Print or Type)

Petitioner's full name (Last, First, Middle initial, Suffix)		
Jeffrey A. LaPole		
Street Address 349 Bentley Drive	**Area Code and Telephone Number** 304-261-5367	
City Inwood	**State** WV	**Zip Code** 25428
Email Address (optional) jlapole@valleyhealthlink.com	**Fax (optional)**	

Respond to the following questions:

1. **What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.**

   Virginia Administrative Code Part V. Practice of Radiologist Assistants

   18VAC85-101-92

2. **Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule.**
   I am requesting review and change of 18VAC85-101-92. The current Code reads that in order for the Radiologist Assistant to be supervised, the Radiologist must be "present in the facility and immediately available". While this rule is appropriate for invasive procedures, it is too restrictive for minimally invasive procedures and diagnostic procedures such as joint injections and fluoroscopy. In recent years, more and more imaging is being interpreted remotely by off-site Radiologists. Amending this code to allow Radiologists Assistants to be supervised for minimally invasive procedures and diagnostic imaging remotely, would allow smaller hospitals to provide these services that the Radiologist Assistant is specifically trained to perform.

3. **State the legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by the board is found in § 54.1-2400 of the Code of Virginia. If there is <u>other</u> legal authority for promulgation of a regulation, please provide that Code reference.**

   This falls under the General Powers and Duties of health regulatory boards, specifically section six that states, "To promulgate regulations in accordance with the Administrative Process Act (§ 2.2-4000 et seq.) that are reasonable and necessary to administer effectively the regulatory system"

Signature: Jeffrey A.LaPole **Date:** 5-3-2023

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Agency **Department of Health Professions**

Board **Board of Medicine**

Chapter **Regulations Governing the Licensure of Radiologic Technology [18 VAC 85 - 101]**

6 comments

All good comments for this forum **Show Only Flagged**

Back to List of Comments

Commenter: Rick Sharp. Valley Health 6/5/23 10:48 am

Remote Supervision

I feel this is necessary. As Health care organizations continue to expand and purchase smaller more rural hospitals Radiology groups cannot physically be present and frequently opt to read remotely. Allowing the Radiology Assistant this rule change will expand the ability for rural areas to get fluoroscopic studies performed in their local hospital as opposed to driving to a large center frequently a good distance away. This rule amendment aligns with the scope of the RA and would be a positive move for the profession.

As a practicing RA I think this is long overdue.

CommentID: **217054**

Commenter: Jeff LaPole, Winchester Radiologists 6/15/23 12:18 pm

Radiologist Assistant Supervision

I support changing the regulations of the Radiologist Assistant to allow supervision of diagnostic procedures (fluoroscopy) and minimally invasive needle procedures to "general" or remote supervision. Currently the regulations read that the Radiologist must be "in the building" in order to supervise the Radiologist Assistant. Changing the regulations would provide greater flexibility in scheduling for more rural healthcare settings and provide greater access to care for our community. With the nationwide shortage of Radiologists, optimizing the use of the resources we have is imperative to keep up with the growing demand. It is important to emphasize that all studies performed by the Radiologist Assistant are reviewed with the Supervising Radiologist before the Physician provides the final interpretation.

I encourage the board to amend the Radiologist Assistant Rules and Regulations to allow for general supervision for diagnostic imaging and minimally invasive needle procedures so we can provide greater access to care for our community.

CommentID: **217266**

Commenter: Medical Society of Virginia 6/19/23 9:49 am

MSV Comment Regarding Regulations Governing the Licensure of Radiologic Technology

Re: Medical Society of Virginia (MSV) Comment Regarding Regulations Governing the Licensure of Radiologic Technology [18 VAC 85 ? 101]

Jun 19, 2023

Dear Dr Harp,

The Medical Society of Virginia (MSV) strongly supports proven efforts to expand healthcare access while maintaining the highest standard of patient care. Unfortunately, any effort to allow for remote supervision of Radiologist Assistants fails to clear that hurdle—and as such, the MSV must oppose this petition.

Virginia's PAs, medical students, and physicians know firsthand how complicated even "minimally invasive procedures" can be. And the fact the petitioner fails to define such procedures gives the MSV great concern regarding potential patient safety issues. Any medical procedure carries risk. When serious complications arise (and they inevitably will) patients deserve an immediate response by a practicing physician with clinical judgment based on years of clinical experience.

Plainly, we are concerned this proposal will lower Virginia's high standard of patient care and increase the potential risk to Virginia patients.

The petition as written must be opposed, but the MSV stands ready to work with all stakeholders to increase healthcare access and empower the Commonwealth's healthcare workforce.

Sincerely,

Clark Barrineau
Assistant Vice President of Government Affairs and Public Policy
Medical Society of Virginia

CommentID: **217299**

Commenter: Virginia Radiological Society 6/19/23 3:29 pm

Regulations Governing the Licensure of Radiologic Technology

June 19, 2023

Re: Regulations Governing the Licensure of Radiologic Technology [18 VAC 85 ? 101]

Dear Dr. Harp,

On behalf of the Virginia Radiological Society, we would like to express our appreciation for the opportunity to provide comment on the petition. The petition seeks to allow for remote supervision of Radiologist Assistants for minimally invasive procedures and diagnostic imaging. We value the work of Radiologist Assistants and recognize the valuable role they play in the patient care team. However, we must oppose the petition for the following reasons. The petitioner leaves "minimally invasive procedures" undefined. Even minimally invasive procedures can have serious complications that would require the attention of a Radiologist. Adverse reaction to contrast being but one example. Additionally, the petition represents a significant shift in how Radiologist Assistants are currently supervised.

While we are in opposition to the petition currently, we would be more than willing to explore this issue with the petitioner, the professional associations representing Radiologist Assistants, and other interested

parties.

Thank you again for the opportunity to comment.

Most Sincerely,

Arun Krishnaraj, MD, FACR
President | Virginia Radiological Society

Richard A. Szucs, MD, FACR
Legislative Committee Chair | Virginia Radiological Society
CommentID: **217311**

Commenter: Jeffrey LaPole 6/27/23 12:39 pm

Clarification of Minimally Invasive Procedures

Clarification of "minimally invasive procedures"

Dr. Harp,

I appreciate the comments posted to the forum and the opportunity to clarify what was meant by "minimally invasive procedures" in the petition to change the rules regarding Radiologists Assistants. Other than diagnostic fluoroscopy, the specific procedures that would be most beneficial to be included in the proposed change are PICC lines (peripherally inserted central catheter) and image guided large joint injections (shoulder, hip, knee) for either therapeutic purposes or for arthrography pre-MRI.

I would also like to address another comment posted and assure its author that Radiologists Assistants are keenly aware of the potential risks and complications from any procedure. Radiologist Assistants are Advanced Practice Clinicians who specialize in performing these procedures. If it would be helpful to alleviate any safety concerns for these procedures, we could mirror the Regulations Governing the Practice of Physician Assistants in Virginia, specifically 18VAC85-50-110 Subdivision two (2) part B. This section reads that Physician Assistants can perform invasive procedures without direct observation or supervision after they have performed three (3) of the procedures and are deemed competent.

I apologize for the confusion and would be glad to discuss the proposed rule change.

Respectfully,
Jeffrey LaPole
CommentID: **217473**

Commenter: American Society of Radiologic Technologists 6/30/23 9:29 am

Regulations Governing the Practice of Radiologic Technology

Dear Dr. Harp and the Virginia Board of Medicine,

The American Society of Radiologic Technologists is the premier association for the medical imaging and radiation therapy profession, with nearly 156,000 members nationally including 4,245 members in the Commonwealth of Virginia.

ASRT's main mission as an organization is to advocate for patient safety by ensuring the technologists providing care remain within their scope of practice and under appropriate clinical supervision. With this mission in mind, I am writing to express concerns over the petition to allow for remote supervision of minimally invasive procedures and diagnostic procedures.

The main concern is over the lack of definition for what procedures would be classified as minimally invasive. Additionally, a radiologist assistant does not have the practice authority to work autonomously. With these concerns, we propose the following wording to balance concerns and accessibility.

Recommendation "A radiologist assistant may provide imaging services that do not require informed patient consent under the remote supervision of a radiologist. If a supervising radiologist is not physically present at the location at which a radiologist assistant is practicing, the radiologist assistant shall provide services for any procedure requiring informed consent only when a physician licensed pursuant to 18VAC85-20, who need not be a radiologist, is physically present at the location and would be responsible for providing intervention or assistance in the event of a medical emergency."

I look forward to working with you as the Department of Health Professions evaluates this petition to amend. ASRT is happy to be a resource on all things related to the medical imaging and radiation therapy professions.

Sincerely,

M Check

Meredith Check, MPP
Manager of Government Relations and Public Policy
ASRT
CommentID: **217586**

Virginia Administrative Code
Title 18. Professional And Occupational Licensing
Agency 85. Board of Medicine
Chapter 101. Regulations Governing the Practice of Radiologic Technology

Part V. Practice of Radiologist Assistants

18VAC85-101-92. Individual responsibilities to patients and to licensed doctor of medicine or osteopathic medicine.

A radiologist assistant shall practice under the direct supervision of a radiologist. Direct supervision shall mean that the radiologist is present in the facility and immediately available to assist and direct the performance of a procedure by a radiologist assistant. The supervising radiologist may determine that direct supervision requires his physical presence for the performance of certain procedures, based on factors such as the complexity or invasiveness of the procedure and the experience and expertise of the radiologist assistant.

Statutory Authority
§§ 54.1-2400 and 54.1-2956.8:1 of the Code of Virginia.

Historical Notes
Derived from Virginia Register Volume 28, Issue 5, eff. December 7, 2011.

Agenda Item: Consideration of Petition for Rulemaking regarding removal of patient care team physician's or podiatrist's name from Schedule II-V prescriptions

Included in your agenda package:

- Petition for Rulemaking filed by Virginia Academy of Physician Assistants to amend 18VAC85-50-160(A) to remove the requirement that the patient care team physician's or podiatrist's name appear on Schedule II-V prescriptions;

- Public comments filed on Town Hall during the public comment period;

- 18VAC85-50-160.

Staff note: This petition received 186 comments on Town Hall. All were in support of the petition.

Action needed:

- Motion to either:

    - Take no action on the petition, clearly stating the reason; or
    - Accept the petition and initiate rulemaking.

COMMONWEALTH OF VIRGINIA
Board of Medicine

9960 Mayland Drive, Suite 300
Richmond, Virginia 23233-1463

(804) 367-4600 (Tel)
(804) 527-4426 (Fax)
Coco.Morton@dhp.virginia.gov

Petition for Rule-making

The Code of Virginia (§ 2.2-4007) and the Public Participation Guidelines of this board require a person who wishes to petition the board to develop a new regulation or amend an existing regulation to provide certain information. Within 14 days of receiving a valid petition, the board will notify the petitioner and send a notice to the Register of Regulations identifying the petitioner, the nature of the request and the plan for responding to the petition. Following publication of the petition in the Register, a 21-day comment period will begin to allow written comment on the petition. Within 90 days after the comment period, the board will issue a written decision on the petition. If the board has not met within that 90-day period, the decision will be issued no later than 14 days after it next meets.

Please provide the information requested below. (Print or Type)

Petitioner's full name (Last, First, Middle initial, Suffix,) Virginia Academy of PAs		
Street Address 250 W. Main Street, Suite 100	**Area Code and Telephone Number** (434) 906-1779	
City Charlottesville	**State** VA	**Zip Code** 22902
Email Address (optional) jonathan.williams@easterassociates.com	**Fax (optional)**	

Respond to the following questions:

1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.

   Regulations Governing the Practice of Physician Assistants
   Part V. Prescriptive Authority
   18VAC85-50-160

2. Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule.

   We request the removal of the patient care team physician's name from Schedule II-V prescriptions. We feel that this revision supports a uniform policy for non-physician prescribers in the state. There has been no indication that the absence of the supervising physician's name on PA prescriptions has resulted in citizen complaints, evidence of patient harm, or a disciplinary hearing. PAs would continue to identify themselves as licensed Physician Assistants, include DEA numbers on schedule II – V prescriptions, and provide the collaborating physician's name and contact information when requested by the patient.

3. State the legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by the board is found in § 54.1-2400 of the Code of Virginia. If there is other legal authority for promulgation of a regulation, please provide that Code reference.

   54.1-2400 and Chapter 29 of Title 54.1 of the Code of Virginia

Signature: Jonathan K. Williams **Date:** 5/12/23

Agency **Department of Health Professions**

Board **Board of Medicine**

Chapter **Regulations Governing the Practice of Physician Assistants [18 VAC 85 - 50]**

186 comments

All good comments for this forum **Show Only Flagged**

Back to List of Comments

Commenter: K Yoder, PA-C 6/5/23 3:32 pm

burdensome and unhelpful

I support the petition to remove the physician's name from prescriptions written by a PA. This is burdensome particularly since most prescriptions are electronic and not all EMR systems have capacity to meet these requirements. Furthermore, the collaborating physician in a group setting changes from day to day and an arbitrary physician's name on the prescription is meaningless as that provider was probably not involved in the patient's care.

The current requirement does nothing to promote patient safety and removing it is a sensible advancement for medicine.

CommentID: **217055**

Commenter: S. Widner 6/5/23 4:28 pm

Unhelpful

I petition to remove the requirement that a patient care team physician's name be included on prescriptions for Schedule II-V drugs- this seems to be a step that can be avoided- for one all EMRs do not have the ability to do this which has potential to hinder patients care- and PA's should have the authority to rx scheduled drugs without having a potential arbitrary patient care team physician on the rx who knows nothing about the patient.

CommentID: **217057**

Commenter: L DeWitz PA-C 6/5/23 4:40 pm

burden to all

I fully support the removal of requirements to include patient care team physician's name on prescriptions for Schedule 2-5 drugs. It serves no purpose and creates extra barriers to patient's getting their medications timely. This requirement wastes the time, not only of our patients, but of

pharmacists having to get hold of us and our front desk staff. It is important to note that the PA's collaborator is usually not directly involved in our patient's care and may not be the provider working that day. Let's please remove bureaucracy that wastes the time of patients and already overburdened healthcare workers. This requirement is antiquated and does not benefit patients.
CommentID: **217059**

Commenter: Phillip Davis 6/5/23 8:48 pm

PAs are licensed medical professionals and are required to have DEA licenses

What is the point of having a supervising physician's name on prescriptions for controlled substances? PAs are licensed, credentialed, and privileged and have DEA licenses to prescribe controlled substances. The Commonwealth of Virginia monitors all prescriptions for controlled substances and provides a monthly prescription report for all licensed providers.

What additional public protection or patient safety does the requirement to list a physician on the prescription add?

PAs are required to have collaborating physicians but those physicians are in no way responsible for the prescriptions that a PA writes and therefore this is an unnecessary regulation.

CommentID: **217061**

Commenter: Emily M. Waller, DMSc, PA-C 6/6/23 11:06 am

Agree

I agree that this requirement should be removed. As part of their prescriptive authority, PAs enter into a written agreement that the supervising physician will supervise the prescriptive practices of the assistant. This is a condition of the employment protocol which all PAs are required to have to be licensed by the board to practice. Therefore, the supervision of prescribing practices is inherent in a PA's employment. Placing the supervising physician's name on all prescriptions does not strengthen this supervision in any way. Additionally, removing this requirement would not weaken the supervision. This requirement is simply a burdensome keystroke that can easily be eliminated without interfering with the supervising relationship between the physician and PA.

CommentID: **217063**

Commenter: Kim Ketchersid 6/7/23 12:47 pm

Barrier to Patient Care

First - The Code of Virginia 18VAC850-160 specifies that PAs should disclose the name, address, and telephone number of the patient care team physician on the prescription. We have been experiencing an uptick in pharmacies declining scripts written by PAs that do not include the name and NPI of their collaborating physician.

Some case examples:

- Patient discharged from the trauma service was denied prescription for pain medication as the script written by the PA did not include the name of the collaborating physician. The patient had to return to the hospital to pick up a paper prescription.
- A patient discharged from the hospitalist service was also denied a pain medication

prescription on discharge, this was not appreciated for several days

I believe this regulation places unnecessary restrictions on PA practice, negatively impacts patient care, and prohibits optimal team practice. It should be repealed.
CommentID: **217069**

Commenter: Portia Tomlinson, PA-C, DFAAPA 6/7/23 6:02 pm

Removal of language that collaborating physician name be on PA prescriptions

As a practicing PA in Virginia, I fully support removal of this language (that the collaborating physician's name be on prescriptions for scheduled 2-5 medications) for the following reasons:

- PAs are licensed, credentialed and have their individual DEA license to prescribe controlled substances
- The Commonwealth of Virginia monitors all prescriptions for controlled substances.
- PAs have extensive training in pharmacology and substance use disorder
- Some ERMs still do not have the ability of including this information and attempts to comply are cost prohibitive so the burden lies with an already over taxed provider
- Attempting to add this information to electronic prescriptions causes delay in patients receiving prescriptions in a timely manner as pharmacists, front desk staff, providers make several phone calls to comply, causing further barriers to patient access
- PAs may have several rotating collaborating physicians that rotate through different clinics. Attempting to find the specific physician also causes further delay in patient care.
- This language adds no additional public protection or patient safety.

I support removal of this language for the benefit of patients.

CommentID: **217071**

Commenter: Stephanie Bork, Virginia Commonwealth University 6/9/23 4:46 pm

Barrier to patient care

Physician Assistants (PAs) are licensed medical providers with individual DEA registrations. Within the State of VA, PA's are allowed to hold prescriptive authority which should allow them to independently write for prescriptions, including controlled substances. The oversight of a physician having to sign every prescription is a barrier to access and patient care. Within the current healthcare climate, there are decreasing amount of physician and non physician providers since the COVID19 pandemic and access to care has only worsened. Continued barriers and restrictions are only hurting patients.

CommentID: **217179**

Commenter: Gerald Weniger, PhD, PA-C 6/12/23 11:25 am

Support

I support the petition to no longer require a physician's name on prescriptions written by a PA. PAs are licensed medical providers who have extensive training in pharmacology and can already retain their own individual DEA numbers. To require a physician's name on a prescription is illogical and burdensome. It does nothing for patient care or patient safety. Furthermore, not all EMR systems are able to meet this requirement.

CommentID: **217188**

Commenter: Bobby Cockram 6/14/23 3:25 pm

Barrier to care

I am supportive of removing this requirement as it poses a barrier to providing safe and efficient care to our patients. Requiring a PA prescribing medications to include a collaborating physician's name on the prescription is an unnecessary burden on patients, physicians, and PA's. It does not increase safety for patients, if anything it may create a safety issue as patients meds are unnecessarily delayed. In addition, it reduces the efficiency in which we can provide patient care services, putting an unnecessary barrier on patient access. I serve as a director in a large healthcare system here in Virginia and I am consistently made aware of situations where patients have been prescribed meds after hospitalization or an ED visit and those prescriptions are being refused to be filled by pharmacies because of this requirement. This results in a delay in patients receiving medications and requires the patient to return to the hospital, ED, or providers office to obtain a new prescription. I am consistently made aware of this unfortunately happening to patients. PAs in Virginia have prescriptive authority and are required to have a DEA registration unique to them and thus should be able to exercise this prescriptive authority without this unnecessary additional requirement.

CommentID: **217254**

Commenter: Al Wilkins 6/14/23 11:13 pm

Unreasonable requirement

This regulation is being applied to PAs without good reason (neither NPs nor physicians in training are subject to similar regulations). This creates an additional burden for PAs and their collaborating physicians, and causes delays in care for their patients.

CommentID: **217261**

Commenter: Kathleen Scarbalis PA-C 6/15/23 11:58 am

Support regulatory change

I support the proposed regulatory change to PA prescribing requirements for the following reasons:

- PAs have individual DEA license numbers. The PA prescribing is responsible, not the collaborating physician. Should a pharmacist or patient have questions regarding the prescription, the prescriber/PA is the best contact.
- PAs have pharmacology training. PAs are trained, licensed and credentialed to appropriately prescribe in Virginia.
- PAs work in a variety of environments. Many EMRs prove difficult to navigate and add a note to the prescription with the collaborating physician name. This is cumbersome and delays care for the patient if the pharmacy must be called. Many hours on hold have been wasted. Requiring facilities to amend EMRs could be cost prohibitive.
- The PA is the best point of contact for a prescription written by the PA. As an example, I have been contacted more than 24 hours after prescription submission. My collaborating physician referred the

pharmacist back to me for information regarding an ADHD medication change. There was a drug shortage, and the family could not pick up the prescribed medication until resolution. This created much stress for the family, poor patient care and an unnecessary delay. I should have been the initial call.

CommentID: **217264**

Commenter: Chris Newlin, PA-C 6/16/23 4:30 pm

Barriers to patient care

My patients who are discharged from the hospital following total knee replacement are often unable to pick up prescriptions due to this unnecessary regulation. I have learned to add the required information to the prescription so my patients aren't burdened. But I fail to see how my attending's name on the prescription stops or prevents an abuse of the prescribing system.

CommentID: **217286**

Commenter: Kayla Jones, PA-C 6/16/23 4:36 pm

Barrier to patient care

why must we pay for a DEA license if a SP is still required to prescribe?
I work in the ER where SP names are not included on the Rx. We get constant calls asking who the SP physician is. It takes up pharmacy time, providers time and causes more stress for the patient. Usually, physicians are not involved in the decision to prescribe a narcotic. Why have their name on the script?

CommentID: **217287**

Commenter: Rebecca Bae 6/16/23 4:53 pm

Agree

Agree

CommentID: **217288**

Commenter: Tiffany Wormuth 6/17/23 12:16 am

Barrier to patient care

I have been a PA for 19 years. Having to have my collaborating physician's name on my prescriptions is a barrier to patient care.

CommentID: **217290**

Commenter: Dakota Nolden PA-C 6/17/23 10:18 am

Agree

Agree with this change. There have been countless times were this was a barrier to patient care and unnecessary exchange with pharmacies to proceed with prescriptions. We have a DEA license

to prescribe and a practice agreement with the MD. If there ever is any issue, we can be contacted and then directly discuss with supervising physician.
CommentID: **217291**

Commenter: Ashley Greer, PA-C 6/17/23 1:45 pm

I agree

I support the petition to remove the physician's name from prescriptions written by a PA. In most settings the collaborating physician in a group setting changes from day to day and an a physician's name on the prescription is meaningless as that provider was probably not involved in the patient's care.

The current requirement does nothing to promote patient safety and removing it is a sensible advancement for medicine.

Thank you

CommentID: **217292**

Commenter: Lorick Fox, PA-C, AACC, DFAAPA 6/18/23 3:27 am

Both misleading and non-helpful

I have been in practice since 1980, hold VA Lic#122.
I have two DEA's, one for NY and one for VA.

Over that 43 year career, in many cases, a patient may have never seen the physician listed as my "supervising physician" and confusingly, may believe the name on the Rx is the provider they saw, a pharmacist attempting to verify information may attempt to contact that MD/DO (who knows nothing of patient except perhaps has seen the chart) and the Prescription Monitoring Program may reflect that MD/DO as the prescriber (which is misleading and in conflict with the entire idea of the PMP).

IAW § 54.1-2952, the physician has no responsibility for the Rx, thus the current situation is misleading, unnecessary and in no way helpful.

This can be changed with only positive effects.

Thanks for your consideration

Lorick Fox, PA-C, AACC, DFAAPA
Associate, American College of Cardiology
Distinguished Fellow, American Academy of Physician Associates
Affiliate, American College of Physicians

CommentID: **217294**

Commenter: Anonymous 6/19/23 9:22 am

Upcoming legislation

I definitely agree!!

CommentID: **217298**

Commenter: Robert A. Glasgow IV, PA-C, MPAS, MPH 6/19/23 10:12 pm

Support Regulatory Change to 18VAC85-50-160

I speak in favor of amending 18VAC85-50-160.

We have our own license, DEA, and NPI. There should be no reason to require a collaborating physician's name.

§ 54.1-2952.1. Prescription of certain controlled substances and devices by licensed physician assistants: requires that we provide *our* name, address, and telephone number, *not* that of our collaborating physician.
The electronic medical record and e-prescribing systems identify the prescriber (the PA) but are quite variable in their ability to identify a collaborating physician on the electronic prescription sent to the pharmacy.

To the best of my knowledge, PAs are the only prescribers in Virginia who are required to have this requirement. There is no evidence that harm has occurred or will occur should the collaborating physician's name not appear on PA prescriptions.

CommentID: **217316**

Commenter: Rosemary Lethbridge 6/20/23 12:02 pm

I agree

I agree with this change and find the current rule a hindrance to patient care.

CommentID: **217352**

Commenter: H. Slezak PA-C 6/20/23 10:13 pm

Unnecessary requirement

Unnecessary requirement

CommentID: **217389**

Commenter: Patrick Ketchersid PA-C 6/22/23 12:15 pm

In favor of repealing this unnecessary burden to patient care

Physician assistants have their own NPI and DEA licenses. Requiring the care team physician's name to be on a PAs prescription for any medication is unnecessary and can lead to delay in delivery of medications to patients who need it.

CommentID: **217418**

Commenter: Anonymous 6/22/23 12:21 pm

Agree

This law is unnecessary.

CommentID: **217419**

Commenter: Sara Nicely 6/22/23 2:06 pm

18VAC 85-50-160

I am in favor of amending 18VAC 85-50-160. PAs are certified by a national certification body, licensed by the Commonwealth, and carry DEA certification. There should be no need for additional steps for prescription authorization that may delay the treatments needed by our patients.

CommentID: **217421**

Commenter: Bettie Rogers 6/22/23 5:12 pm

Unnecessary Regulation

As a nurse of 30 years, I am a strong advocate to remove delays in patient care that come from unnecessary red tape. I had many patients on scheduled medications and programs like the PMP are more effective in monitoring safe prescriptive patterns. My patients have spinal cord injuries and it takes a lot of effort for them or their care takers to go to a pharmacy to pick up medications. Many of them have had to wait HOURS which is an inconvenience that could be righted be removing this regulation.

CommentID: **217423**

Commenter: Tatsiana Singh, Commonwealth Primary Care 6/24/23 7:07 pm

Physician's information should not be required to be provided when PA prescribe medications

The requirement to include physician's name on the PA's prescriptions does not improve patient safety but creates logistical difficulties during patient visits to the clinic. Every time I eprescribe, I have to manually add my supervising physician's information to the prescription as it is not automatically set in the EMR.

CommentID: **217435**

Commenter: Dara Wotherspoon, PA-C 6/25/23 11:26 am

Agree with Removal of this Requirement

I agree with removing this requirement as it can be a barrier for patient care

CommentID: **217437**

Commenter: Anonymous 6/25/23 1:08 pm

Agree to amend

I speak in favor of amending 18VAC85-50-160.

As PAs, we have our hold license, DEA, and NPI. There should be no reason to require a collaborating physician's name on a prescription.

The electronic medical record and e-prescribing systems identify the prescriber (the PA) but are quite variable in their ability to identify a collaborating physician on the electronic prescription sent to the pharmacy.

To the best of my knowledge, PAs are the only prescribers in Virginia who are required to have this requirement. There is no evidence that harm has occurred or will occur should the collaborating physician's name not appear on PA prescriptions.

CommentID: **217439**

Commenter: Anonymous 6/25/23 3:05 pm

Agree with removal

Agree this should be removed

CommentID: **217442**

Commenter: Emily Revenson, PA-C 6/26/23 8:29 am

Adding patient's care team physician name an unnecessary obstacle.

Requirement of the physician's name on the patient's prescription adds an unnecessary logistical burden which delays patient care (should one accidentally fail to manually add the name before e-prescribing). Physician Assistants follow a contract with their collaborating physicians. PA's who prescribe these medications have their own DEA number and NPI. No other prescriber in the Commonwealth is required to document this.

Requirement of the physician's name may lead to misinformation in pharmacy records, reflecting incorrect prescriber information and confusing the patient.

Please amend legislation to remove the requirement to include patient care team's physician's name on prescriptions for schedule ii-iv drugs.

CommentID: **217443**

Commenter: Sarah Hamaker, PA-C 6/26/23 8:08 pm

Agreed

PAs are certified by a national certification body, licensed by the Commonwealth of Virginia, and certified by the DEA to prescribe controlled substances. This requirement both delays patient care and inhibit optimal team practice.

CommentID: **217463**

Commenter: Rachel Bastianelli, PA-C 6/26/23 11:56 pm

Agreed

Agreed

CommentID: **217466**

Commenter: Mark Ford, PA-C 6/27/23 6:11 am

Prescription burdensome regulation

Thank you for considering and removing language that requires physician names on prescriptions along side their physician assistant. As you are already aware, we are highly trained providers who comply with state regulations for extra training regarding concerning Schedule drugs. The current legislation is not only redundant but unnecessary. Even with the best of intentions it stimulates call backs from pharmacies and lost time rewriting prescriptions. Thank you for cleaning up the legislation and moving forward. Mark Ford. 24 years Orthopedics. Fredericksburg,VA

CommentID: **217467**

Commenter: R Isdell, PA-C 6/27/23 8:36 am

Agree

Delays patient care. Burden.

CommentID: **217468**

Commenter: Jessica Moore-Scheeler PA-C 6/27/23 10:44 am

Agree with removal

Unnecessary ruling that impedes patient care. As a provider with a DEA I should be allowed and capable of making the best decisions for patients including prescribing controlled substances without my supervising physicians name on the script.

CommentID: **217470**

Commenter: Elizabeth Palmer PA-C 6/27/23 11:25 am

Signature

Agree

CommentID: **217471**

Commenter: Amanda Osei PA-C 6/27/23 3:52 pm

Signature

Endorse removal

CommentID: **217475**

Commenter: Tiffany Thompson, DMSc, PA-C 6/27/23 5:18 pm

Signature

Agree with removal

CommentID: **217476**

Commenter: Erin Bigelow, PA-C 6/27/23 5:51 pm

Agree with removal

Agree

CommentID: **217477**

Commenter: Katherine Vita 6/27/23 6:22 pm

Agree w/ Removal

Agree with removal; as PAs we have our own DEA number/license. The removal will improve and expedite patient care.

CommentID: **217478**

Commenter: Erin Poston PA-C 6/28/23 7:48 am

Agree with removal

There are plenty of practice protocols in place that negate the need to have the supervising physician's name on the prescriptions. Having the supervisors name could prevent delay in patient access to appropriate medications in a timely manner for their health. In addition, there is excessive unnecessary work for the practitioners when there is a discrepancy in who is the supervising physician for the PA at the time the prescription was written. Most often the PA is writing prescriptions without the physician's direct oversight. Each practice dictates how much oversight each PA has and therefore this gives flexibility in each practice, deciding how the supervising physician wants to oversee the PA.

CommentID: **217481**

Commenter: Evan Ritter, MD 6/28/23 12:30 pm

Agree with removal

Agree with removal

CommentID: **217485**

Commenter: Lesley Coots 6/28/23 1:55 pm

Agree with Removal

This is a huge barrier to timely patient care and should be removed immediately. PAs are fully licensed providers with their own DEA license. They should be able to prescribe without restriction.

CommentID: **217492**

Commenter: B Casey PA-C 6/28/23 2:15 pm

Agree with removal

I agree with this removal. My DEA and VA license should allow me to prescribe within my scope of practice. The need to add a physician's name cause extra paperwork and processing time for patients to receive their prescriptions.

Thank you for your consideration.

CommentID: **217494**

Commenter: Erin MacMillan 6/28/23 2:23 pm

Agree with removal

The Code of Virginia 18VAC850-160 specifies that PAs should disclose the name, address, and telephone number of the patient care team physician on the prescription. We have been experiencing an uptick in pharmacies declining scripts written by PAs that do not include the name and NPI of their collaborating physician.

Some case examples:

- Patient discharged from the thoracic service was denied prescription for pain medication as the script written by the PA did not include the name of the collaborating physician. The patient had to return to the hospital to pick up a paper prescription.
- A patient discharged from the hospitalist service was also denied a pain medication prescription on discharge, this was not appreciated for several days

I believe this regulation places unnecessary restrictions on PA practice, negatively impacts patient care, and prohibits optimal team practice. It should be repealed.

CommentID: **217495**

Commenter: Monica Cooper, PA 6/28/23 2:33 pm

Barrier to patient care

Removal would improve patient care, remove unnecessary barriers

CommentID: **217496**

Commenter: Meredith Dhillon PA-C 6/28/23 2:41 pm

I support Removal

Removing the requirement of SP name on controls would eliminate barriers to patient care, too many pharmacies are holding up patient's medications.

CommentID: **217498**

Commenter: Olushola Ilogho 6/28/23 3:05 pm

I agree with removal

I agree with removal.

CommentID: **217502**

Commenter: Anonymous 6/28/23 5:20 pm

Amend requirement

I speak in favor of amending 18VAC85-50-160.

As PAs, we have our hold license, DEA, and NPI. There should be no reason to require a collaborating physician's name on a prescription.

To the best of my knowledge, PAs are the only prescribers in Virginia who are required to have this requirement. There is no evidence that harm has occurred or will occur should the collaborating physician's name not appear on PA prescriptions.

CommentID: **217503**

Commenter: Evan Turnbull, MPAS, PA-C, UVA Health 6/28/23 6:18 pm

This is a common sense update

Since Virginia is a collaborative agreement state between a MD and PA instead of a supervising agreement state, it is unnecessary and nonsensical to require a physician's name, NPI and DEA number on my prescriptions. I am the evaluating provider and the treating provider, and many times independent in decision making from a collaborating physician. For that reason I am responsible for what I prescribe and my name and IDs are the only necessary credentials needed to validate my prescriptions, having certification to practice medicine under this collaborative agreement and prescribing authority in Virginia for schedule 2-5 and nonscheduled medications. Any argument against this change, for example fears of abuse, accountability or proper decision-making, are baseless. Protections against all of these are already in place through the legal system, board of medicine, scope of practice guidelines, standard of care, our nationally standardized and accredited training and health system/practice oversight. By eliminating the MD credential requirement it will eliminate confusion for the patient about who treated them, and especially eliminate unnecessary calls and prescription fulfillment delays from the pharmacy if the MD information is not available or incomplete. In short, this necessary change will improve patient care delivered by PAs and the patient's experience. Thank you

CommentID: **217506**

Commenter: Laura Paletta-Hobbs, MD 6/28/23 6:49 pm

Agree with removal

I agree with the removal of this requirement

CommentID: **217508**

Commenter: Christopher Allen 6/28/23 7:02 pm

Agree with removal

Agree with proposed removal language.

CommentID: **217510**

Commenter: Jenna Rolfs, DMSc, PA-C 6/28/23 7:27 pm

Agree with removal.

I agree with the removal of this requirement.

CommentID: **217512**

Commenter: Steve Young, PA-C 6/28/23 8:16 pm

Agree to remove

PA's have a license to practice medicine and have achieved prescriptive authority through education and the DEA. This should be removed as it can delay care to our patients and it is unnecessary.

CommentID: **217515**

Commenter: Stanley Liu, MD 6/28/23 8:22 pm

Agree with removal

Agree with removal

CommentID: **217516**

Commenter: Carolyn Chapon, PA-C 6/28/23 9:15 pm

Agree with amendment

I work in orthopedic surgery and assist with post operative orders. Patients are experiencing significant delays in receiving their post operative pain medication from what can be quite painful procedures. We often receive multiple phone calls throughout the day from patients waiting at the pharmacy unable to pickup their medications after surgery due to our SP's name not being on the prescription. APPs have our own separate DEA license and this is becoming an obstacle to providing quality care. I support removing this requirement in order to ensure patients are able to receive their medications in a timely manner.

Thank you for you consideration,

CC

CommentID: **217519**

Commenter: Rebecca Agbayani, PA-C 6/28/23 9:30 pm

Agree

I fully support the removal of requirements to include a physician's name, NPI, and DEA information on Schedule II-V prescriptions.

The collaborating physician is rarely directly involved in the patient's care on a day-to-day basis, and requiring their information on these prescriptions is an unnecessary burden in their role as

collaborator. Additionally, as PA's we have our own license, NPI, and DEA, so are fully able and expected to carry the burden of responsibility and liability that comes with prescribing medications. This unnecessary paperwork step increases the amount of time I spend in front of my computer or on the phone rather than with my patients, and can result in delays of timely filling of prescriptions at the pharmacy.

This is an easy win to remove some bureaucratic red tape and make everyone's jobs a little easier.
CommentID: **217520**

Commenter: Gopika Suraj, MD 6/28/23 9:57 pm

Agree with removal

Agree with removal

CommentID: **217522**

Commenter: Kelly Botta 6/28/23 10:47 pm

Agree - remove.

Agree with removal. Unnecessary burden to patient, PA, and physician. Why require us to hold a DEA license if this is to remain?

CommentID: **217525**

Commenter: Leslie Teets Moses, MD 6/29/23 4:37 am

Agree with removal

As stated, this is a barrier to prompt patient care

CommentID: **217528**

Commenter: Alecia Battle, NP 6/29/23 7:08 am

Please remove this unnecessary burden to patient care

I agree with removal

CommentID: **217529**

Commenter: Carolyn Marcelo, MD 6/29/23 7:12 am

Agree with removal

I agree with the removal of this requirement.

CommentID: **217530**

Commenter: Jeremy Welsh DHSc, JD, PA-C 6/29/23 7:17 am

Remove

Agree. Please remove unnecessary obstacles.

CommentID: **217531**

Commenter: Stephen Biederman 6/29/23 7:31 am

Agree with removal

Agree with removal

CommentID: **217533**

Commenter: Catherine Marcelo, MD 6/29/23 7:59 am

Agree with removal

I agree with the removal of this requirement.

CommentID: **217534**

Commenter: David Goldberg 6/29/23 8:00 am

I agree

Agree with removal.

CommentID: **217535**

Commenter: Hospitalist 6/29/23 8:01 am

I agree

I agree with the removal.

CommentID: **217536**

Commenter: Eziafa Oduah 6/29/23 8:22 am

Agree

Agree given scope of PA practice

CommentID: **217537**

Commenter: Casey Cable, MD 6/29/23 8:28 am

I support

I support.

CommentID: **217538**

Commenter: Christina Perry, PA-C 6/29/23 8:58 am

Agree with removing this, it limits the practice of competent providers.

Agree with removing this, it limits the practice of competent providers.

CommentID: **217540**

Commenter: Tara Thompson, NP 6/29/23 9:05 am

Agree with removal

Agree with removal.

CommentID: **217542**

Commenter: Katelyn Hellman, DNP FNP-c 6/29/23 9:30 am

In-agreement

Liberating prescribing power to match that of other advanced practice providers helps to increase patient access to care, as well as increasing safety, satisfaction and timelessness of care delivery without interrupting physician work-flow.

CommentID: **217544**

Commenter: Jamie Jennette, NP 6/29/23 11:31 am

Agree with removal

Agree with removal

CommentID: **217547**

Commenter: Kristen Bardaro 6/29/23 12:26 pm

Petition governing practice for Physician Assistants

I support

CommentID: **217548**

Commenter: Robert DeGrazia, VCU 6/29/23 12:42 pm

I agree

I agree with the removal

CommentID: **217549**

Commenter: Anonymous 6/29/23 12:42 pm

suport

obviously in support. Silly that this even needs to be a petition

CommentID: **217550**

Commenter: MJ 6/29/23 12:54 pm

I AGREE WITH REMOVAL

I AGREE WITH REMOVAL

CommentID: **217551**

Commenter: MADISON JOHNSON, PA-C 6/29/23 12:55 pm

Petition governing practice for Physician Assistants

Petition governing practice for Physician Assistants

I support

CommentID: **217552**

Commenter: Veronica Nolden 6/29/23 2:14 pm

Support

Completely support!

CommentID: **217553**

Commenter: Aubrey Stoll 6/29/23 2:33 pm

support

I completely support this petition.

Aubrey Stoll

CommentID: **217554**

Commenter: Paul Franklin 6/29/23 4:10 pm

I agree with removal, and support petition

I agree with removal of physician requirement on PA's controlled substance prescriptions.

CommentID: **217555**

Commenter: Areej Syed 6/29/23 4:16 pm

Schedule II-V drugs petition

Agree with removal

CommentID: **217556**

Commenter: Justin Latimer 6/29/23 4:24 pm

Agree

I agree

CommentID: **217557**

Commenter: Therese Podgorski 6/29/23 7:30 pm

I agree with removal

I agree with removal.

CommentID: **217559**

Commenter: Courtney Kumar, NP 6/29/23 10:07 pm

Agree

Agree

CommentID: **217561**

Commenter: Jennifer Beckman, PA-C 6/30/23 5:33 am

Agree with petition

This creates an unnecessary barrier to patient care. APPs carry their own DEA licenses and should be able to use it for prescribing.

CommentID: **217564**

Commenter: Jaclyn Dalton 6/30/23 8:07 am

Petition

I agree

CommentID: **217567**

Commenter: Tessa Heinz, PA-C 6/30/23 8:12 am

Agree

CommentID: **217568**

Commenter: Morgan McDowell DNP WHNP Centra Health 6/30/23 8:14 am

Barrier to patient care

This is a huge barrier to patient care and access. Please remove this requirement for our PA colleagues in healthcare. They are required to have their own DEA.

CommentID: **217569**

Commenter: Liz Melcher, FNP-BC 6/30/23 8:22 am

I agree with the removal of this requirement

I agree with the removal of this requirement.

CommentID: **217570**

Commenter: Meredith 6/30/23 8:22 am

Amendment

I agree with the removal of this requirement.

CommentID: **217571**

Commenter: Blakley Sproles DMSc, MPAM, PA-C 6/30/23 8:23 am

I agree with removing this, it limits the practice of advanced practice providers

I agree with removing this, it limits the practice of advanced practice providers and negatively impacts patient care.

CommentID: **217572**

Commenter: Lindsey Dummeldinger, PA-C 6/30/23 8:24 am

Agree with petition to remove requirement.

I agree with removal of this requirement.

CommentID: **217573**

Commenter: Dana Wilkinson, PA-C 6/30/23 8:27 am

Agree

Barrier to patient care

CommentID: **217575**

Commenter: Stephanie Porter 6/30/23 8:27 am

remove the requirement for co-signature on scheduled prescriptions

I agree with the removal of this requirement.

CommentID: **217576**

Commenter: Spencer Pollok, PA-C 6/30/23 8:30 am

Agree to Amendment of 18VAC85-50-160(A)

I agree with the removal of this requirement.

CommentID: **217577**

Commenter: Colin Malcolm 6/30/23 8:31 am

Petition

Agree

CommentID: **217578**

Commenter: James Leake 6/30/23 8:31 am

PA Petition

I agree with the removal of this requirement

CommentID: **217579**

Commenter: mark watson 6/30/23 9:03 am

I agree with the removal of this requirement

I agree with the removal of this requirement

CommentID: **217583**

Commenter: Anonymous 6/30/23 9:20 am

Agree

I agree with the removal of this requirement.

CommentID: **217585**

Commenter: Brenna McCarty, NP 6/30/23 9:34 am

Agree with removal

Agree with removal

CommentID: **217587**

Commenter: Chamberlin 6/30/23 10:01 am

I agree

"I agree with the removal of this requirement."

CommentID: **217588**

Commenter: Tracey Watts, PMHNP; Centra Health 6/30/23 10:09 am

Delay in patient care

I agree with the removal of this requirement.

CommentID: **217589**

Commenter: Dr. Amy Johnson, DNP, FNP-C 6/30/23 11:35 am

PA Prescriptive Authority

I believe that this requirement should be removed.

CommentID: **217594**

Commenter: James Marcouillier 6/30/23 12:18 pm

I agree

I agree with the removal of this requirement.

CommentID: **217595**

Commenter: Stephanie Padilla, DMSc, PA-C 6/30/23 12:35 pm

I agree with the removal of this requirement

I agree with the removal of this requirement.

CommentID: **217596**

Commenter: Kendalyn Felts, DMSc, PA-C 6/30/23 12:58 pm

Agree

I agree

CommentID: **217598**

Commenter: Amber Balzer 6/30/23 1:31 pm

I agree with the removal of this requirement

I agree with the removal of this requirement

CommentID: **217599**

Commenter: Anonymous 6/30/23 3:10 pm

Remove requirement

I agree with the removal of this requirement.

CommentID: **217601**

Commenter: William Fluker PAc centra 6/30/23 3:40 pm

Pa scripts supervision

I agree with removal of this requirement

CommentID: **217605**

Commenter: Jordan Watkins PA-C 6/30/23 4:51 pm

agree

Agree with removal of requirement

CommentID: **217607**

Commenter: Dr. Michele Donoghue DEM, ENP-C, FNP-C, MSN, RNC 6/30/23 6:56 pm

Agree

Agree to proposed amendment

CommentID: **217609**

Commenter: Heather Goldston AGACNP-BC 6/30/23 11:13 pm

Agree with removal of requirement

This requirement should be removed.

CommentID: **217612**

Commenter: Alice Ann Howard, PA-C 7/1/23 9:14 am

Removal

I agree with the removal of the physicians name on prescriptions. It is needless and delays care for the patients. Physician assistants have their own DEA and their name alone ahe be in prescription

CommentID: **217614**

Commenter: Kristyn Rudisill, PA-C 7/1/23 9:55 am

Remove barrier to patient care and medication access

I support the removal of the requirement for physician information on controlled substance scripts for PAs. This restriction is a barrier to patient care and has led to limitations in patient access to medications and incorrect pharmacy restrictions on scripts that are not controlled substances, creating scenarios for risk of patient harm. The collaborating physician name/information provides no benefit on scripts, especially considering independent visits by the physician assistant in the first place.

CommentID: **217615**

Commenter: Kumar 7/1/23 1:20 pm

Agree with removal

Agree with removal

CommentID: **217616**

Commenter: Madison Mayle PA-S 7/1/23 4:07 pm

Agree

I agree with the removal of this requirement.

CommentID: **217619**

Commenter: Bradley Wagner 7/1/23 8:35 pm

Petition

I agree with the removal of this requirement to prevent delay in patient's care.

CommentID: **217621**

Commenter: Rebecca Snell 7/2/23 3:49 pm

Agree

Agree w removal

CommentID: **217623**

Commenter: Ryan M Cannon 7/2/23 7:53 pm

Petition to remove requirement patient care team physician's name on prescriptions

Agree to remove

CommentID: **217624**

Commenter: Timothy Johnson, MD 7/2/23 10:34 pm

Agree with removal

I agree with the removal of this requirement.

CommentID: **217629**

Commenter: Joshua Wilson PA-C 7/3/23 7:39 am

Outdated Requirement

This is an outdated policy which only serves to add red tape to a process. Our hospital system required the attending's name on every prescription, because they could not keep track of changes in which medications were controlled and which were not. We should be targeting this type of legislation for removal in an age where healthcare is having difficulty with hiring and retaining enough staff.

CommentID: **217630**

Commenter: Mike Petrikonis 7/3/23 9:41 am

Update Needed

I am writing to amend 18VAC85-50-160(A) to remove the requirement that a physician's name be included on any prescription for Schedule II-V drugs prescribed by a PA.

This requirement causes both delays in patients getting necessary medications and places undue burden on other members of the healthcare team, such as physicians. In a time where access to healthcare is challenging paired with a growing national physician shortage, we need to adjust how we deliver health care and requirements to fit the needs of our patients!

Thank you for your consideration!

CommentID: **217633**

Commenter: William Lombardi, DNP, AG-ACNP-BC 7/3/23 12:24 pm

Agree with requirement removal.

Agree with removing this requirement to increase patient access to treatment.

CommentID: **217637**

Commenter: Lauren Huck 7/3/23 12:31 pm

Remove physician name requirment

Agree with requirement removal

CommentID: **217638**

Commenter: Ruth Fogelgren 7/3/23 12:32 pm

Update required. Benefit of requiring MD name?

Benefit to pts?

CommentID: **217639**

Commenter: Christina Taylor, NP 7/3/23 12:32 pm

Agree

Agree with petition

CommentID: **217640**

Commenter: Kimberly Gahring 7/3/23 12:33 pm

Remove requirement

Agree to remove requirements

CommentID: **217641**

Commenter: Stephanie Good, DMSc, MPAS, PA-C 7/3/23 12:33 pm

Agree with removal

Agree with removal

CommentID: **217642**

Commenter: Tuyetanh Eichholz, PA-C 7/3/23 12:33 pm

Agree with removal

Agree with removal.

CommentID: **217643**

Commenter: Anonymous 7/3/23 12:36 pm

DEA

Agree with removal

CommentID: **217644**

Commenter: Alana Harrison, ARNP-BC 7/3/23 12:38 pm

Agree with removal of unnecessary requirement

The requirement for MD cosignature for prescriptions of this kind is out of step with current PA training and scope of practice. It creates another unnecessary hurdle in attempts to increase access to care, particularly for those who are already underserved.

CommentID: **217645**

Commenter: Katherine Shook 7/3/23 12:38 pm

Agree with Removal

Agree with Removal

CommentID: **217646**

Commenter: Caleb Booth PA-C 7/3/23 12:44 pm

Agree with requirement removal

Agree with requirement removal

CommentID: **217647**

Commenter: Emily Stubbs, UVA 7/3/23 12:45 pm

Remove requirement for physician name

Please consider removing this requirement and increasing access to care for all patients.

CommentID: **217649**

Commenter: Corrie Carter 7/3/23 12:46 pm

Update required. Agree with removal.

PAs are individual providers that work in multitudes of settings, many in operative, ICU, and surgical specialties. Requiring a co-signer for schedule II can delay patient care.

CommentID: **217650**

Commenter: Tammy Tedsen, MSN, APRN, ACNPC-AG 7/3/23 12:51 pm

Agreed with removal

Agree with proposal to remove requirement for MD name on PA prescriptions.

CommentID: **217651**

Commenter: Johnnie Carrico APRN FNP-BC 7/3/23 12:52 pm

Agree with removal of this requirement.

I agree with the removal of this requirement.

Having this requirement for signature can cause delay in patient care.

CommentID: **217652**

Commenter: Emily West 7/3/23 12:57 pm

I agree with removal of this requirement

Having the physician's name is confusing and unhelpful to the patient.

CommentID: **217653**

Commenter: Rachel Chai, PA-C (UVA) 7/3/23 12:57 pm

Agree with removing this requirement

PAs are nationally certified, licensed in the state of Virginia, and carry DEA licensure. The requirement to include a physician's name on prescriptions is outdated and unnecessary. It is well within the scope of practice of PAs to sign and order prescription medications without being required to include a physician's name. Removing this requirement is likely increase patient access to care.

CommentID: **217654**

Commenter: James Shorten M.S PA-C 7/3/23 1:03 pm

remove requirement

Agree with removing this requirement. It is outdated.

CommentID: **217655**

Commenter: Jenna Campo 7/3/23 1:05 pm

Petition

Agree with removing this requirement.

CommentID: **217656**

Commenter: Jessica Kassay-McAllister, DNP, UVA HEALTH 7/3/23 1:06 pm

Agree with removal

Agree with removing this requirement.

CommentID: **217657**

Commenter: Heather Passerini 7/3/23 1:38 pm

Petition to remove requirement to include patient care team physician's name on prescriptions for S

I agree with removing this requirement.

CommentID: **217659**

Commenter: GM Pugh, PA-C 7/3/23 1:39 pm

Agree with removal

I agree with removal

CommentID: **217660**

Commenter: Anonymous 7/3/23 1:56 pm

Agree with removal

Agree with removal

CommentID: **217661**

Commenter: Susan C. Herndon NP-C, AOCNP 7/3/23 2:30 pm

NP Supports Change in Regulation for PA Colleagues

As one of the thousands of practicing Nurse Practitioners in the Commonwealth with a DEA license, I am able to prescribe scheduled medications without the name of a collaborating physician included. I request my Physician's Associate colleagues (who also hold the same DEA license and similar collaborating practice agreements) be relieved of the extra and unnecessary burden the current regulation requires. Thank you.

CommentID: **217662**

Commenter: John G Rogers, Jr 7/3/23 2:57 pm

Agree with removal

As a patient, simplifying the prescription process, especially renewal authorization, would be greatly appreciated.

CommentID: **217663**

Commenter: Sarah Lepore, UVA Children's 7/3/23 4:42 pm

Agree with removal

Requiring a co-signer for schedule II can delay patient care.

CommentID: **217665**

Commenter: UVa 7/3/23 6:34 pm

removal of requirement

I agree with the removal of this requirement.

CommentID: **217666**

Commenter: Carolyn Driscoll PhD FNP-C 7/3/23 6:39 pm

Petition to remove requirement to include patient care team physician's name on prescriptions for S

Remove requirement to include patient care team physician's name on prescriptions for Schedule II-V drugs. This is unneccesary.

CommentID: **217668**

Commenter: Allison Kirkner, ACNP-BC; UVA Health 7/4/23 12:56 am

Agree with removal

Agree with removal of MD requirement for PA colleagues.

CommentID: **217671**

Commenter: Lara Myers 7/4/23 6:07 am

Agree with removal

Agree with removal of physicians' name on scheduled prescriptions

CommentID: **217675**

Commenter: Matthew Robertson, MSN, ACNP-BC 7/4/23 6:23 am

Petition to remove requirement to include patient care team physician's name on prescriptions

I am in support of the current petition to remove the requirement to include patient care team physician's name on prescriptions for Schedule II-V drugs. This requirement impedes the efficient care provided by physician associates, and it does not provide any proven benefit to the public.

CommentID: **217676**

Commenter: Kimberly Sapre, DMSc, PA-C, CAQ-EM, DFAAPA 7/4/23 8:32 am

Support proposed change

I speak in favor of the proposed regulatory change.

PAs are medical professionals with a DEA license allowing prescriptive authority for Schedule II-V medications. They follow standards of care and prescribe medications as indicated. The current regulation implies PAs require oversight for prescribing controlled medications. Our NP colleagues do not require this oversight, and PAs should also not require such oversight for prescriptions.

CommentID: **217679**

Commenter: Joelle Kidder, PA-C 7/4/23 11:03 am

Agree with the removal...it can be a barrier to care for the patients we serve.

The rule is an outdated one and needs to go.

CommentID: **217683**

Commenter: Anonymous 7/4/23 1:03 pm

Agree with removal

Agree with removal

CommentID: **217685**

Commenter: Xavier D Lennon 7/4/23 2:32 pm

PA's can write!

Yes please. No need include Physician Name on all Rx.

CommentID: **217686**

Commenter: Samuel Beishline, PA-C 7/5/23 7:47 am

Outdated Rule

Requiring a collaborating physicians name on a prescription is an obsolete requirement and need not be a rule.

CommentID: **217706**

Commenter: Anonymous 7/5/23 8:42 am

petition

Agree with removal.

CommentID: **217710**

Commenter: Pamela Tetro FNP-C, CDCES, PMHNP- candidate 7/5/23 10:09 am

Please remove/ unnecessary.

Agree w/ removal.

CommentID: **217717**

Commenter: Isabel Burgess, PA-C (UVA Health) 7/5/23 11:37 am

Agree with removal

Agree with removal

CommentID: **217724**

Commenter: Courtney A. Corboy, PA-C 7/5/23 11:38 am

Delays in Patient Care

The policy as written causes barriers to patient care. Specific examples that have affected my personal clinical practice include:

- Delay in patient discharge from hospital due to needing physician name on post surgical opiate prescription from hospital in-house pharmacy.
- Delay in patient receiving post surgical opiate prescription sent to patient's local pharmacy due to physician name requirement. Patient unable to get pain medication and returned to ED.

This policy causes inconvenience to providers and patients that can cause significant delays to patient care. The policy prevents PAs from practicing to their appropriate and full scope of practice. PAs are trained to practice within a collaborative healthcare team and are utilized to provide access to patient care. Allow PAs to do this by removing this requirement!

CommentID: **217725**

Commenter: Jacquelin Smith PA-C 7/5/23 12:39 pm

Agree with removal

Collaborating physicians do not review and authorize every single medication prior to or after prescribing. Thus, this is an obsolete rule that no longer applies.

CommentID: **217726**

Commenter: Bridget Moss 7/5/23 12:43 pm

prescription practices

Physician Assistants have thorough training and are competently able to prescribe any type of medication. Their practice should not be limited by this, or require co-signatures by another clinician. This is redundant, unnecessary, and wastes both clinicians and patients' time.

CommentID: **217728**

Commenter: Ayni A Sharif 7/5/23 12:47 pm

Petition to remove requirement to include patient care team physician's name on prescriptions for S

I agree with the removal of physician's name on prescriptions on the scheduled prescriptions.

CommentID: **217729**

Commenter: Denise Melissa Brooks PA-C 7/5/23 1:02 pm

Petition

I agree with removal.

CommentID: **217731**

Commenter: Francis James Kelleher, P.A.-C. 7/5/23 1:26 pm

Removal of team physician's name from prescriptions written by physician assistants

It is confusing for a patient to see the name of a provider on their prescription container other than the provider who actually prescribed the medication. It serves no useful purpose to have any other name on the prescription container. As a physician assistant since 1977, I can assure you that the current regulation only leads to confusion.

CommentID: **217732**

Commenter: Melody Irby, PA-C 7/5/23 2:46 pm

Support proposed removal of physician name for scheduled medication

I work in an underserved field of medicine. I currently have no local medical Director or physician care team. While this does not change my day to day operations, this could be a barrier to patient care if there were an issue with their prescriptions.

CommentID: **217737**

Commenter: Anonymous 7/5/23 3:11 pm

in support of this petition

1. PAs are trained medical professionals who practice team-based care and follow standards of care. They consult a physician(s) as indicated.

2. PAs have a DEA license, and should not require oversight by physicians to prescribe controlled medications.

3. Eliminating both regulations (physician review and signature) will allow PAs to practice at the top of their license and training, reduces unnecessary redundancies and therefore increases pt access.

4. Please remove these current regulation redundancies that impede access to care for patients within the commonwealth.

CommentID: **217739**

Commenter: Marie Thomas 7/5/23 3:13 pm

I agree with removal of this outdated rule

I agree with the removal of this.

CommentID: **217741**

Commenter: Jennifer Choffel, MSN, ACNPC-AG, PCCN, UVA Health 7/5/23 3:19 pm

Agree with removal

Agree with removal

CommentID: **217744**

Commenter: John B Gillum 7/5/23 3:37 pm

Provision to remove supervising physician on scheduled drug prescriptions

This really serves no purpose and I'm not sure why it's required.

CommentID: **217746**

Commenter: Kristin Cheatham, NNP UVA Hospital 7/5/23 4:56 pm

Requirement for a Physician's Name Should be Removed

PAs are trained medical professionals who practice team based care and follow standards of care. They consult a physician as indicated.

PAs have a DEA license and should not require oversight by physicians to prescribe controlled medications.

CommentID: **217748**

Commenter: Irum Ziauddin, DMSc, PA-C 7/5/23 5:27 pm

PA Practice

Agree with removal of barriers to practice

CommentID: **217750**

Commenter: UVa 7/5/23 5:38 pm

support for prescription authority

i support the proposal to remove the need to have supervising physician name on prescriptions for controlled substances prescribed by physician assistants

CommentID: **217751**

Commenter: Payal Kakadiya 7/5/23 5:54 pm

Agree with Removal

Agree with removal of physician's name

CommentID: **217753**

Commenter: Jennifer Herdman, FNP-BC 7/5/23 8:09 pm

Agree with removal

Agree with removal

CommentID: **217761**

Commenter: Anonymous 7/5/23 8:16 pm

agree with removal!

Agree with removal of requirement!

CommentID: **217762**

Commenter: Rejahn Rogers, NNP-BC 7/5/23 8:17 pm

practice expansion!

Agree with removal of requirement and APP practice expansion!

CommentID: **217763**

Commenter: Jamie Van Ness RN 7/5/23 10:05 pm

Agree with removal

Agree with removal

CommentID: **217765**

Commenter: Casey Howell, FNP-C 7/5/23 10:37 pm

Agree with removal, unnecessary

Agree with removal, unnecessary

CommentID: **217767**

Commenter: Casey Vinett AGPCNP-C 7/5/23 10:53 pm

Agree with removal

Agree with removal

CommentID: **217768**

Commenter: Ashlee L. 7/5/23 10:54 pm

I agree with removal

I agree with removal of having a physician's name on prescriptions submitted by a physician assistant.

CommentID: **217769**

Virginia Administrative Code
Title 18. Professional And Occupational Licensing
Agency 85. Board of Medicine
Chapter 50. Regulations Governing the Practice of Physician Assistants

Part V. Prescriptive Authority

18VAC85-50-160. Disclosure.

A. Each prescription for a Schedule II through V drug shall bear the name of the patient care team physician or podiatrist and of the physician assistant.

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

Statutory Authority
§54.1-2400 of the Code of Virginia.

Historical Notes
Derived from VR465-05-1 § 6.3, eff. February 1, 1989; amended, Virginia Register Volume 6, Issue 20, eff. August 1, 1990; Volume 8, Issue 12, eff. April 8, 1992; Volume 8, Issue 25, eff. October 8, 1992; Volume 10, Issue 9, eff. February 23, 1994; Volume 13, Issue 21, eff. August 6, 1997; Volume 32, Issue 7, eff. January 15, 2016; Volume 37, Issue 13, eff. March 16, 2021.

Agenda Item: Consideration of Petition for Rulemaking regarding change to collaboration and consultation requirements for physician assistants

Included in your agenda package:

- Petition for Rulemaking filed by Virginia Academy of Physician Assistants to amend 18VAC85-50-110(1) to change requirements for review by the patient care team physician or podiatrist to "provide appropriate consultation/collaboration for complex clinical cases and patient emergencies as noted in the written or electronic practice agreement for the patient evaluation process";

- Public comments filed on Town Hall during the public comment period;

- 18VAC85-50-110.

Staff note: Of the 29 public comments received, 28 were in support of the petition. One was mistakenly filed with this petition but meant to show support for the other petition for rulemaking regarding physician assistants. None were in opposition.

Action needed:

- Motion to either:
    - Take no action on the petition, clearly stating the reason; or
    - Accept the petition and initiate rulemaking.

COMMONWEALTH OF VIRGINIA
Board of Medicine

9960 Mayland Drive, Suite 300
Richmond, Virginia 23233-1463

(804) 367-4600 (Tel)
(804) 527-4426 (Fax)
Coco.Morton@dhp.virginia.gov

Petition for Rule-making

The Code of Virginia (§ 2.2-4007) and the Public Participation Guidelines of this board require a person who wishes to petition the board to develop a new regulation or amend an existing regulation to provide certain information. Within 14 days of receiving a valid petition, the board will notify the petitioner and send a notice to the Register of Regulations identifying the petitioner, the nature of the request and the plan for responding to the petition. Following publication of the petition in the Register, a 21-day comment period will begin to allow written comment on the petition. Within 90 days after the comment period, the board will issue a written decision on the petition. If the board has not met within that 90-day period, the decision will be issued no later than 14 days after it next meets.

Please provide the information requested below. (Print or Type)

Petitioner's full name (Last, First, Middle initial, Suffix,) Virginia Academy of PAs		
Street Address 250 W. Main Street, Suite 100	**Area Code and Telephone Number** (434) 906-1779	
City Charlottesville	**State** VA	**Zip Code** 22902
Email Address (optional) jonathan.williams@easterassociates.com	**Fax (optional)**	

Respond to the following questions:

1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.
   Regulations Governing the Practice of Physician Assistants
   Part IV. Practice Requirements
   18VAC85-50-110

2. Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule.

   We feel that the current requirements for review by a patient care team physician are inconsistent and unduly burdensome and propose the following revision to Part (1) to support a uniform policy for non-physician clinicians in the state. We believe this amendment strengthens the relationship of the Patient Care Team and the involvement of the collaboration physician.
   1. Provide appropriate consultation/collaboration for complex clinical cases and patient emergencies, as noted in the written or electronic practice agreement for the patient evaluation process.

3. State the legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by the board is found in § 54.1-2400 of the Code of Virginia. If there is <u>other</u> legal authority for promulgation of a regulation, please provide that Code reference.

   54.1-2400 and Chapter 29 of Title 54.1 of the Code of Virginia

Signature: Jonathan K. Williams **Date:** 5/12/23

VIRGINIA REGULATORY TOWN HALL

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Agency Department of Health Professions

Board Board of Medicine

Chapter Regulations Governing the Practice of Physician Assistants [18 VAC 85 - 50]

29 comments

All good comments for this forum **Show Only Flagged**

Back to List of Comments

Commenter: K Yoder, PA-C 6/5/23 3:38 pm

reduce burdens to medical practice

I support the petition to amend 18VAC85-50-110(1) as noted. Every practice situation is unique and appropriate consultation and collaboration standards as determined at the practice level will allow the medical team to practice with the highest efficiency and maximize the ability to care for the most patients.

CommentID: **217056**

Commenter: S. Widner 6/5/23 4:33 pm

Barriers

I petition to remove the language specifying that the patient care team physician review the clinical course and treatment plan by a patient care physician for a patient that presents for the same acute complaint twice in a single episode of care- I feel that as a PA if we have concerns as a provider regarding a patient case we would be willing to discuss with the supervising physician- but should not be a requirement to discuss all cases that fall into that category- can be cumbersome for the patient which can also lead to distrust from the patient regarding the PA.

CommentID: **217058**

Commenter: L. DeWitz PA-C 6/5/23 5:22 pm

Please amend 18VAC85-50-110(1)

Please amend 18VAC85-50-110(1) to not have specific verbiage requiring a physician be involved in patient care after presenting twice in a single episode of care. I work in psychiatry and patients frequently don't improve after 2 visits, especially when finding the medication that works for them. It does not benefit my patient to have them involved at this point in their care and would waste the valuable time of my collaborating psychiatrist. We are severely short-staffed in mental health and removing these barriers is essential to getting more patients seen. PAs are trained to ask our

collaborator for assistance when needed and PAs work as a part of a healthcare team. Please know that we will do as we are trained and remove these unnecessary barriers to patient care.
CommentID: **217060**

Commenter: Phillip Davis, MHA, MPAS, PA-C 6/5/23 9:19 pm

COMMENTS REGARDING PETITION TO CHANGE 18VAC85-50-110.

Each PA is required to have a written Practice Agreement with their team physician. My understanding is that unless the physician is directly involved in the patient's care, they are not liable for that patient's outcome.

As a physician assistant who is licensed by the Commonwealth of Virginia and credentialed to practice medicine, I understand my own limitations and in all cases ensure I have a practice agreement in place to protect patient safety and ensure I am practice within my scope of care. As a collaborating member of the healthcare team, each PA has the responsibility and accountability to the patient.

If a patient fails to improve as expected, it is incumbent upon the PA (or any health practitioner for that matter) to ensure the patient is referred in a timely matter. I have issues with "fails to improve as expected". Who determines "improve as expected". PAs and all medical professionals have a duty to the patient and this petition to change the wording in 18VAC85-50-110 will in no way affect patient outcomes and will ensure physicians are available for complex cases.

I would reiterate that PAs are licensed medical professionals who by training and education are aware, as should any provider, of their scope of practice and limitations. In my mind, the *Practice Agreement* should determine the conditions for which a patient is re-evaluated.

To provide the best and safest possible care, PAs are trained and educated to practice within their scope of practice and in accordance with their *Practice Agreement. Standard of Care* does not change regardless of the level of care and it is incumbent upon each practitioner to ensure they are meeting the standard of care.

Changing the wording to remove ambiguity will serve to ensure PAs continue to practice within their scope of care and ensure the standard of care is provided to provide the best possible outcomes for patients entrusted to their care.

CommentID: **217062**

Commenter: E Waller DMSc, PA-C 6/6/23 11:20 am

Agree with Change

I agree that the phrasing of 18VAC85-50-110(1) should be changed as stated. This change is more in line with the nature of the supervising physician- PA relationship. This relationship is built on collaboration and trust. The new phrasing strengthens that trust. It says to the PA, "I trust that you will collaborate when necessary, on any patient, whether the patient is presenting for the first or the third time."

CommentID: **217064**

Commenter: Gerald Weniger, PhD, PA-C 6/12/23 11:35 am

Support

PAs are required to have an established practice agreement with their collaborating physician. Therefore, their scope of practice is clear, and they should be aware of their own limitations (just as physicians are). If a patient fails to improve as expected, it should be the responsibility of the PA to assess the situation and change treatment, speak with the collaborating physician, and/or refer. Just because a patient returns for follow-up does not mean that something was done wrong initially, nor does it mean that the situation is complex. To mandate via law that a patient be seen just because they returned does not make much sense.

CommentID: **217189**

Commenter: Kathleen Scarbalis PA-C

6/15/23 12:02 pm

Support regulatory change

I support the proposed regulatory change to language regarding physician/PA appropriate consultation rather than require review after the same complaint twice for the following reasons:

- PAs provide professional, team-based medical care. When a consultation or referral is needed, it will be sought. As a team member, the PA will assess the patient and provide the best care, including consultation as needed. The second visit rule is too restrictive.
- PAs have practice agreements. The practice level agreement is discussed with the PA/physician. Both providers have an understanding of the consultation process and when it is needed for that practice setting.
- There are many patients that may require an expected second visit with the same complaint. I work in pediatrics. I do not often prescribe medication for the initial visit runny nose and cough and recommend follow up-for the 'same acute complaint' if there is not improvement. Then the patient returns with the same complaint in three weeks. Do I need to have this case reviewed by a physician when seeing this patient? Right now, by regulation, I do. Is this a waste of time and resources for the physician? Absolutely! Does this patient truly need to be seen by a physician? Not likely, but if I thought they did, I would for best patient care.

CommentID: **217265**

Commenter: Robert A. Glasgow IV, PA-C, MPAS, MPH

6/19/23 10:22 pm

Support Regulatory Change to 18VAC85-50-110

I speak in favor of the proposed regulatory change.

PAs are medical professionals and have a long history of providing team-based health care. The current language implies that a PA would not seek out consultation when a patient fails to improve. Being trained in the medical model, a PA would of course seek out consultation when indicated, as would any other clinician who follows the standard of care.

CommentID: **217318**

Commenter: Sara Nicely

6/22/23 2:15 pm

Support change

I support the amendment to 18VAC 85-50-110. PAs are trained to provide team-based care and to recognize their limitations within their scope of practice. The nature of collaborative team practice is to determine when the needs of a patient exceed the knowledge and skillset of a provider and to seek further opinion. This could occur on an initial visit with a patient or at a later follow-up. The prescribed content of the current legislative language is not reflective of patient needs. For

example, significant improvement in a patient's condition may not be expected and continued care on subsequent follow-up by a PA may not be out of line with the training and scope of the PA. A dictated determination for follow-up with a physician could be appropriately determined at the practice level to meet the practice and patient needs, but it should not be dictated at a legislative level.
CommentID: **217422**

Commenter: Dara Wotherspoon, PA-C 6/25/23 11:32 am

Support Change

I support the change in this regulation. In the event, that patient was not improving it would be standard of care to consult the collaborating team, whether that was your direct collaborating physician or perhaps a specialists who is also caring for the patient.

CommentID: **217438**

Commenter: Monica Cooper, PA 6/28/23 2:35 pm

Barrier to care

This would help remove barrier to care, especially in more rural settings where providers are limited and work load heavy.

CommentID: **217497**

Commenter: Meredith Dhillon PA-C 6/28/23 2:44 pm

I support this change

I support removing this barrier to patient care and allowing more time spent with patient care.

CommentID: **217499**

Commenter: Christopher Allen 6/28/23 7:09 pm

Support change

I support the amendment to 18VAC 85-50-110. PAs are trained to provide collaborative team-based care within their scope of practice. The foundations of a collaborative practice is to determie when the needs of a patient exceed the knowledge and skillset of a provider and to seek further opinion. This could occur on an initial visit with a patient or at a later follow-up. The prescribed content of the current legislative language is not reflective of patient needs. For example, significant improvement in a patient's condition may not be expected and continued care on subsequent follow-up by a PA may not be out of line with the training and scope of the PA. A dictated determination for follow-up with a physician could be appropriately determined at the practice level to meet the practice and patient needs, but it should not be dictated at a legislative level.

CommentID: **217511**

Commenter: Jenna Rolfs, DMSc, PA-C 6/28/23 7:30 pm

Support the Change

I support the amendment to 18VAC 85-50-110.

CommentID: **217513**

Commenter: Rebecca Agbayani, PA-C 6/28/23 9:36 pm

Agree

I support the proposed amendment of 18VAC85-50-110(1) to better reflect the collaborative nature of physicians and PA's working at the top of their licenses to provide access to quality care for patients. The new phrasing reinforces the trust between and imperative upon all medical providers to recognize their knowledge and limitations, and to collaborate/refer/seek consultation when it would benefit the patient, regardless of when in the course of treatment that is.

CommentID: **217521**

Commenter: Anonymous 6/28/23 9:59 pm

Agree

Agree

CommentID: **217523**

Commenter: Evan Turnbull, MPAS, PA-C, UVA Health 6/28/23 10:20 pm

Support proposed amendments

I agree with the proposed amendment as written, and I second the opinions of my colleagues below. Additionally, I am in favor of removing unnecessarily restrictive language like what we have now that hinders patient care and access to care, language that shows a profound misunderstanding of the training of a PA and the patient care delivered by a PA, a profound misunderstanding of the dynamic PA-MD collaborative relationship, and poorly worded language with legal bias. As written, a prosecuting attorney is handed a clear and objective timetable of two visits to pin against a medical team, yet leaves the medical team with vague and subjective language to try and interpret in every patient encounter. A PA could also misinterpret the two visit rule and delay appropriate consultation on the first visit believing the standard of care only requires escalation of care if needed after a second visit. I would argue that standard of care for PAs is a national requirement of practice since a PA's training is nationally accredited, and nationally certified by one certification body. The definition of two visits with a patient regardless of circumstance, chief complaint and practice setting is not standard of care. What IS standard of care, as my colleagues have already mentioned, is that the PA would use his or her clinical judgement to determine when care needs to be brought to a physician, or a referral to a specialist made, at ANY point in the management of that patient, regardless of which visit it is. Thank you.

CommentID: **217524**

Commenter: Kelly Botta, PA-C, MSPAS 6/28/23 10:56 pm

Agree with proposed change

Agree to strike the specific 2 visit from legal documents. It is impossible to legislate when care should be collaborative. The detail of 1, 2, 10 etc is antiquated and the number of visits is irrelevant to providing appropriate, safe patient care. This should be determined by the collaborating physician and PA and will vary widely among experience and speciality. Recommend this be an advisory comment for physician-PAs to consider during hiring and collaborative agreement formation, but not included in regulatory statutes.

CommentID: **217526**

Commenter: Jeremy Welsh, DHSc, JD, PA-C 6/29/23 7:21 am

Agree with proposed change

Agree

CommentID: **217532**

Commenter: Christina Perry DHSc., PA-C 6/29/23 9:02 am

Agree with the proposed change

PA's are trained to understand their abilities and limits. We practice team-based care and always seek consultation when necessary. This regulation puts unnecessary red tape on patient care, and increases administrative burden unnecessarily. I fully support the proposed change

CommentID: **217541**

Commenter: Madison Mayle PA-S 7/1/23 4:09 pm

Support

I support this proposed change.

CommentID: **217620**

Commenter: Ryan M Cannon 7/2/23 7:55 pm

collaboration and consultation with physician assistants

Agree to proposed change

CommentID: **217625**

Commenter: Kimberly Sapre, DMSc, PA-C, CAQ-EM, DFAAPA 7/4/23 8:24 am

Support proposed change

I speak in favor of the proposed regulatory change.

PAs are trained in the medical model and are adept at providing team-based health care. PAs follow the standards of care and will consult with a collaborating physician when needed. The current regulation implies that practicing PAs would not seek consultation, and the language should be removed.

CommentID: **217678**

Commenter: Ayni A Sharif 7/5/23 12:55 pm

Regulations Governing the Practice of Physician Assistants [18 VAC 85 ? 50]

Agree with the proposed change.

CommentID: **217730**

Commenter: Sally Ann Miller 7/5/23 3:14 pm

in support of this petition

1. PAs are trained medical professionals who practice team-based care and follow standards of care. They consult a physician(s) as indicated.

2. PAs have a DEA license, and should not require oversight by physicians to prescribe controlled medications.

3. Eliminating both regulations (physician review and signature) will allow PAs to practice at the top of their license and training, reduces unnecessary redundancies and therefore increases pt access.

4. Please remove the current regulation redundancies that impede access to care for patients within the commonwealth.

CommentID: **217742**

Commenter: Rachel Chai, PA-C (UVA) 7/5/23 3:17 pm

Agree with the proposed change

I agree with the proposed change. PAs are nationally certified, licensed providers in the state of Virginia and this rule is a barrier to care for patients and undermines PAs ability to practice medicine at the top of their scope and license.

CommentID: **217743**

Commenter: Tuyetanh Eichholz, PA-C 7/5/23 3:30 pm

Agree with proposed change

PAs are trained medical professionals and consult with physicians when indicated. By removing both regulations, it would lead more access to patient care.

CommentID: **217745**

Commenter: UVa 7/5/23 5:40 pm

support for prescription authority

I support the proposal to remove the need to have supervising physician name on prescriptions for controlled substances prescribed by physician assistants.

CommentID: **217752**

Commenter: Anonymous

7/5/23 11:06 pm

Agree

I agree with the proposal. Let PAs practice according to their training! The most dangerous person in medicine is someone who doesn't know what they don't know- this is regardless of the degree or letters behind your name. The expectation is that anyone practicing in the medical field will be responsible enough to consult when necessary. Kept how it is the law hinder access to medical care for patients and causes further confusion & divide between MDs, DOs, PAs, and NPs.

CommentID: **217770**

Virginia Administrative Code
Title 18. Professional And Occupational Licensing
Agency 85. Board of Medicine
Chapter 50. Regulations Governing the Practice of Physician Assistants

Part IV. Practice Requirements

18VAC85-50-110. Responsibilities of the patient care team physician or podiatrist.

A patient care team physician or podiatrist shall:

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

2. Be available at all times to collaborate and consult with the physician assistant.

Statutory Authority
§54.1-2400 of the Code of Virginia.

Historical Notes
Derived from VR465-05-1 § 4.1, eff. February 1, 1989; amended, Virginia Register Volume 6, Issue 20, eff. August 1, 1990; Volume 8, Issue 12, eff. April 8, 1992; Volume 8, Issue 25, eff. October 8, 1992; Volume 10, Issue 9, eff. February 23, 1994; Volume 13, Issue 21, eff. August 6, 1997; Volume 19, Issue 18, eff. June 18, 2003; Volume 29, Issue 20, eff. July 3, 2013; Volume 33, Issue 1, eff. October 5, 2016; Volume 33, Issue 19, eff. June 29, 2017; Volume 34, Issue 25, eff. September 20, 2018; Volume 37, Issue 13, eff. March 16, 2021; Volume 37, Issue 26, eff. September 15, 2021.

Agenda Item: Adoption of revised policy on meetings held with electronic participation pursuant to statutory changes

Included in your agenda package:

- Proposed revised electronic participation policy;
- Virginia Code § 2.2-3708.3

Action needed:

- Motion to revise policy on meetings held with electronic participation as presented.

Virginia Department of Health Professions

Meetings Held with Electronic Participation

Purpose:

To establish a written policy for allowing electronic participation of board or committee members for meetings of the health regulatory boards of the Department of Health Professions or their committees.

Policy:

Electronic participation by members of the health regulatory boards of the Department of Health Professions or their committees shall be in accordance with the procedures outlined in this policy.

Authority:

This policy for conducting a meeting with electronic participation shall be in accordance with Virginia Code § 2.2-3708.3.

Procedures:

1. One or more members of the Board or a committee may participate electronically if, on or before the day of a meeting, the member notifies the chair and the executive director that he/she is unable to attend the meeting due to:

    a. a temporary or permanent disability or other medical condition that prevents the member's physical attendance;

    b. a medical condition of a member of the member's family requires the member to provide care that prevents the member's physical attendance;

    c. the member's principal residence is more than 60 miles from the meeting location identified in the required notice for such meeting; or

    d. the member is unable to attend to the meeting due to a personal matter and identifies with specificity the nature of the personal matter.

    No member, however, may use remote participation due to personal matters more than two meetings per calendar year or 25% of the meetings held per calendar year rounded up to the next whole number, whichever is greater.

2. Participation by a member through electronic communication means must be approved by the board chair or president. The reason for the member's electronic participation shall

be stated in the minutes in accordance with Virginia Code § 2.2-3708.3(A)(4). If a member's participation from a remote location is disapproved because it would violate this policy, it must be recorded in the minutes with specificity.

3. The board or committee holding the meeting shall record in its minutes the remote location from which the member participated; the remote location, however, does not need to be open to the public and may be identified by a general description.

Code of Virginia
Title 2.2. Administration of Government
Subtitle II. Administration of State Government
Part B. Transaction of Public Business
Chapter 37. Virginia Freedom of Information Act

§ 2.2-3708.3. (Effective September 1, 2022) Meetings held through electronic communication means; situations other than declared states of emergency

A. Public bodies are encouraged to (i) provide public access, both in person and through electronic communication means, to public meetings and (ii) provide avenues for public comment at public meetings when public comment is customarily received, which may include public comments made in person or by electronic communication means or other methods.

B. Individual members of a public body may use remote participation instead of attending a public meeting in person if, in advance of the public meeting, the public body has adopted a policy as described in subsection D and the member notifies the public body chair that:

1. The member has a temporary or permanent disability or other medical condition that prevents the member's physical attendance;

2. A medical condition of a member of the member's family requires the member to provide care that prevents the member's physical attendance;

3. The member's principal residence is more than 60 miles from the meeting location identified in the required notice for such meeting; or

4. The member is unable to attend the meeting due to a personal matter and identifies with specificity the nature of the personal matter. However, the member may not use remote participation due to personal matters more than two meetings per calendar year or 25 percent of the meetings held per calendar year rounded up to the next whole number, whichever is greater.

If participation by a member through electronic communication means is approved pursuant to this subsection, the public body holding the meeting shall record in its minutes the remote location from which the member participated; however, the remote location need not be open to the public and may be identified in the minutes by a general description. If participation is approved pursuant to subdivision 1 or 2, the public body shall also include in its minutes the fact that the member participated through electronic communication means due to a (i) temporary or permanent disability or other medical condition that prevented the member's physical attendance or (ii) family member's medical condition that required the member to provide care for such family member, thereby preventing the member's physical attendance. If participation is approved pursuant to subdivision 3, the public body shall also include in its minutes the fact that the member participated through electronic communication means due to the distance between the member's principal residence and the meeting location. If participation is approved pursuant to subdivision 4, the public body shall also include in its minutes the specific nature of the personal matter cited by the member.

If a member's participation from a remote location pursuant to this subsection is disapproved because such participation would violate the policy adopted pursuant to subsection D, such

disapproval shall be recorded in the minutes with specificity.

C. With the exception of local governing bodies, local school boards, planning commissions, architectural review boards, zoning appeals boards, and boards with the authority to deny, revoke, or suspend a professional or occupational license, any public body may hold all-virtual public meetings, provided that the public body follows the other requirements in this chapter for meetings, the public body has adopted a policy as described in subsection D, and:

1. An indication of whether the meeting will be an in-person or all-virtual public meeting is included in the required meeting notice along with a statement notifying the public that the method by which a public body chooses to meet shall not be changed unless the public body provides a new meeting notice in accordance with the provisions of § 2.2-3707;

2. Public access to the all-virtual public meeting is provided via electronic communication means;

3. The electronic communication means used allows the public to hear all members of the public body participating in the all-virtual public meeting and, when audio-visual technology is available, to see the members of the public body as well;

4. A phone number or other live contact information is provided to alert the public body if the audio or video transmission of the meeting provided by the public body fails, the public body monitors such designated means of communication during the meeting, and the public body takes a recess until public access is restored if the transmission fails for the public;

5. A copy of the proposed agenda and all agenda packets and, unless exempt, all materials furnished to members of a public body for a meeting is made available to the public in electronic format at the same time that such materials are provided to members of the public body;

6. The public is afforded the opportunity to comment through electronic means, including by way of written comments, at those public meetings when public comment is customarily received;

7. No more than two members of the public body are together in any one remote location unless that remote location is open to the public to physically access it;

8. If a closed session is held during an all-virtual public meeting, transmission of the meeting to the public resumes before the public body votes to certify the closed meeting as required by subsection D of § 2.2-3712;

9. The public body does not convene an all-virtual public meeting (i) more than two times per calendar year or 25 percent of the meetings held per calendar year rounded up to the next whole number, whichever is greater, or (ii) consecutively with another all-virtual public meeting; and

10. Minutes of all-virtual public meetings held by electronic communication means are taken as required by § 2.2-3707 and include the fact that the meeting was held by electronic communication means and the type of electronic communication means by which the meeting was held. If a member's participation from a remote location pursuant to this subsection is disapproved because such participation would violate the policy adopted pursuant to subsection D, such disapproval shall be recorded in the minutes with specificity.

D. Before a public body uses all-virtual public meetings as described in subsection C or allows members to use remote participation as described in subsection B, the public body shall first

adopt a policy, by recorded vote at a public meeting, that shall be applied strictly and uniformly, without exception, to the entire membership and without regard to the identity of the member requesting remote participation or the matters that will be considered or voted on at the meeting. The policy shall:

1. Describe the circumstances under which an all-virtual public meeting and remote participation will be allowed and the process the public body will use for making requests to use remote participation, approving or denying such requests, and creating a record of such requests; and

2. Fix the number of times remote participation for personal matters or all-virtual public meetings can be used per calendar year, not to exceed the limitations set forth in subdivisions B 4 and C 9.

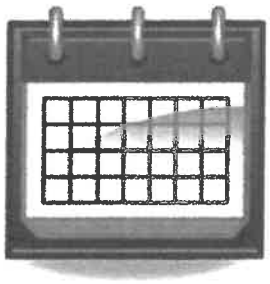
Any public body that creates a committee, subcommittee, or other entity however designated of the public body to perform delegated functions of the public body or to advise the public body may also adopt a policy on behalf of its committee, subcommittee, or other entity that shall apply to the committee, subcommittee, or other entity's use of individual remote participation and all-virtual public meetings.

2022, c. 597.

The chapters of the acts of assembly referenced in the historical citation at the end of this section(s) may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

Next Meeting Date of the Executive Committee is

December 1



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 and be aware that it may not be approved.

In order for the agency to be in compliance with the travel regulations, please submit your request for today's meeting no later than

September 3, 2023