Legislative Committee Meeting

Virginia Board of Medicine

May 17, 2019

8:30 a.m.

Legislative Committee

Virginia Board of Medicine
Friday, May 17, 2019, 8:30 a.m.
9960 Mayland Drive, Suite 200
Board Room 4
Henrico, VA 23233

Page

Call to Order – Ray Tuck, DC, Chair

Roll Call

Egress Instructions.....i

Approval of Minutes of September 7, 2018 1-15

Adoption of Agenda

Public Comment on Agenda Items (15 minutes)

DHP Director Report..... -----

Executive Director Report ..... -----

New Business

1. Regulatory/Policy Actions from the 2019 General Assembly..... 16
2. Chart of Regulatory Actions 45
3. Response to Petition for Rulemaking 46
4. Letter regarding opioid regulations impact on patient care 51
5. Reminder 122

Announcements

Next Meeting: September 6, 2019

Adjournment

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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VIRGINIA BOARD OF MEDICINE
LEGISLATIVE COMMITTEE MINUTES

Friday, September 7, 2018 Department of Health Professions Henrico, VA

Public Hearing – Proposed Amendments to Regulations – Licensed Midwives and Physician Assistants

Dr. Tuck opened the public hearing at 8:39 a.m., and announced that there were no speakers signed up to comment on the proposed amendments to the regulations. He then asked the public attendees if anyone wanted to comment.

There being no public comment, the floor closed at 8:40 a.m.

CALL TO ORDER: The meeting of the Legislative Committee convened at 8:41 a.m.

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

MEMBERS PRESENT:
Ray Tuck, DC, Vice-President, Chair
David Giammittorio, MD
Karen Ransone, MD
David Taminger, MD
Svinder Toor, MD

MEMBERS ABSENT:
Alvin Edwards, PhD
Jane Hickey, JD

STAFF PRESENT:
Jennifer Deschenes, JD, Deputy Director, Discipline
Barbara Matusiak, MD, Medical Review Coordinator
Colanthia Morton Opher, Deputy Director, Administration
Barbara Allison-Bryan, MD, DHP, Chief Deputy
Lisa Hahn, DHP, Chief Operating Officer
Elaine Yeatts, DHP Senior Policy Analyst
Erin Barrett, JD, Assistant Attorney General
Cheryl Clay, Administrative Assistant

OTHERS PRESENT:
A. Rose Rutherford, VAPA, President
Jeremy Welsh, VAPA, President-Elect
Sara Heisler, VHHA
Richard Grossman, Vectre
Lindsay Walton, Macaulay & Jamerson
Tyler Cox, HDJ

EMERGENCY EGRESS INSTRUCTIONS

Dr. Taminger provided the emergency egress instructions.

APPROVAL OF MINUTES OF JANUARY 19, 2018

Dr. Ransone moved to approve the meeting minutes of January 19, 2018 as presented. The motion was seconded and carried unanimously.

ADOPTION OF AGENDA

Dr. Toor moved to accept the agenda as presented. The motion was seconded and carried unanimously.

PUBLIC COMMENT

There was no public comment

DHP DIRECTOR'S REPORT

Dr. Allison-Bryan, MD, Chief Deputy provided a preview of her presentation on emergency licensure in times of crisis she will give at the 38th Annual CLEAR conference later this month. She explained that CLEAR is similar to FSMB in that it gathers regulators from all over the world to discuss among other things, administration, legislation and policy.

EXECUTIVE DIRECTOR'S REPORT

No report.

NEW BUSINESS

1. **Review of Guidance Documents**

Ms. Yeatts reviewed with the Committee the guidance documents that had not been reviewed, revised, or readopted in the past four years. She advised that a preliminary review has been conducted by staff and the following recommendations are being made:

85-2, Assistant Attorney General Opinion of October 25, 1986 on who can do a school physical examination – staff recommends retention

85-6, Guidance on competency assessments for three paid claims revised July 2, 2012 – staff recommends reaffirmation

85-8, Authority for physician assistants to write Do Not Resuscitate Orders,

adopted February 23, 2012 – staff recommends reaffirmation

85-9, Policy on USMLE Step attempts, adopted October 24, 2013 - staff recommends reaffirmation

85-11, Sanctioning Reference Points Instruction Manual, revised by Board, August 2011 – this document is due for review by VisualResearch, Inc.

85-12, Telemedicine, revised June 22, 2017- staff makes the following recommendations for the purpose of clarity to footnote 3:

Although the term "store-and-forward technologies" is not defined by statue, it is defined by regulation of the Virginia Department of Health for the purpose of Medicare and Medicaid covered services, as: "store and forward" means when prerecorded images, such as x-rays, video clips, and photographs are captured and then forwarded to and retrieved, viewed and assessed by a provider at a later time. Some common applications include (i) teledermatology, where digital pictures of a skin problem are transmitted and assessed by a dermatologist (ii) teleradiology, where x-ray images are sent to and read by a radiologist; and (iii) teleretinal imaging, where images are sent to and evaluated by an ophthalmologist to assess for diabetic retinopathy." 12VAC 30-121-70(7)(a).

85-13, Guidelines on Performing Procedures on the Newly Deceased for Training Purposes – Adopted January 22, 2004 - staff makes the following recommendations:

Section 54.1-2961 of the Code of Virginia provides:

The Board of Medicine shall adopt guidelines concerning the ethical practice of physicians practicing in emergency rooms, surgeons, and interns and residents practicing in hospitals, particularly hospital emergency rooms, or other organizations operating graduate medical education programs. These guidelines should not be construed to be or to establish standards of care or to be regulations and shall be exempt from the requirements of the Administrative Process Act (§2.2-400 et seq.). The Medical College of Virginia of Virginia Commonwealth University, and the Virginia School of Medicine, the Eastern Virginia Medical School and the Medical Society of Virginia, and the Virginia Hospital and Health Care Association shall cooperate with the Board in the development of these guidelines.

The guidelines shall include, but need not be limited to (i) the obtaining of informed consent from all patients or from the next of kin or legally authorized representative, to the extent practical under the circumstances in which medical care is being rendered, when the patient is incapable of making an informed decision, after such patients or other persons have been informed as to which physicians, residents, or interns will perform the surgery or other invasive procedure (ii) except in emergencies and other unavoidable situations, the need, consistent with the informed consent, for an attending physician to be present during the surgery or other invasive procedure; (iii) policies to avoid situations ,unless the circumstances fall within an exception in the Board's guidelines or the policies of the relevant hospital, medical school or other organization operating the graduate medical education

program, in which at surgeon, intern or resident represents that he will perform a surgery or other invasive procedure that he then fails to perform; and (iv) policies addressing informed consent and the ethics of appropriate care of patients in emergency rooms. Such policies shall take into consideration the nonbinding ban developed by the American Medical Association in 2000 on using newly dead patients as training subjects without the consent of the next of kin or other legal representative to extend practical under the circumstances in which medical care is being rendered.

85-15 Guidelines Concerning the Ethical Practice of Attending Physicians and Fellows, Residents and Interns – Adopted January 22, 2004 - staff recommend changing the word "must" to "should" since must implies that the document is enforceable.

85-16 Questions and Answers on Continuing Competency Requirements for the Virginia Board of Medicine - staff recommends the following amendments:

4. Who maintains the required documents for verification of continuing competency? Hours?

It is the practitioner's responsibility to maintain the certificates and any other continuing competency forms or records for six years following renewal ~~in 2002 and thereafter~~. Do not send any forms or documents to the Board of Medicine unless requested to do so.

5. What are "Type 1" hours?

Type 1 hours (at least 30 each biennium) are those that can be documented by an accredited sponsor or organization sanctioned by the profession. If the sponsoring organization does not award a participant with a dated certificate indicating the activity or course taken and the number of hours earned, the practitioner is responsible for obtaining a letter on organizational letterhead verifying the hours and activity. All 60 continuing competency hours each biennium may be Type 1 hours.

14. Are there any specific topics included in the biennial requirement of 60 hours of CE?

If you perform or supervise anesthesia in your practice, you must obtain four hours of Type 1 CE in anesthesia topics each biennium.

The Code of Virginia also requires certain prescribers identified by the Director of the Department of Health Professions to complete two hours of Type 1 continuing education in each biennium on topics related to pain management, the responsible prescribing of covered substances, and the diagnosis and management of addiction. Prescribers who are required to complete such continuing education for the coming biennium are notified no later than January 1 of each odd-numbered year.

85-18 Practitioners' Help Section – Definitions and explanations for terminology used in Practitioner Profile System and Frequently Asked Questions, revised November 22, 2010 – staff recommends this document be repealed.

85-19 Practitioner Information System – Glossary of Terms, revised November 22, 2010 – staff recommends reaffirmation

85-20 1992 Opinion of the AG on the Corporate Practice of Medicine – staff recommends this document be retained. Some concern was expressed about the length of the document and that most practitioners may read just the last paragraph. Ms. Deschenes explained that these documents are mostly read by the attorney not the practitioners, and that the Attorney General's opinion carries more weight that the Board's guidance documents.

85-21 Official Opinion of the Attorney General May 1995: Employment of physician by a for profit corporation - staff recommends this document be retained.

85-23 Board policy on the use of confidential consent agreements, adopted 10/9/03 – staff recommended the following revisions -

Policy of the Virginia Board of Medicine on
the Use of Confidential Consent Agreements

Section 54.1-2400(14)

Pursuant to the provisions of Section 54.1-2400(14), the Board of Medicine may enter into a confidential consent agreement with a practitioner only in cases involving minor misconduct where there is little or no injury to a patient or the public and little likelihood of repetition by the practitioner. The board cannot enter into a confidential consent agreement if there is probable cause to believe the practitioner has (i) demonstrated gross negligence or intentional misconduct in the care of patients or (ii) conducted his practice in such a manner as to be a danger to the health and welfare of his patients or the public.

The determination as to the appropriateness of a confidential consent agreement shall be ~~delegated to the President, or another board member designated by the President, at the~~ made by the Board and/or Board staff at the probable cause stage through a review and recommendation by the Executive Director or Medical Review Coordinator. ~~For any case identified by the President for resolution by a confidential consent agreement, "appropriateness" includes determining any violation or terms, and authorizing entry on behalf of the Board.~~ The types of cases that may be subject to the use of a confidential consent agreement will include, but are not limited to, the following:

- Failure to complete required hours of continuing education
- Failure to complete the physician profile
- Advertising

85-24 Guidance on the Use of Opioid Analgesics in the Treatment of Chronic Pain, revised October 24, 2013 - staff recommends this document be repealed.

85-25 Process for delegation of informal fact-finding to an agency subordinate - staff recommends this document be repealed.

85-26 Guidance Document on Compliance with Law for Licensed Midwives, revised June 20, 2013 – recommendation: have the Midwifery Advisory Board review and recommend to the Full Board revisions or repeal

85-27 Role of Licensed Midwives in Newborn Hearing Screening, Documentation, and Reporting, revised June 20, 2013 - have the Midwifery Advisory Board review and recommend to the Full Board revisions or repeal

85-28 Authority of Licensed Midwives to Order Tests, revised October 26, 2017 - have the Midwifery Advisory Board review and recommend to the Full Board revisions or repeal

MOTION: After a brief discussion, Dr. Toor moved to approve all the recommendations en bloc. The motion was seconded by Dr. Ransone and carried unanimously.

2. **Periodic review of regulations**

Elaine Yeatts advised the Committee that Dr. Harp and Ms. Deschenes had reviewed Chapters 15 and 20 and recommend that both chapters be retained with no amendments to Chapter 15 and only edits and clarifications for Chapter 20.

18VAC85-20-26. Patient records.

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

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

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

D. Practitioners shall maintain a patient record for a minimum of six years following the last patient encounter with the following exceptions:

1. Records of a minor child, including immunizations, shall be maintained until the child reaches the age of 18 or becomes emancipated, with a minimum time for record retention of six years from the last patient encounter regardless of the age of the child; or

2. Records that have previously been transferred to another practitioner or health care provider or provided to the patient or his personal representative; or

3. Records that are required by contractual obligation or federal law to be maintained for a longer period of time.

E. ~~From October 19, 2005, practitioners~~ Practitioners shall post information or in some manner inform all patients concerning the time frame for record retention and destruction. Patient records shall only be destroyed in a manner that protects patient confidentiality, such as by incineration or shredding.

F. When a practitioner is closing, selling or relocating his practice, he shall meet the requirements of § 54.1-2405 of the Code of Virginia for giving notice that copies of records can be sent to any like-regulated provider of the patient's choice or provided to the patient.

18VAC85-20-29. Practitioner responsibility.

A. A practitioner shall not:

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

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

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

B. Advocating for patient safety or improvement in patient care within a health care entity shall not constitute disruptive behavior provided the practitioner does not engage in behavior prohibited in A 2 of this section.

18VAC85-20-90. Pharmacotherapy for weight loss.

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

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

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

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

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

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

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

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

18VAC85-20-121. Educational requirements: Graduates of approved institutions.

A. Such an applicant shall be a graduate of an institution that meets the criteria appropriate to the profession in which he seeks to be licensed, which are as follows:

1. For licensure in medicine. The institution shall be approved or accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association, or by the Committee for the Accreditation of Canadian Medical Schools or its appropriate subsidiary agencies or any other organization approved by the board.

2. For licensure in osteopathic medicine. The institution shall be approved or accredited by the ~~Bureau of Professional Education of the~~ American Osteopathic Association Committee on Osteopathic College Accreditation or any other organization approved by the board.

3. For licensure in podiatry. The institution shall be approved and recommended by the Council on Podiatric Medical Education of the American Podiatric Medical Association or any other organization approved by the board.

B. Such an applicant for licensure in medicine, osteopathic medicine, or podiatry shall provide evidence of having completed 12 months of satisfactory postgraduate training as an intern or resident in one program or institution when such a program or institution is approved by an accrediting agency recognized by the board for internship and residency training.

C. For licensure in chiropractic.

1. If the applicant matriculated in a chiropractic college prior to July 1, 1975, he shall be a graduate of a chiropractic college accredited by the American Chiropractic Association or the International Chiropractic Association or any other organization approved by the board.

~~1~~ 2. If the applicant matriculated in a chiropractic college on or after July 1, 1975, he shall be a graduate of a chiropractic college accredited by the Commission on Accreditation of the Council of Chiropractic Education or any other organization approved by the board.

~~2. If the applicant matriculated in a chiropractic college prior to July 1, 1975, he shall be a graduate of a chiropractic college accredited by the American Chiropractic Association or the International Chiropractic Association or any other organization approved by the board.~~

18VAC85-20-122. Educational requirements: graduates and former students of institutions not approved by an accrediting agency recognized by the board.

A. A graduate of an institution not approved by an accrediting agency recognized by the board shall present documentary evidence that he:

1. Was enrolled and physically in attendance at the institution's principal site for a minimum of two consecutive years and fulfilled at least half of the degree requirements while enrolled two consecutive academic years at the institution's principal site.

2. Has received a degree from the institution.

~~2.~~ 3. Has fulfilled the applicable requirements of § 54.1-2930 of the Code of Virginia.

~~3.~~ 4. Has obtained a certificate from the Educational Council of Foreign Medical Graduates (ECFMG), or its equivalent. Proof of licensure by the board of another state or territory of the United States or a province of Canada may be accepted in lieu of ECFMG certification.

~~4.~~ 5. Has had supervised clinical training as a part of his curriculum in an approved hospital, institution or school of medicine offering an approved residency program in the specialty area for the clinical training received or in a program acceptable to the board and deemed a substantially equivalent experience, if such training was received in the United States.

~~5.~~ 6. Has completed one year of satisfactory postgraduate training as an intern, resident, or clinical fellow. The one year shall include at least 12 months in one program or institution approved by an accrediting agency recognized by the board for internship or residency training or in a clinical fellowship acceptable to the board in the same or a related field. The board may substitute continuous full-time practice of five years or more with a limited professorial license in Virginia and one year of postgraduate training in a foreign country in lieu of one year of postgraduate training.

~~6. Has received a degree from the institution.~~

B. A former student who has completed all degree requirements except social services and postgraduate internship at a school not approved by an accrediting agency recognized by the board shall be considered for licensure provided that he:

1. Has fulfilled the requirements of subdivisions A 1 through 5 of this section;

2. Has qualified for and completed an appropriate supervised clinical training program as established by the American Medical Association; and

3. Presents a document issued by the school certifying that he has met all the formal requirements of the institution for a degree except social services and postgraduate internship.

Part IV. Licensure: Examination Requirements.

18VAC85-20-140. Examinations, general.

A. The Executive Director of the Board of Medicine or his designee shall review each application for licensure and in no case shall an applicant be licensed unless there is evidence that the applicant has passed an examination equivalent to the Virginia Board of Medicine examination required at the time he was examined and meets all requirements of Part III (18VAC85-20-120 et seq.) of this chapter. If the executive director or his designee is not fully satisfied that the applicant meets all applicable requirements of Part III of this chapter and this part, he shall refer the application to the Credentials Committee for a determination on licensure.

B. A Doctor of Medicine or Osteopathic Medicine who has passed the examination of the National Board of Medical Examiners or of the National Board of Osteopathic Medical Examiners, Federation Licensing Examination, or the United States Medical Licensing Examination, or the examination of the Licensing Medical Council of Canada or other such examinations as prescribed in §54.1-2913.1 of the Code of Virginia may be accepted for licensure.

C. A Doctor of Podiatry who has passed the National Board of Podiatric Medical Examiners examination and has passed a clinical competence examination acceptable to the board may be accepted for licensure.

D. A Doctor of Chiropractic who has met the requirements of one of the following may be accepted for licensure:

1. An applicant who graduated after January 31, 1996, shall document successful completion of Parts I, II, III, and IV of the National Board of Chiropractic Examiners examination (NBCE).

2. An applicant who graduated from January 31, 1991, to January 31, 1996, shall

document successful completion of Parts I, II, and III of the National Board of Chiropractic Examiners examination (NBCE).

3. An applicant who graduated from July 1, 1965, to January 31, 1991, shall document successful completion of Parts I, II, and III of the NBCE, or Parts I and II of the NBCE and the Special Purpose Examination for Chiropractic (SPEC), and document evidence of licensure in another state for at least two years immediately preceding his application.

4. An applicant who graduated prior to July 1, 1965, shall document successful completion of the SPEC, and document evidence of licensure in another state for at least two years immediately preceding his application.

~~E. The following provisions shall apply for applicants taking Step 3 of the United States Medical Licensing Examination or the Podiatric Medical Licensing Examination:~~

~~1. Applicants for licensure in medicine and osteopathic medicine may be eligible to sit for Step 3 of the United States Medical Licensing Examination (USMLE) upon evidence of having passed Steps 1 and 2 of the United States Medical Licensing Examination (USMLE).~~

~~2.~~ Applicants who sat for the United States Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensure Examination (COMPLEX-USA) shall provide evidence of passing ~~Steps 1, 2, and 3~~ 000 within a 10-year period unless the applicant is board certified in a specialty approved by the American Board of Medical Specialties or the Bureau of Osteopathic Specialists of the American Osteopathic Association.

~~3. Applicants shall have completed the required training or be engaged in their final year of required postgraduate training.~~

~~4.~~ F. Applicants for licensure in podiatry shall provide evidence of having passed the National Board of Podiatric Medical Examiners Examination to be eligible to sit for the Podiatric Medical Licensing Examination (PMLEXIS) in Virginia.

18VAC85-20-220. Temporary licenses to interns and residents.

A. An intern or resident applying for a temporary license to practice in Virginia shall:

1. Successfully complete the preliminary academic education required for admission to examinations given by the board in his particular field of practice, and submit a letter of confirmation from the registrar of the school or college conferring the professional degree, or official transcripts confirming the professional degree and date the degree was received.

2. Submit a recommendation from the applicant's chief or director of graduate medical education of the approved internship or residency program specifying acceptance. The beginning and ending dates of the internship or residency shall be specified.

3. Submit evidence of a standard Educational Commission for Foreign Medical

Graduates (ECFMG) certificate or its equivalent if the candidate graduated from a school not approved by an accrediting agency recognized by the board.

B. The intern or resident license applies only to the practice in the hospital or outpatient clinics where the internship or residency is served. Outpatient clinics in a hospital or other facility must be a recognized part of an internship or residency program.

C. The intern or resident license shall be renewed annually upon the recommendation of the chief or director of graduate medical education of the internship or residency program.

A residency program transfer request shall be submitted to the board in lieu of a full application.

D. The extent and scope of the duties and professional services rendered by the intern or resident shall be confined to persons who are bona fide patients within the hospital or who receive treatment and advice in an outpatient department of the hospital or outpatient clinic where the internship or residency is served.

E. The intern and resident shall be responsible and accountable at all times to a fully licensed member of the ~~staff~~ faculty where the internship or residency is served. The intern and resident is prohibited from employment outside of the graduate medical educational program where a full license is required.

F. The intern or resident shall abide by the respective accrediting requirements of the internship or residency as approved by the Liaison Council on Graduate Education of the American Medical Association, American Osteopathic Association, American Podiatric Medical Association, or Council on Chiropractic Education.

18VAC85-20-225. Registration for voluntary practice by out-of-state licenses.

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

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

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

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

4. Pay a registration fee of $10; and

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

18VAC85-20-235. Continued competency requirements for renewal of an active license.

A. In order to renew an active license biennially, a practitioner shall attest to completion of at least 60 hours of continuing learning activities within the two years immediately preceding renewal as follows:

1. A minimum of 30 of the 60 hours shall be in Type 1 activities or courses offered by an accredited sponsor or organization sanctioned by the profession.

a. Type 1 hours in chiropractic shall be clinical hours that are approved by a college or university accredited by the Council on Chiropractic Education or any other organization approved by the board.

b. Type 1 hours in podiatry shall be accredited by the American Podiatric Medical Association, the American Council of Certified Podiatric Physicians and Surgeons or any other organization approved by the board.

2. No more than 30 of the 60 hours may be Type 2 activities or courses, which may or may not be approved by an accredited sponsor or organization but which shall be chosen by the licensee to address such areas as ethics, standards of care, patient safety, new medical technology, and patient communication.

a. Up to 15 of the Type 2 continuing education hours may be satisfied through delivery of 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 one hour of providing such volunteer services. For the purpose of continuing education credit for voluntary service, documentation by the health department or free clinic shall be acceptable.

b. Type 2 hours may include teaching in a healthcare profession field.

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

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

D. The board shall periodically conduct a random audit of its active licensees to determine compliance. The practitioners 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.

H. The board may grant an exemption for all or part of the requirements for a licensee who :

1. Is practicing solely in an uncompensated position, provided his practice is under the direction of a physician fully licensed by the board; or

2. Is practicing solely as a medical examiner, provided the licensee obtains six hours of medical examiner training per year provided by the Office of the Chief Medical Examiner.

18VAC85-20-410. Requirements for low-, medium- or high-risk sterile mixing, diluting or reconstituting.

A. Any mixing, diluting or reconstituting of sterile products that does not meet the criteria for immediate-use as set forth in 18VAC85-20-400 A shall be defined as low-, medium-, or high-risk compounding under the definitions of Chapter 797 of the U.S. Pharmacopeia (USP).

B. ~~Until July 1, 2007, all low-, medium-, or high-risk mixing, diluting or reconstituting of sterile products shall comply with the standards for immediate-use mixing, diluting or reconstituting as specified in 18VAC85-20-400. Beginning July 1, 2007, doctors~~ Doctors of medicine or osteopathic medicine who engage in low-, medium-, or high-risk mixing, diluting or reconstituting of sterile products shall comply with all applicable requirements of the USP Chapter 797. Subsequent changes to the USP Chapter 797 shall apply within one year of the official announcement by USP.

C. A current copy, in any published format, of USP Chapter 797 shall be maintained at the location where low-, medium- or high-risk mixing, diluting or reconstituting of sterile products is performed.

Ms. Yeatts concluded the periodic review by saying that if all the recommendations are accepted, they will be presented to the Full Board on October 18 and adopted as fast track changes.

MOTION: Dr. Toor moved to accept all the recommendations as presented. The motion was seconded by Dr. Taminger and carried unanimously.

ANNOUNCEMENTS

Ms. Deschenes announced that Matt Tracey with DHP's Media Production Unit has requested the board member's assistance in mimicking the setup of a formal hearing for internal training purposes.

Ms. Yeatts advised that the Department has submitted 14 bills for the 2019 General Assembly session. One is a proposal to amend the language in Impaired Practitioners Act. Another proposal submitted addresses e-prescribing, which will go into effect in 2020, the Department is recommending specific exemption to the boards to issue waivers with parameters until the process is completely in place.

Next meeting – January 11, 2019

Adjournment - With no other business to conduct, the meeting adjourned at 9:22 a.m.

Ray Tuck, Jr., DC
Vice-President, Chair

William L. Harp, MD
Executive Director

Colanthia Morton Opher
Recording Secretary

Agenda Item: **Regulatory/Policy Actions from the 2019 General Assembly**

Staff Note: Here you will find legislation from the 2019 Session that requires the promulgation of emergency regulations, standard regulations, studies and policy changes.

Action: For information only.

Board of Medicine
Regulatory/Policy Actions – 2019 General Assembly

EMERGENCY REGULATIONS:

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

APA REGULATORY ACTIONS

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

NON-REGULATORY ACTIONS

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

Future Policy Actions:

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

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

Board of Medicine
Report of the 2019 General Assembly

HB 1952 Patient care teams; podiatrists and physician assistants.

Chief patron: Campbell, J.L.

Summary as passed House:

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

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

HB 1970 Telemedicine services; payment and coverage of services.

Chief patron: Kilgore

Summary as passed:

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

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

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

Chief patron: Stolle

Summary as introduced:

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

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

HB 2169 Physician assistants; licensure by endorsement.

Chief patron: Thomas

Summary as passed:

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

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

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

Chief patron: Kilgore

Summary as passed:

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

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

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

Chief patron: Bagby

Summary as introduced:

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

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

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

Chief patron: Landes

Summary as passed:

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

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

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

Chief patron: Pillion

Summary as passed:

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

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

HB 2559 Electronic transmission of certain prescriptions; exceptions.

Chief patron: Pillion

Summary as passed House:

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

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

HB 2731 Lyme disease; disclosure of information to patients.

Chief patron: Edmunds

Summary as passed House:

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

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

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

Chief patron: Chase

Summary as passed:

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

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

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

Chief patron: Peake

Summary as introduced:

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

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

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

Chief patron: Chafin

Summary as passed:

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

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

SB 1439 Death certificates; medical certification, electronic filing.

Chief patron: McClellan

Summary as passed:

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

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

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

Chief patron: Vogel

Summary as passed:

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

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

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

Chief patron: Dunnavant

Summary as passed:

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

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

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

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

Chief patron: DeSteph

Summary as introduced:

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

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

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

Chief patron: Newman

Summary as introduced:

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

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

CHAPTER 137

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

[H 1952]

Approved February 22, 2019

Be it enacted by the General Assembly of Virginia:

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

§ 54.1-2900. Definitions.

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

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

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

"Board" means the Board of Medicine.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 54.1-2951.2. Issuance of a license.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAPTER 169

An Act to amend and reenact §§ 54.1-3002 and 54.1-3603 of the Code of Virginia, relating to composition of the Boards of Nursing and Psychology; health regulatory boards; staggered terms.

[H 2228]

Approved February 27, 2019

Be it enacted by the General Assembly of Virginia:

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

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

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

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

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

§ 54.1-3603. Board of Psychology; membership.

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

2. That for appointments to the Board of Nursing pursuant to § 54.1-3002 of the Code of Virginia, as amended by this act, that are set to begin July 1, 2021, one registered nurse and one licensed practical nurse shall be appointed for a term of one year, and any remaining appointments shall be for a term of four years. Thereafter, all appointments to the Board of Nursing shall be for a term of four years, as provided in § 54.1-3002 of the Code of Virginia, as amended by this act.

3. That for appointments to the Board of Psychology pursuant to § 54.1-3603 of the Code of Virginia, as amended by this act, that are set to begin July 1, 2020, one member shall be appointed for a term of one year, one member shall be appointed for a term of two years, and any remaining appointments shall be for a term of four years. Thereafter, all appointments to the Board of Psychology shall be for a term of four years, as provided in § 54.1-3603 of the Code of Virginia, as amended by this act.

4. That for appointments to the Board of Dentistry pursuant to § 54.1-2702 of the Code of Virginia that are set to begin July 1, 2020, one member shall be appointed for a term of one year, one member shall be appointed for a term of two years, and any remaining appointments shall be for a term of four years. Thereafter, all appointments to the Board of Dentistry shall be for a term of four years, as provided in § 54.1-2702 of the Code of Virginia.

5. That for appointments to the Board of Long-Term Care Administrators pursuant to § 54.1-3101 of the Code of Virginia that are set to begin July 1, 2019, one licensed nursing home administrator and one assisted living facility administrator shall be appointed for a term of one year, and any remaining appointments shall be for a term of four years. Thereafter, all appointments to the Board of Long-Term Care Administrators shall be for a term of four years, as provided in § 54.1-3101 of the Code of Virginia.

6. That for appointments to the Board of Medicine pursuant to § 54.1-2911 of the Code of Virginia that are set to begin July 1, 2020, three members shall be appointed for a term of two years, and any remaining appointments shall be for a term of four years. Thereafter, all appointments to the Board of Medicine shall be for a term of four years, as provided in § 54.1-2911 of the Code of Virginia.

7. That for appointments to the Board of Veterinary Medicine pursuant to § 54.1-3802 of the Code of Virginia that are set to begin July 1, 2019, the citizen member shall be appointed for a term of three years, and any remaining appointments shall be for a term of four years. Thereafter, all appointments to the Board of Veterinary Medicine shall be for a term of four years, as provided in § 54.1-3802 of the Code of Virginia.

8. That for appointments to the Board of Audiology and Speech-Language Pathology pursuant to § 54.1-2602 of the Code of Virginia that are set to begin July 1, 2022, one speech-language pathologist shall be appointed for a term of two years, and any remaining appointments shall be for a term of four years. Thereafter, all appointments to the Board of Audiology and Speech-Language Pathology shall be for a term of four years, as provided in § 54.1-2602 of the Code of Virginia.

9. That for appointments to the Board of Pharmacy pursuant to § 54.1-3305 of the Code of Virginia that are set to begin July 1, 2022, one citizen member and one pharmacist shall be appointed for a term of three years, and any remaining appointments shall be for a term of four years. Thereafter, all appointments to the Board of Pharmacy shall be for a term of four years, as provided in § 54.1-3305 of the Code of Virginia.

10. That for appointments to the Board of Counseling pursuant to § 54.1-3503 of the Code of Virginia that are set to begin July 1, 2021, one member shall be appointed for a term of two years, two members shall be appointed for a term of three years, and any remaining appointments shall be for a term of four years. Thereafter, all appointments to the Board of Counseling shall be for a term of four years, as provided in § 54.1-3503 of the Code of Virginia.

VIRGINIA ACTS OF ASSEMBLY -- 2019 SESSION

CHAPTER 379

An Act to amend the Code of Virginia by adding a section numbered 54.1-2937.1, relating to Board of Medicine; retiree license.

[H 2457]

Approved March 14, 2019

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 54.1-2937.1 as follows:

§ 54.1-2937.1. Retiree license.

A. The Board may issue a retiree license to any doctor of medicine, osteopathy, podiatry, or chiropractic who holds an unrestricted, active license to practice in the Commonwealth upon receipt of a request and submission of the fee required by the Board. A person to whom a retiree license has been issued shall not be required to meet continuing competency requirements for the first biennial renewal of such license.

B. A person to whom a retiree license has been issued shall only engage in the practice of medicine, osteopathy, podiatry, or chiropractic for the purpose of providing (i) charity care, as defined in § 32.1-102.1, and (ii) health care services to patients in their residence for whom travel is a barrier to receiving medical care.

CHAPTER 664

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

[H 2559]

Approved March 21, 2019

Be it enacted by the General Assembly of Virginia:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAPTER 224

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

[S 1439]

Approved March 5, 2019

Be it enacted by the General Assembly of Virginia:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAPTER 681

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

[S 1557]

Approved March 21, 2019

Be it enacted by the General Assembly of Virginia:

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

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

A. As used in this section:

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

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

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

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

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

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

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

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

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

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

to information related to such registered patient.

§ 54.1-3442.6. Permit to operate pharmaceutical processor.

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

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

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

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

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

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

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

INTRODUCED

19104189D

HOUSE JOINT RESOLUTION NO. 682

Offered January 9, 2019
Prefiled January 9, 2019

Requesting the Department of Health Professions to study options for utilizing physicians trained outside the United States to address shortages of physicians in rural and underserved areas of the Commonwealth. Report.

Patrons—Tran and Lopez

Referred to Committee on Rules

WHEREAS, according to the Department of Health Professions (the Department), as of 2016, only seven percent of Virginia physicians are employed in non-metropolitan counties in the Commonwealth; and

WHEREAS, there is a shortage of physicians in rural and underserved areas of the Commonwealth; and

WHEREAS, foreign-trained physicians are often willing to serve in remote, rural areas and underserved communities, and have the potential to alleviate the shortage of physicians in rural areas of the Commonwealth;

WHEREAS, in order to practice in the United States, foreign-trained physicians must meet the same strict requirements applied to graduates of United States medical schools; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Health Professions be requested to study options for utilizing physicians who already reside in the Commonwealth but were trained outside the United States to address shortages of physicians in rural and underserved areas of the Commonwealth. The Department shall convene a workgroup composed of representatives of the Department of Health Professions; the Department of Health; the Virginia Rural Health Association; the Virginia Health Workforce Development Authority; the Medical Society of Virginia, including licensed physicians trained within and outside of the United States; groups representing the interests of immigrants to the Commonwealth; groups representing health care providers, including the Virginia Hospital and Healthcare Association; representatives of graduate medical education programs in Virginia; and such other stakeholders as the Department deems appropriate to assist with such study.

In conducting its study, the Department of Health Professions shall (i) identify the need for physicians in the Commonwealth's rural and underserved communities; (ii) describe, to the extent practicable, the population of foreign-trained physicians in the Commonwealth and the potential economic impact to Virginia if these physicians are able to practice to the full extent of their training; (iii) identify initiatives and programs from other states that assist foreign-trained physicians in preparing for the United States Medical Licensing Examination (USMLE); (iv) identify Commonwealth licensing requirements that pose unnecessary barriers to practice in the Commonwealth for foreign-trained physicians; (v) identify steps the Commonwealth has already taken to facilitate practice in the Commonwealth for foreign-trained physicians; (vi) identify and review policies that assess the readiness of residency programs in the Commonwealth for foreign-trained physicians who have gained professional experience in supervised internships and other work experiences outside of the United States; (vii) identify options for addressing English-language barriers that foreign-trained physicians encounter in preparing for licensure examinations, including the USMLE; and (viii) assess the degree to which existing programs in Virginia facilitate the ability of foreign-trained physicians to practice in rural and underserved areas of the Commonwealth, and identify potential new policies or programs.

All agencies of the Commonwealth shall provide assistance to the Department of Health Professions for this study, upon request.

The Department of Health Professions shall submit to the Governor and the General Assembly an interim executive summary and a report of its findings and recommendations no later than December 1, 2019. The final executive summary and a report of its findings and recommendations shall be submitted to the Governor and the General Assembly by July 1, 2020. Each executive summary shall state whether the Department of Health Professions intends to submit the document for publication as a House or Senate document, shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports, and shall be posted on the General Assembly's website.

Agenda Item: Regulatory Actions - Chart of Regulatory Actions
As of May 1, 2019

Chapter		Action / Stage Information
[18 VAC 85 - 20]	Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic	Result of periodic review [Action 5167] Fast-Track - *At Governor's Office* [Stage 8449]
[18 VAC 85 - 20]	Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic	Supervision and direction for laser hair removal [Action 4860] Final - *At Secretary's Office* [Stage 8535]
[18 VAC 85 - 50]	Regulations Governing the Practice of Physician Assistants	Result of periodic review [Action 5168] Fast-Track - *At Governor's Office* [Stage 8450]
[18 VAC 85 - 110]	Regulations Governing the Practice of Licensed Acupuncturists	Result of periodic review [Action 5169] Fast-Track - *At Governor's Office* [Stage 8451]
[18 VAC 85 - 120]	Regulations Governing the Licensure of Athletic Trainers	Result of periodic review [Action 5170] Fast-Track - *At Governor's Office* [Stage 8452]

Agenda Item: Response to petition for rulemaking

Included in your agenda package:

- Copy of petition from Dr. Luke Vetti
- Copy of notice in Townhall (comment may be received through 5/14/19 and will be provided to Committee at the meeting
- Sections of regulation requested for amendments

Action:

Recommendation to the Board to:

1) Initiate rulemaking and adopt amendments by a fast-track action;
2) Initiate rulemaking and adopt a Notice of Intended Regulatory Action; OR
3) Deny petitioner's request for amendments

COMMONWEALTH OF VIRGINIA
Board of Medicine

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

(804) 367-4600 (Tel)
(804) 527-4426 (Fax)

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.

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

Petitioner's full name (Last, First, Middle Initial, Suffix,) Vetti, Luke, T		
Street Address 611 Watkins Centre Parkway, Ste. 170	**Area Code and Telephone Number** 804-837-4144	
City Midlothian	**State** VA	**Zip Code** 23114
Email Address (optional) lvetti@aol.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 Medicine, Osteopathy, Podiatry, and Chiropractic, 18 VAC 85-20-10 et. seq., specifically 18 VAC85-20-141 "Licensure by endorsement," section 4, and 18VAC85-20-350 "Informed consent," section B.

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

We would like American Board of Podiatric Medicine (ABPM) added to the regulations as this board is recognized by the Council on Podiatric Medicine and the American Podiatric Medical Association for board certification, and as more podiatrists get certified by ABPM we would like it to be included in the regulations.

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.

   We cite 54.1-2400 of the Code of Virginia giving the Board of Medicine the ability to make these changes.

Signature: 

Date: March 19, 2019

Request for Comment on Petition for Rulemaking

Promulgating Board: **Board of Medicine**

Regulatory Coordinator: Elaine J. Yeatts
(804)367-4688
elaine.yeatts@dhp.virginia.gov

Agency Contact: William L. Harp, M.D.
Executive Director
(804)367-4558
william.harp@dhp.virginia.gov

Contact Address: Department of Health Professions
9960 Mayland Drive
Suite 300
Richmond, VA 23233

Chapter Affected:

18 vac 85 - 20: **Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic**

Statutory Authority: State: Chapter 29 of Title 54.1

Date Petition Received 03/20/2019

Petitioner Dr. Luke Vetti

Petitioner's Request

To include the American Board of Podiatric Medicine in regulations for endorsement and informed consent for podiatrists.

Agency Plan

In accordance with Virginia law, the petition has been filed with the Register of Regulations and will be published on April 15, 2019 and posted on the Virginia Regulatory Townhall at www.townhall.virginia.gov. Comment on the petition will be requested until May 14, 2019 and may be posted on the Townhall or sent to the Board. Following receipt of all comments on the petition, the Board will decide whether to make any changes to its regulations. The matter will be considered by the full Board at its meeting on June 13, 2019.

Publication Date 04/15/2019 *(comment period will also begin on this date)*

Comment End Date 05/14/2019

18VAC85-20-141. Licensure by Endorsement.

To be licensed by endorsement, an applicant shall:

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

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

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

4. Hold current certification by one of the following:

a. American Board of Medical Specialties;

b. Bureau of Osteopathic Specialists;

c. American Board of Foot and Ankle Surgery;

d. Fellowship of Royal College of Physicians of Canada;

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

f. College of Family Physicians of Canada;

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

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

Statutory Authority

§ 54.1-2400 of the Code of Virginia.

Historical Notes

Derived from Volume 34, Issue 25, eff. September 5, 2018.

18VAC85-20-350. Informed Consent.

A. Prior to administration, the anesthesia plan shall be discussed with the patient or responsible party by the health care practitioner administering the anesthesia or supervising the administration of anesthesia. Informed consent for the nature and objectives of the anesthesia planned shall be in writing and obtained from the patient or responsible party before the procedure is performed. Such consent shall include a discussion of discharge planning and what care or assistance the patient is expected to require after discharge. Informed consent shall only be obtained after a discussion of the risks, benefits, and alternatives, contain the name of the anesthesia provider, and be documented in the medical record.

B. The surgical consent forms shall be executed by the patient or the responsible party and shall contain a statement that the doctor performing the surgery is board certified or board eligible by one of the American Board of Medical Specialties boards, the Bureau of Osteopathic Specialists of the American Osteopathic Association, or the American Board of Foot and Ankle Surgery. The forms shall either list which board or contain a statement that doctor performing the surgery is not board certified or board eligible.

C. The surgical consent forms shall indicate whether the surgery is elective or medically necessary. If a consent is obtained in an emergency, the surgical consent form shall indicate the nature of the emergency.

Statutory Authority

§§ 54.1-2400 and 54.1-2912.1 of the Code of Virginia.

Historical Notes

Derived from Volume 19, Issue 18, eff. June 18, 2003; amended, Virginia Register Volume 32, Issue 22, eff. July 27, 2016.

Agenda Item: Letter Regarding Opioid Regulations Impact on Patient Care

Staff Note: Included you will find an e-mail from Sydney Rab regarding the Board's regulations for the prescribing of opioids, Dr. Harp's response, a second e-mail article, a blog regarding the regulation of opioids and a copy of the Board's regulations. Mr. Rab asks the Board to reconsider its regulations.

Action: Discussion of Mr. Rab's comments and consider any issues with the regulations that may require revision.

Commonwealth of Virginia

Harp, William <william.harp@dhp.virginia.gov>

Regulations Governing the Prescribing of Opioids and Buprenorphine

1 message

sydney e rab <msydrab@comcast.net> Tue, Apr 30, 2019 at 5:14 PM
To: William.harp@dhp.virginia.gov
Cc: Julie <jslartist@comcast.net>

Dr. Harp please see my attached letter. Thank you, Sydney E. Rab

Harp Opioids.doc
39K

Sydney E. Rab, Esq.

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(804) 231-0589
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April 30, 2019

William L. Harp, M.D.
9960 Mayland Drive, Suite 300
Richmond, Va. 23233
William.harp@dhp.virginia.gov

Re: Regulations Governing the Prescribing of Opioids and Buprenorphine, 18VAC85-21 (September 18, 2017).

Dear Dr. Harp:

My purpose in writing is to encourage reconsideration of the referenced Regulations, placed in the Virginia Register on November 27, 2017, in view of the recent statement of the Centers for Disease Control and Prevention ("CDC"), in commentary just published in the New England Journal of Medicine.

Virginians, including my own wife, with chronic pain receiving palliative care for years have since the 2017 Regulations been punished for the crimes of others, the drug abusers. As you predicted, "use of drug screens [have] create[d] disincentives for primary care physicians to treat pain using opioid therapy," and some "individuals who [have] lost access [to prescription opioids] have turned to cheaper, more accessible and more potent black market opioid alternative [hence] an unintended consequence of the regulations may be a shift in demand from legal prescriptions to illegal street drugs." See Volume 34, Issue 7, Va. Register of Regulations, at 747. Physicians are deterred by the Regulations and ignoring the real needs of the chronically ill.

The CDC now clearly suggests physicians should not use the guidelines to taper the chronically ill patients from the medication helpful in managing their pain. The earlier guidelines from the CDC were meant to discourage primary care physicians from starting non-cancer patients on opioids. Overreaction, instead, has left those successfully managed patients scrambling for substitutes and considering suicide.

Physicians in the Commonwealth of Virginia must be immediately advised of the current CDC advice. Prompt action on your part will be beneficial relief for countless Virginia citizens. Your consideration is appreciated.

Yours truly,

Sydney E. Rab
Sydney E. Rab, Esq.

Commonwealth of Virginia

Harp, William <william.harp@dhp.virginia.gov>

Fwd: Letter re: Opioids

1 message

Harp, William <william.harp@dhp.virginia.gov>
To: msydrab@comcast.net

Fri, May 3, 2019 at 11:47 AM

Dear Mr. Rab:

Thank you for your message. It resonates with what the Board of Medicine has heard from patients and their loved ones from time to time.

Initially, it should be said that the Board wants all patients in Virginia to get competent and safe care for their medical conditions. The opioid regulations were promulgated for that reason, to provide guidelines for practitioners that would have them be more thoughtful and cautious in their prescribing. The Board first developed regulations for pain management in 2007, but it was not until the Commissioner of Health declared a public emergency in November 2016 and legislation was proposed in the 2017 Session of the General Assembly that regulations came to fruition.

If you have read the regulations, you are aware that they 1) do not have a ceiling dose or MME/day limit, 2) do not require a reduction of opioid analgesic other than to ensure that a patient is prescribed the lowest, effective dose, and 3) that the rationale for continuance of treatment and the dose that is written be clearly documented in the patient's medical record. In essence, the prescriber has great latitude in prescribing for any patient; it just has to be done competently, safely, and be well-documented.

.In March of 2016, the CDC published its Guidelines on Prescribing Opioids for Chronic Pain. An outline of the guidelines were sent to prescribers in Virginia by the Secretary of Health and Human Resources in May of 2016. The Board believes that some prescribers may have seized upon the mention of 50 MME/day and 90 MME/day as "upper limits" on opioid prescribing. Further, some prescribers may have thought that the guideline was enforceable federal law, and it is not. The Board of Medicine sent a follow-up letter in early August of 2016. Attached you will find the letter from the Secretary of Health and Human Resources and a follow-up letter from the Board of Medicine to its licensees about the CDC Guidelines.

The Board of Medicine believes that there are ongoing misconceptions about the Board's regulations. it has been encouraging prescribers to read the regulations to dispel any myths they may have developed from word-of-mouth information. Not understanding the regulations can be a disincentive to prescribe for chronic pain or maintain the treatment of patients in one's practice that have been stable, functional, and without signs of abuse for years. And practitioners pay attention to articles in newspapers, over the airwaves, and on the Internet about pain management practices being raided by enforcement. These factors, and more, can impact practitioners' willingness to engage in pain management.

This year the Board has undertaken an effort to ensure that all the Board's licensees read the regulations and learn how to appropriately taper a patient's dose of opioids. The Board is offering the Stanford University continuing education course on tapering that emphasizes mutual decision-making by the patient and the practitioner in the tapering process.

The Board's newsletter, sent several times a year to its licensees, has had articles in it relative to your concerns. Here are the links to the 3 most recent editions for your review. They have items that seek to clarify the regulations and the appropriate handling of opioids in any patient.

https://www.dhp.virginia.gov/medicine/newsletters/BoardBrief87.pdf

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To further clarify the Virginia Board's regulations and the CDC's stance, the CDC media statement from April 24, 2019 will be incorporated into the next newsletter.

The Board is also in receipt of your e-mail of May 2, 2019. Per your request that the Board reconsider its regulations and make sure licensees are informed, your items will be placed in the agenda packet for the Board's Legislative Committee. It will meet May 17, 2019 at the Department of Health Professions, 9960 Mayland Drive, in the 2nd floor conference center at 8:30 AM. There will be a public comment period early in the meeting. You are welcome to share your thoughts with the Board at that time.

I hope this is helpful to you.

With kindest regards,

William L. Harp, MD

Executive Director

Virginia Board of Medicine

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2 attachments

Sect Hazel Ltr on CDC Guidelines.pdf
164K

Board of Medicine Letter to Licensees Regarding CDC Guidelines.doc
30K

Commonwealth of Virginia

Harp, William <william.harp@dhp.virginia.gov>

CDC: Painkillers No Longer Driving Opioid Epidemic – Pain News Network | Speciosa.org

1 message

Sydney Rab <msydrab@comcast.net>
To: William.harp@dhp.virginia.gov
Cc: Julie <jslartist@comcast.net>

Thu, May 2, 2019 at 11:16 AM

Dr. Harp:

Following up from my recent letter, I add this commentary. Please respond with the action you would take to free our disabled community from the present adversity.

Thank you,
Sydney E. Rab

http://speciosa.org/cdc-painkillers-no-longer-driving-opioid-epidemic-pain-news-network/

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CDC: Painkillers No Longer Driving Opioid Epidemic

March 26, 2017

By Pat Anson, Editor

A top official for the Centers for Disease Control and Prevention has acknowledged that prescription painkillers are no longer the driving force behind the nation's so-called opioid epidemic.

In testimony last week at a congressional hearing, Debra Houry, MD, Director of the CDC's National Center for Injury Prevention and Control, said that heroin and illicit fentanyl were primarily to blame for the soaring rate of drug overdoses.

"Although prescription opioids were driving the increase in overdose deaths for many years, more recently, the large increase in overdose deaths has been due mainly to increases in heroin and synthetic opioid overdose deaths, not prescription opioids. Importantly, the available data indicate these increases are largely due to illicitly manufactured fentanyl," **Houry said in her prepared testimony** before the House Energy and Commerce Committee's Oversight and Investigations Subcommittee.

The CDC blamed over 33,000 deaths on opioids in 2015, less than half of which were linked to pain medication.

While painkillers may be playing less of a role in the overdose epidemic, Houry believes pain medication is still a gateway drug for many abusers. She cited statistics from Ohio showing that nearly two-thirds of the people who overdosed on heroin or fentanyl received at least one opioid prescription in the seven years before their deaths.

"The rise in fentanyl, heroin, and prescription drug involved overdoses are not unrelated," Houry said. "While most people who misuse prescription opioids do not go on to use heroin, the small percentage (about four percent) who do account for a majority of people recently initiating heroin use."

Houry also disputed reports that efforts to reduce opioid prescribing have led to increased use of illegal drugs. It was her office that oversaw the development of controversial CDC

guidelines that discourage doctors from prescribing opioids for chronic pain.

DEBRA HOURY, MD

"Some have suggested that policies meant to limit inappropriate opioid prescribing have led to an increase in heroin use by driving people who misuse opioids to heroin," Houry testified. "Recent research, however, has indicated otherwise. One study found that the shift to heroin use began before the recent uptick in these policies, but that other factors (such as heroin market forces, increased accessibility, reduced price, and high purity of heroin) appear to be major drivers of the recent increases in rates of heroin use."

The "recent research" Houry cited was **a report published in the *New England Journal of Medicine*** in January, 2016 – a full two months before the CDC opioid guidelines were even released. She offered no evidence to support her claim that the guidelines were having no impact on heroin use.

Some Patients Turning to Illegal Drugs

According to **a recent survey of over 3,100 patients** by *Pain News Network* and the International Pain Foundation, the CDC guidelines have reduced access to pain care, harmed many patients and caused some to turn to illegal drugs for pain relief.

Over 70 percent said their opioid doses have been reduced or cutoff by their doctors in the past year. And one out of ten patients (11%) said they had obtained opioids illegally for pain relief since the guidelines came out.

"The one person I know who says the recent guidelines have helped (is) my neighbor who is a heroin dealer. He says business has quadrupled since doctors have started becoming too afraid to help people in pain," one patient wrote.

"This has caused me far more pain and suffering in my life, and increased my stress and anxiety, and depression, because nobody seems to care that I suffer like this," said another

patient. "This has also caused me to turn to using heroin, because I have nothing left now at this point and cannot suffer like this."

"Because people are unable to get adequate pain relief from prescribed medications due to the fear instilled to doctors by these 'guidelines,' most people, in my experience, are turning to heroin. This explains not only an increase in overdoses but also an increase in suicide from chronic pain patients," wrote another.

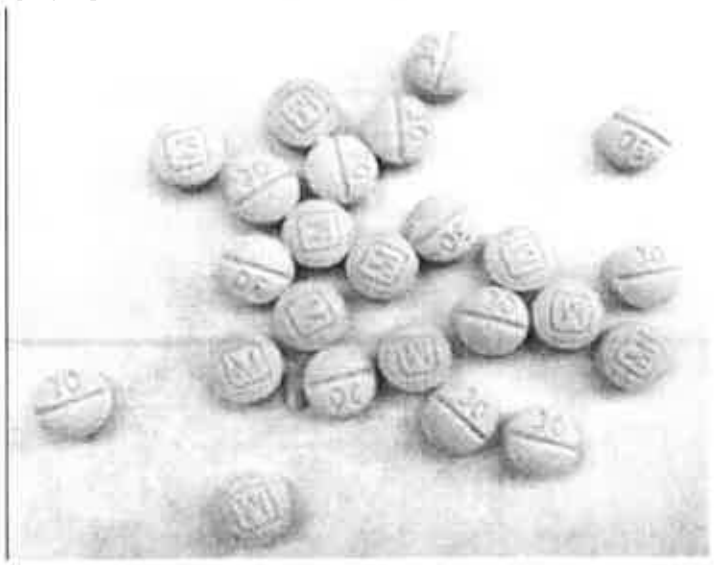
"I found it easier to get medications through the black market than through my doctor. I spend about $1,000 per month in medications through the black market, but in the end that is less than the deductible on my insurance. And they deliver to my house!" a patient said.

"My fear right now is that I've been using medications I buy from a dealer. They appear to be real and thus far I've been OK, but I'm afraid that I may eventually hit a bad batch laced with fentanyl," said a patient.

Houry's testimony came on the same day the Drug Enforcement Administration warned that **counterfeit painkillers made with fentanyl have killed dozens of people in the Phoenix area.**

The DEA said at least 32 deaths in the last 18 months in Maricopa County, Arizona have been linked to fake pills laced with fentanyl that were disguised to look like oxycodone tablets. In nearly 75% of the overdoses, examiners also found dipyrone (Metamizole), a painkiller banned for use in the U.S. since 1977.

Fentanyl is a synthetic opioid 100 times more potent that morphine. It is sold legally in sprays, patches and lozenges to treat severe chronic pain.



COUNTERFEIT OXYCODONE (DEA PHOTO)

The DEA says illicit batches of fentanyl are being made in China and exported to Mexico, where drug dealers mix it with heroin or turn it into counterfeit medication before smuggling it into the U.S.

The DEA released detailed demographic information on the age, sex and ethnicity of the people who overdosed in Arizona. It did not say how many of the dead were patients looking for pain relief.

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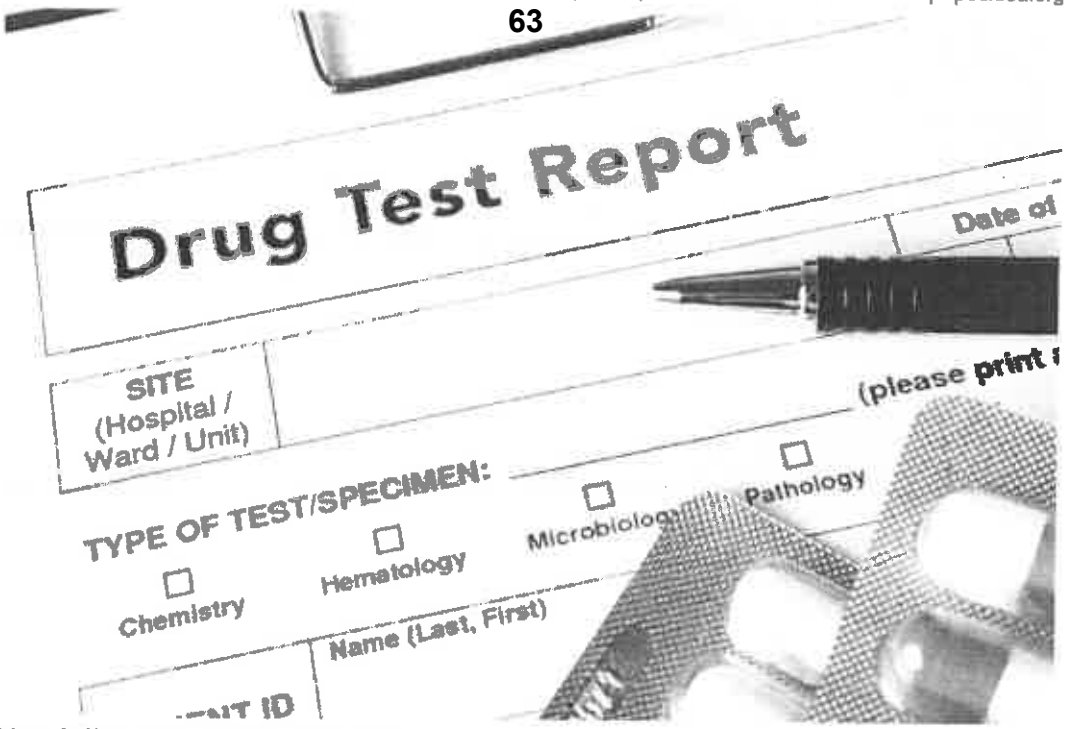

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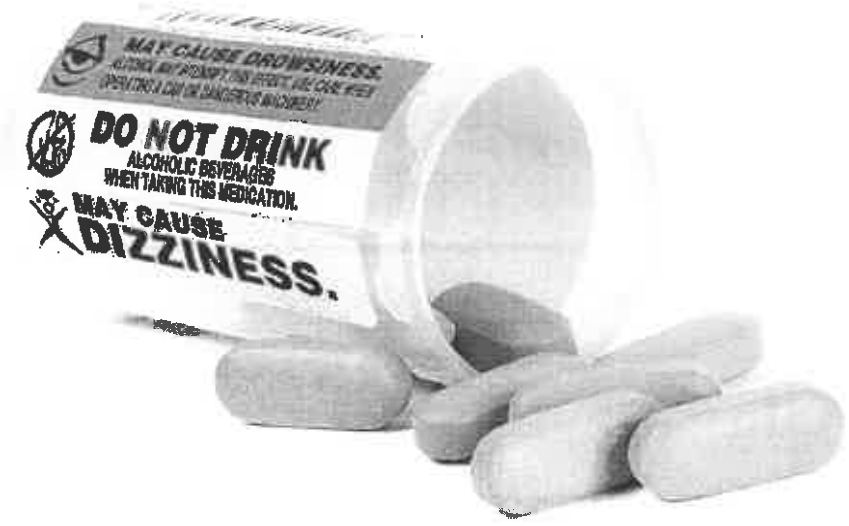

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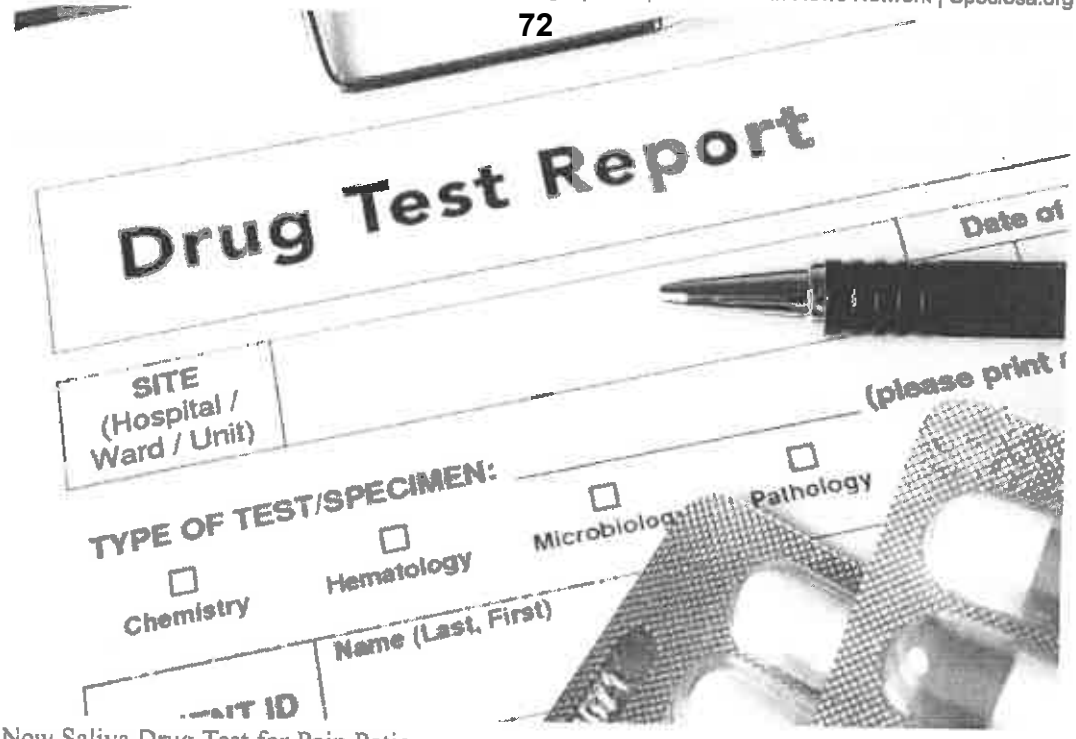

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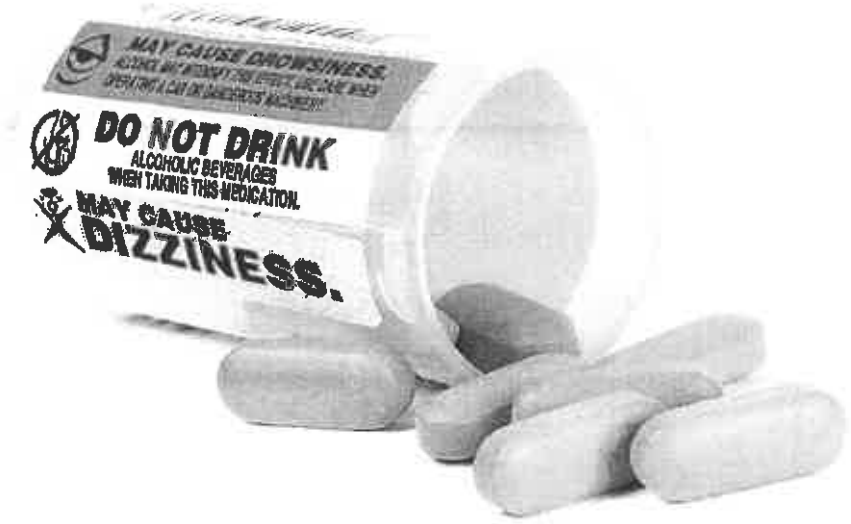

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Gin 15 hours ago

What did she say? Pain medication was responsible for less than half of the 33k deaths? What – 12k? Yet they went after doctors and opiate prescribing with crazy determination! Yet of those 12k deaths, less than 25% were due to actual patient / doctor prescribing – the vast majority caused by deference. So now we're really looking at 3k deaths a year possibly caused by the overprescribing of opiates. Wow what an epidemic!!! However, there are over 90k deaths per year reportedly caused by alcohol – with zero therapeutic or medical benefit to alcohol – yet it's left alone. Seen any alcohol epidemic headlines lately? And cigarettes kill over 440k per year – with absolutely no medical benefits to smoking. So – my question is: why is there such an extreme focus on prescription opioids?? (Statistics can be found in Judy Foreman's novel A NATION IN PAIN).

Linda 16 hours ago

FINALLY!! Someone GETS it! My 34 yr old son has cried in my arms, because he wants to die. He can't handle the pain anymore, because he's extremely under medicated. Heroin is his next option. These people are dying from mixing fentanyl with heroin, so give people back their meds, quit prescribing fentanyl outpatient and the numbers from accidental overdoses and suicides will improve.

Brenda 10 hours ago

Linda, research kratom for your son. It helps with pain.

Gerorge Neil 16 hours ago **76**

My roomate is a Chronic Pain Patient and I watch her suffer everyday since all this cutting back of her medication it isn't bad enough for the to take her life or turn to street drugs but if other people are hurting worse than her I can unerstand them turning to Herion or street drugs but what they are getting is killing them so I have read alot on facebook at the Chronic Pain Support Group and alot of them are already talking about taking their lives because of the pain. What about the oath that Doctors take to do no harm. The CDC started all of this with their so called guidelines that they probally knew would scare off the Primary Care Doctors first and thats what it did they drop their patients with no medication no refferal and no care and all the other agencys followed suite the CDC VA DEA HHS CMM CMS FDA then for good measure the CMS want to use the MME formula which will cut everones medicines by at least half so what are you ganna do now let more die or turn things around and let the Doctors do the jobs they were meant to do?

William Mangino II M.D. 16 hours ago

The fact, even if true, that 2/3 of persons who had overdosed on fentanyl/heroin had (also, according to Debra Houry, M.D.) received at least one opioid prescription during the seven year span of time leading up to their overdose; tells us nothing about whether the opioid prescription was their "first" initiation to an opioid of any kind, whether they got it for a legitimate pain complaint, whether they took it themselves or sold (diverted) it, and whether they were "addicts" before receiving such a prescription.

Thus there is no basis for Doctor Houry's speculative opinion that prescriptions for opioids constitute a "gateway" for subsequent use of heroin.

I personally feel that after interviewing over a thousand abusers of all types of narcotics in a prison population where the interviewed inmates had nothing to protect by lying; two "facts" stand out: (1), OxyContin "snorters" can do 12-14, 80 mg. tablets a day…without much adverse side effects, and (2), most of the guys I interviewed said they were using street drugs long before hitting-up on medical practices with false pain complaints.

It is precisely because Doctor Houry and her associates "jumped the gun" by accusing overprescribing of opioids as a reason why heroin addiction has increased…which is enough of a "myth" and "prejudice" type accusation to cause a real "chilling effect" on even "legitimate" pain prescribing, sufficient to get doctors offices closed down on the excuse that DEA or AG officers are "investigating" the doctor – and that, even when the evidence is questionable: some doctors will get convicted on what certainly (in light of our mass

national hysteria associated with prescribing pain killers) must be the easiest of all criminal charges to obtain convictions on: and which further serves to "marginalize" pain sufferers' from obtaining the only medication that works for "them."

Cathy Reiner 16 hours ago

Cathyh1957

We have tried to tell the CDC HHS the CMS the FDA the VA and even going so far as to make the Doctors use the MME to amke our medication to be cut so low that it would and will not control the kind of Chronic Pain that most of the Pain Managent patients have.We suffer everyday and it seems our crys have fallen on deaf ears we fell no one in the Goverment Agencys care anything about us or if we suffer.

We taake our medication the way they are writen I was on 30mg of oxycodone every 4 to 6 hours as needed which I received 150 per month and I have a pain pump inplanted in me that was giving me 1.26mg for 12 hour during the night and 1.12mg for 12 hours thuring the night to help me sleep when laying in one position at night. My Doctor who is a Chronic Pain Specialist has cut me back 30mg of oxycodone by mouth aday and cut my pain pump back from 37mg in 24hrs to 6mg in a 24 hour period.

Since the cuts I can no longer wash dishes or do any cleaning of the house I only bath 2 times a week because it is so painful I am already in a wheelchair but my quality of life is half of what is was. I am begging all the people that believe all you have done is saving us try to remember we are human and we are not emune from pain and we don't want to live having to take medicine evryday but we have had to except that is how our lives are ad will never be the same but we are not Drug Addicts we use 1 Doctor 1 Pharmcey everything we have tried to tell you is happening and is it worth all the Deaths it is causing worth it?

Jonathan 16 hours ago

Like many of you I have been watching this snowball roll down hill towards all of the legitimate patients being made as scapegoats. I have been appalled by the lack of honesty in the way the numbers have been reported always with a slant to sensationalize the worst of the worst. I want to share some information I have compiled that will I'm sure add fuel to this new's. I received a letter in December United Health was dropping Oxycontin from the formulary as of Jan. 1, a little background, I had gastric bypass surgery in 2002 and an open hernia repair in 2004. the repair failed and 7 days after the re repair I had the staples removed and within hours 85% of the 2.5 ft incision was open like a zip lock bag. It took 3 years, 13 surgeries, 3 rounds with a wound-vac, a fistula, the removal of my abdominal wall three times due to infection and a plastic surgeon to fix it. I remember asking the surgeon what I had too do to be able to take Tylenol again and he laughed! When the swelling went down the pain set in from the adhesion and scar tissue and muscles being pulled out of sorts. I've since had two inguinal hernias a P.E, and recurring aspiration pneumonia that they can't find a reason for now on case 45. I'm 47 own my own company, have 4 kid's, go to the gym every day, bike, run, don't smoke, drink just want to live! Ironically the surgeon who screwed me was abusing stolen pain meds from the hospital pharmacy at the time, but it was covered up. I have been on the same regiment of la/sa for 4 years until January, due to my history I don't absorb long acting well so my Dr and I have settled on 3x day but mainly relying on short acting for my most effective relief. We made a plan to taper down and then taper back up on Opana ER until I got back to to full dose. We got PA for 2x a day and on day 20 she changed the dose to 40mg. In the past this would have been a therapy change, no problem getting through ins. they denied as to soon. 20 phone calls later my Dr. spoke to the Pharmacist and She said, we thought you were titrating him off? My Dr said no, why would I? They approved me for 60 days and I got a letter saying my request for 3 times a day was denied, but could be approved if under the 90 MED which was less than the first approval I got in January. Today I called as my 60 days was up to get a clear answer and confirmed what I found in their latest documents. As of January 1. non cancer pain is limited to the 90 MED limit, period. Despite me already having a pain management specialist and meeting all the hoops, The only way to return to the dose I was on before the first of the year is to appeal. I get the broad brush they are painting with, but I also confirmed while I can't get more than 30 mg of opana a day, I can however get my 150 30 mg oxycodone with no problem. if I really want it I can also get 412 percocet's or 412 vicoden, all on the supply limit without restriction for 1 copay each. So is it about the safety or about the money? From their document dated today called "United Healthcare Addresses increased Opioid Use and Dependence" They tout in 2015 alone a 41% in Opioid prescriptions written, 45% in number of Physicians prescribing Opioids and a 41% decrease in pharmacies dispensing Opioids. So take these numbers and what the CDC released today and understand there are some smoke and mirrors going on and peoples lives are at stake here. It's time to break the silence!

All comments are moderated and will generally be approved within 24 hours, so please be patient. Comments that are uncivil, profane, libelous, name-calling, off-topic, or contain spam and/or self-promotion will be deleted. Sharing of links to

Rochelle 4 days ago

Dr. Alba, describe the Somatic Therapy please. I was diagnosed with RSD/CRPS twenty five years ago by a W/C MD. They go out of their way to not diagnose this pain syndrome because it's a very expensive, lifetime problem. I wasn't able to obtain good pain management for almost 18 months. At the time it was only in my left foot. He didn't tell me what RSD stood for nor explain what I might be facing. I spent several hours in the library researching RSD. Computers were nothing like today and all I could find was a paragraph about Causalgia, discovered by a Civil War doc, and it had something to do with nerve damage. Good, I thought at the time, can't be THAT bad. Silly me. I didn't push for treatment as my regular W/C MD would prescribe low dose pain meds for my right knee injury. During the care for the knee, developed a deathly allergy to aspirin and non steroidal. Almost died when given a prescribed mega dose of Aspirin. When treatment was started, my first pain doc was very conservative. No pain meds, which was fine with me. He prescribed tricyclics, which caused cardiac dysrhythmias. He stopped those and placed me on the Catrapres patch. It caused my BP to bottom out. He did do a Lumbar Sympathetic Block to confirm the diagnosis. It stopped all the foot pain. I then learned what exactly lay in store for me. He sent me to a Therapist at the hospital I worked at. She got laid off so my care was transferred to the head of the department, a Psychiatrist. Nice doctor, but after trying three different SSRI's decided I just couldn't tolerate them. Never have been able to tolerate many meds, and this thing about natural endorphins, is a joke for my brother and me. We have always had zero pain tolerance. My pain doc discovered early on my case was difficult at best. My first SCS worked wonderfully. Had two other ones after it died after only 15 months. Ran it on high for 24/7. Had two Pumps. Neither worked very well and my body rejected the second one and it never got refilled. Can't tolerate morphine, codeine, fentanyl. Demerol led to gives and severe chest pain. Codeine and Methadone made me throw up. Great I am thinking, what's left? I wasn't placed on pain meds the first four years. PT was tried, but it only exacerbated the now rapidly spreading monster which was overtaking my body. So forgive me if I don't jump on the bandwagon for a treatment modality I don't have the energy to even look up exactly what it is. The damage is done, everything that can be done, has been, all to no avail. I've had every Block for upper and lower extremities. More temporary catheters for both upper and lower extremities. I don't choose to be a guinea pig any longer.

petition drives, websites or personal email addresses may also result in your comment not being posted.

Rochelle Odell 4 days ago

I just spent two hours on my PC researching Deb Houry, Emory University and the CDC. Dr. Houry is NOT an employee at the CDC, but an Assistant Professor Administrator in Emergency Medicine at Emory no less. As an Administrator, she doesn't even get her hands bloody. Her big title is from Emory, but the CDC seems to have adopted it, thus the connection between the two. Her other speciality is basically preventing and treating abuse in women. Admirable, but what the heck does it have to do with chronic pain diseases, pain management, etc? Nada, zero, zip, NOTHING! She also teaches against suicide from violence and stops PTSD in the ED. What is wrong with this picture?? First, the CDC has an openly ANTI OPIOID MD, write their now damaging 2016 Pain Guidelines, that have hurt far more than helped. Then, the CDC sends an Emory Associate Professor to speak to our elected officials. I am appalled, angry and disgusted by the CDC and Emory. For any who have never worked at a University hospital, an Associate Professor is an alumni of said Medical School. Sounds great and they may have to teach occasionally and write papers. Then, upon further searching, learned Emory, which is in yes Atlanta, GA, just where the CDC has its headquarters. Emory awards grants to organizations like the CDC for research. The CDC turns around and awards grants to universities and orgs. And which department at Emory got awarded a FIVE MILLION DOLLAR GRANT to the very ED Dr. Deb Houry leads. Talk about the good old boy, I'll scratch your back if you scratch mine! She was NO MORE QUALIFIED to address Congress than the first MD the CDC authorized to write the very damaging Guidelines. Gee, you think the families of any chronic pain patient who have committed suicide or who has tried thanks to their loved one taking their life due to unbearable pain needs to inform Dr. Houry, she is anti suicide. Her real email address is DHoury.emory.edu. If you try to contact her at the CDC, you may not get very far. With this cross grant giving, isn't that collusion or something illegal? I am in too much pain right now to even look up any words. I just think it's pathetic people throw around false titles, represent areas they really aren't qualified to represent. Those of us who live with chronic pain every hour of every day, have had every treatment modality forced on us, until all that was left was pain medication, and for so many, it ended up being the proverbial rug pulled from under us. We know more about pain management, responsible OPIOID medication! Start writing your elected officials. Do the same searches I did. These morons need to be stopped!

Search

pam 2 days ago

Great find!! Is did email this witch awhile back and actually rec'd a letter back not once addressing chronic pain but threw in my face il about the opiod epidemic and addiction! Need,ess to say I was not pleasant when i wrote her, Angry I was and still am very angry!!! Why the f*** should myself nd the millions more like me have to live the rest of whats left of my life suffering so bad i want to die, Life liberty and the pursuit of happiness!?!? What a travesty !!

Dr. Alba 4 days ago

In my experience working in healthcare with thousands of people in chronic pain, the vast majority are not drug seekers – they are relief seekers. While there are exceptions, opioids have not been found to be effective in the long term for chronic, noncancer pain, and they pose significant risks including addiction, side effects. and death (even when taken as directed). The harms often outweigh the benefits.
Wait, before you get angry please consider this. Limiting opioid prescriptions, without providing safe, effective pain relief, is not the answer. And that strategy, in addition to not addressing the pain problem, may lead to numerous unintended consequences, including increased use of illicit opioids, addiction and overdose deaths.
What if physicians and patients were given research-proven tools to reduce and even resolve pain, without the risks associated with opioids? Do you think they would be interested? Clinical trials conducted at a major health system in Michigan with thousands of participants demonstrated that Somatic Functional Therapy (SFT), either one-on-one or in population health programs, produced significant improvement in chronic pain (nearly 40% of conditions resolved and 80% were improved) and related problems such as anxiety, depression, and sleep disturbance. Furthermore, 67% of those taking pain medications (including opioids) either reduced use or stopped taking them altogether. Of note, no one forced them to do this, they did this on their own as their pain symptoms and health

improved.

Furthermore, physicians trained in SFT are able to improve health outcomes and patient satisfaction, while reducing their opioid prescribing. Why aren't we pursuing these types of safe, effective approaches to address the opioid crisis nationally?

pam 2 days ago · 1 like

Dr. Alba, I invite you to step in my shoes for a few months. in order for you to get the full effect of my life, you must allow me to continually beat your back with a baseball bat all day every day as thats how mine looks and feels, you must allow me to drop a 100lb slab of burning concrete on your back as well, as my every inch of my spine feels as if its being crushed. you must allow me to drag your hips along the concrete road, chipping away at your bones, you must allow me to send electric type shocks down your legs, piercing, stabbing, burning tyoe elctric shocks, you must allow me to wrap your feet i. a zillion burning pins while tying your ankles off with burning ropes, you must allow me to beat your knees with a hammer over and over and your upper legs will have heavy weights on top of them so that every time you try to go upstairs your legs become weaker and weaker. It will be extremely difficult for you to even make it up five steps. You must also allow your peers treat you like a POS. you will be degraded, abused, mistreated, stigmatized as a drug addict and pill seeker, you will be discriminated against, and you most certainly will be treated like a dam criminal!!! In order for you to get the full effect you will have to allow your peers to put you thru every alternative therapy out there, every OTC AND NSAIDS that will rip apart your stomach and liver, you will be put thru many epidurals that will increase your pain and leave you with adhesive arachnoiditis. You will be put thru two failed spinal fusions that will leave you with severe nerve damage. Now see I have been suffering for ten long painful years,. I did everything the medical community told me to do. Your challenge is for just a few months, as I probably won't be around to see you suffer for years. I have been pu thru years of physical therapy, massage, chiro, accupuncture, OTC AND NSAIDS that tore my liver and stomach up, two failed spinal fusions that left me with severe nerve damage, back braces, tens, heat, jce, water therapy, discectomies, steriods, nerves burned, eating healthy, exercise, holistic, herbal, over the past five years ive had hundreds of facet injections, trigger point injections and SI joint injections that intensify the pain, every non opiod medication that gave me horrible side effects. Ive done everything MY BODY, NOONE ELSES, MY BODY could take and my wallet could not afford!! Opiods were my LAST RESORT!! and when my old dr found what worked i was guven a QUALITY OF LIFE! For years I was on the SAME STABKE DOSE – how dare you say opiods don't work for long term pain when for eight

years they continued to work just fine, until the dam corrupt government and thier sidekicks the CDC, DEA, FDA AND PROP interfered where they do not belong! Between a dr and pt, having drs running scared if they treat thier pain pts with opiods. Drs are abandoning thier pain pts, lowering thier lifesaving meds to ineffective doses or abruptly stopping them, leaving the pt to go thru what could be deadly withdrawal. We are being left with either turning to the streets for relief or worse SUICIDE!! Any time you feel up for the challenge let me know . Ill be honest the amount of pain you will endure will have you begging god to take you!!! You will suffer from anxiety and depression and every dr you call for help will turn you away and make you feel like giving up! What right do any if you so called doctors have to tell a long term chronic intractable pain pt what does and doesn't work when you cannot feel what another feels!?!? I am so disgusted to live in a country that is killing off the chronically ill!! denying legitimate pain pts LIFESAVING PAIN MEDICATION!!!

Cecelia Kuhn 14 hours ago

It Sounds like you have Ankylosing Spondylitis like me.

Kimberly Palmer 3 days ago

Dr. Alba,

Forgive me, but can you explain how…
"opioids… pose significant risks including addiction"
that
"Furthermore, 67% of those taking pain medications (including opioids) either reduced use or stopped taking them altogether. Of note, no one forced them to do this, they did this on their own as their pain symptoms and health improved."

If the risk of addiction is so great then how can a whopping 67% of patients taking pain medications, including opioids, all decide of their own accord, not forced, to reduce or stop taking them altogether ?

I think the later statement shines a bright light back onto the first.

There are studies, that largely get ignored, that show that people who suffer with chronic pain do not become addicted nor do they feel euphoric when taking pain medications.

Jody Keaghey 5 days ago

I have lived in Chronic pain for years. 8 to be exact. I have several loved ones here that started out with Norco and Lortab and are now on Crystal meth and heroin. I was started on the tramadol/flexeril combo for Fibro and back problems and when it wouldn't work they began prescribing get Norco. When I realized I was developing a habit the fear of addiction hit me and I began to search for alternatives. Here in the state of Louisiana Marijuana is not legal so we can't legally use it for pain. I will you it decreases it by half. This is the fight we need to be fighting. It is safer, non addictive and doesn't have to be smoked but can be used safely in a controlled environment where it doesn't damage our lungs etc. However the government is too busy building their synthetic forms to market right now and haven't approved it yet because they can't make the money . There is also a medication that is an Antabuse drug. It's called Naltrexone. I researched it. Low doses under 4.5 MG of it have been show to help patients with Fibromyalgia, MS, Lupus, Parkinsons and other conditions by blocking pain receptors in the brain and releasing endorphins and decreasing fatigue. Taking it, you can't take opiates at all, but I have been on it a year and it has given me my life back. It's made in a compounding pharmacy and about 35.00 a month. Please research LDN . Please help push for Marijuana decriminalization and legalization because it can be used safely with the LDN.

85

Pam 4 days ago · 1 like

That's great thT you found something that works for you. Yes marijuana helps ease severe pain, anxiety, ptsd, etc. BUT please keep in mind it does not work for everyone. Therefore, pain pts should have any and all options available, whether it is opiods, marijuana, kratom, etc., we are all created differently. we all tolerate pain differently and we all tolerate opiods. kratom or marijuana differently. What works for some may not work for others…

MK 6 days ago

Commenting on this site does no good, UNLESS WE ALSO TAKE ACTION. It is not that difficult to formally PROTEST. It is not that expensive to formally PROTEST. It does take some time and organization.

Pam 5 days ago

Chronic pain patients had a protest back in October, it wasn't a huge turnout as many could not get to the White House, due to either financial problems or the overbearing pain. There were several guest speakers, doctors, etc. Unfortunately the protest did not even make the news, wonder why that was..smdh. Please join the facebook support groups, there is one called Vet fight back,and there is awesome info and they are dighting back as much as possible, pain patient advocay week as well is coming up in April. There are also support groups on facebook , just search chronic pain and many groups will pop up..

Rochelle Odell 6 days ago

What Your is not stating is all it takes is one hit of heroin and the user is hooked. My meds were all stopped in 2016, and my CRPS/RSD pain has spiraled it of control. My right hand has become so contracted and painful, it has become useless. I have become housebound. My dog needs to see the Vet, but I haven't driven since December 2016. I have never experienced pain like this before. This is insane, all due to the CDC's Guidelines. I personally cannot tolerate Fentanyl. Beginning to think if I could have access to illegal pain meds, it might be worth a try, but it's too costly and illegal, not viable options. Using heroin is never an option. There are too many of us suffering, severely, from having the meds we used responsibly, that used to allow us to function as normally as possible considering the circumstances. Perhaps the CDC and DEA need to LISTEN to our stories, really listen for once and make appropriate changes to both Guidelines.

Sherry Sherman A week ago · 1 like

Thank you Jane for the members of the committee as you read my mind. I have a lot of information I want to send Debra Houry again. Including the one from 12/26/16 in which the CDC admitted to double and triple counting deaths. Heroin turns to morphine. Fentanyl isn't known if legal or illicit, whether or not scripts were legal or stolen etc. ect. This is all a complete and utter lie from our trusted government officials and it must stop. The CDC Guidelines must be undone and not re-written as they the FDA, DEA, VA, HHS and many more have a lot of blood on their hands. They cherry picked the study to fit their needs and didn't even know we have a long term study on opioids of over 10 years without Hyperalgesia. Yes, you heard me correctly it's been done and all one needs to do is email me at Ssherman1123@outlook.com and I will gladly send it and many more.

We are also doing a radio show that will run for 24 hours with all CPP's as commercials. If you would like to speak for a 13 minute segment and/or do a 90 second commercial please email me at the same address above. Title your email "Radio Show or Long Term Study." I will get it to you as soon as possible as they are due by 4/13/17 and I have all information I can send by email.

This article doesn't even begin to tell the truth, but we must persist and the truth will be told. Too many Veterans and Civilians have suffered needlessly at the hands of their idiotic guidelines as too many have made them laws.

Our doctors need to be able to do the job they went to school for without fear of the DEA. I speak to people every day who are being hurt by physicians who are no longer writing their life saving opioid medications. We didn't ask to be given a chronic illness and/or chronic pain no matter what the reason and would gladly give it back.

All of those who've done the damage need to be held accountable and should feel our pain for 24 hours. I guarantee you they'd want to give it back ASAP and then we can all say " No thank you it's yours for life now." How do you think they would feel then if they felt it for just 24 hours when we have to feel it 24 hours a day – 365 days a year?

Sincerely,
Sherry Sherman, CRNP, MSN, BSN, CPC, CCS, CPPM
US Pain Ambassador and Advocate
Too many chronic illnesses to list

Jane 4 days ago

Hi Sherry,

I would be very interested in the study you refer to on hyperaglesia. I've followed the responses to the Opioid Restricting Guideline and seen a progression from "there's no evidence that opioids are effective for chronic pain" (because they haven't done anything he studies) to "opioids may not work and may make chronic pain worse" to "we now KNOW that opioids don't work for chronic pain and make pain worse". It seems like a perverse game of telephone! I've read quite a few paper on OIH and never seen any credible evidence that it is anything but rare, unpredictable and poorly understood rather than widespread and inevitable. I will email you.

Patti Young A week ago

This is what I am afraid of happening to Chronic Pain Patients. Called collateral damage as a result of CDC guidelines. It threatens Drs, who could prescribe responsibly from doing so! I also believe some of this mess has to do with the previous Government requirements that were placed on Drs' to treat pain. They took that literally and started over prescribing Opiates for pain issues that probably did not need such a strong approach. Patients' started expecting a prescription for a pain pill to cure their pain. I think it was the wrong way to think and it began the emphasis on Pain by the governement.
I do not think Pain should be ignored, but there has to be less control over the Drs' so they can do their job!

Steve Glass A week ago · 1 like

NOW..WE TRIED TO TELL YOU.
AND I'M NOT A HEROIN USER,BUT KNOW ALOT OF PEOPLE IN MY TOWN ….FROM HERE TO DENVER,AN EPISODE ON DRUGS INC. CONFIRMED IT: HERION SEEKING /USE UP EXPONENTIALLY AS A DIRECT RESULT OF "GUIDELINES" PERIOD. NOW REPEAL THIS AND LET THE DRS. THAT WENT IN TO THIS FIELD RESUME DOING THIER JOB WITHOUT BEING SCARED AND BULLIED!!! 40 YEAR PAIN SUFFERER.. .000 OVERDOSES!!!
STEVE GLASS KNOXVILLE TN

Jane A week ago · 1 like

Many of you are directing your comments to Deb Houry as though she's reading this site. Maybe she is, but maybe she isn't. Copy your comments directly to her, and to the members of the subcommittee she testified in front of. Maybe she's the one left holding the bag now that there's a new HHS secretary and Tom Frieden is out. Maybe she is reasonable or has finally seen the light. Maybe she would begin to listen….
Here are two email addresses I found for her: dhoury@emory.edu and vjz7@cdc.gov
Get a new Yahoo or gmail email if you need to.

Here's the list of members of the House Energy and Commerce Committee's Oversight and Investigations Subcommittee

Republican Members

Tim Murphy (Pennsylvania – 18) – Chairman

Morgan Griffith (Virginia – 09) – Vice Chairman

Joe Barton (Texas – 06)

Michael Burgess (Texas – 26)

Susan Brooks (Indiana – 05)

Chris Collins (New York – 27)

Tim Walberg (Michigan – 07)

Mimi Walters (California – 45)

Ryan Costello (Pennsylvania – 6)

Buddy Carter (Georgia – 01)

Greg Walden (Oregon – 02) – Ex Officio

Democratic Members

Diana DeGette (Colorado – 01) – Ranking Member

Janice Schakowsky (Illinois – 09)

Kathy Castor (Florida – 14)

Paul Tonko (New York – 20)

Yvette Clarke (New York – 09)

Raul Ruiz (California – 36)

Scott Peters (California – 52)

Frank Pallone (New Jersey – 06) – Ex Officio

Pam 6 days ago

Sad to say, there are manyain warriors who have contacted Miss Houry a year ago, and the reps that are listed as well as many more. I wrote to this smug smiling killer, and she even wrote me back, BUT there was ZERO reference to chronic pain pts and 100% references to the "fictious opiod epidemic" She pretty much ignored the pleas from pain pts nationwide. I highly doubt she's listening now, as the addiction driven agenda put in place under Obama's watch, continues to worsen and many lives lost to suicide due to this witchhunt meant nothing to her, These murdering corrupt lawmakers may never know what 24/7 intractable pain is like to the public, but I don't doubt for a second that there are many of them that do take opiods to ease thier pain. Keep in mind there are different sets of rules for "we the people" and those who are responsible for committing genocide. As much as I

wish for all of them to walk in our shoes, the thing is they will never know what agony is like. they have thier private drs and pharmacies on speeddial.They are all a bunch of hypocrits!! Oh and on the news today I heard that our asshole governor here in NJ, will be on his way to the White House to lead the opiod task force. We all are doomed!!

Jane 4 days ago

Somewhere along the line, someone on the addiction treatment side got the ear of the CDC. My guess is that it was the relative of someone who died from heroin or fentanyl or …. I further suspect that this person or the relative needed someone to blame, and prescription opioids fit that bill. It was the low hanging fruit. The CDC did everything it could to avoid objective reasoning, cautions, counter-arguments or transparency. They steamrolled it through. Their story was opioids were to blame and they were sticking to it. Well, that didn't work. Now Trump's story is that all the illegal heroin and fentanyl and … is coming from Mexico and if he builds a wall it will solve the problem. It won't, either. But maybe the tide is turning a little and maybe now there's a small crack through which a glimmer of truth can get through. There must be someone with a story that can crack the armor of the heartless politicians and beaurocrats. They need to hear all the stories! Maybe a champion will emerge who has a parent, spouse, child, neighbor, best friend with chronic pain who has had their opioids cut off. A year ago wasn't the right time because no one was willing to listen. Maybe they aren't ready yet, but the more that it becomes clear that the CDC was wrong, the better the chance that someone will eventually listen. Don't give up!

dorlee A week ago

Thank you for the info above. I will start writing. I hope everyone else will also. I think we are starting to put a little pressure on the folks that started this mess. Maybe it is wishful thinking but we need to keep going.

have a heart donate2.png

Kara Rowe A week ago

I'm in so much pain tonight I can't even muster up an intelligent response to the absolutely absurd claims by this so-called doctor Hourly!

Shameful. It's all just too shameful.

Pain patients we just need to keep fighting!

Please feel free to join me on FB at chronic pain reform.

IJ Morris A week ago · 1 like

CDC or ANY government agency has NO business telling doctors how to treat their patients. What you have done to us is criminal and all of us need to find legal support to go after these idiots. Think of the elderly that can't move without pain medication… LIKE ME!! Whoever wants to move forward with protecting us from the government EVER interfering with legitimate doctor/patient HIPAA treatment, go to Moveon.org or someone make another suggestions. We need to start a Facebook group if one has not been started already. I am disgusted to say I am a US Citizen. What have you done to our country and citizens, government? And who let you???? I also suffer from Chronic Lyme and other co-infections that cause pain that the CDC refuses to acknowledge yet has per an article personal financial ties to pharma companies? Is this true CDC and if so, what are we the Citizens doing about it?

Totally disgusted Medicare patient-

dorlee A week ago

There is a new (to me at least) facebook group called Vets Fight Back. They are representing veterans and regular citizens to have better health care, fight back against CDC, DEA etc. and the CDC being the cause of now non treatment. I don't know much yet but it might be worth a look. We all need to find the biggest groups and get involved. I don't know if there are too many smaller groups but maybe we would have better luck joining the groups with the most numbers. I think everyone is too scattered and our voices are not heard. Any ideas?

Jenifer Markoe A week ago · 1 like

Actually alcohol is the gateway drug. Most kids are drinking first then get the stuff at some party. Please be honest.

Teraysah Barker 6 days ago

Alcohol and cigarettes ARE the gateways....

FOLLOW PNN

PNN CATEGORIES

Karen Stasiak A week ago

More smoke and mirrors from Houry, I can't say that I am surprised. I wonder if "they" have yet considered the other damage done to pain patients,i.e., stress related illnesses? Or even just the fact of turning a large segment of Americans into bitter citizens, feeling completely abandoned by our so-called leaders. My pain clinic (5 years there) was taken over by different doctors, and I have undergone cuts which have me at less than half of what I used to take (with no ill effects, or problems whatsoever). Yet upon my last visit, when I responded to being questioned as to how I was doing by telling him that the most recent cut (3 1/2 weeks prior to appt.)was the hardest one to adjust to, his response was that I needed to detox. He said that cutting it again wouldn't be fair to me. How does that make any sense….somehow detox would be? Then what??? When I asked him what I would do afterwards for pain relief, he answered with the news that I should seek a new doctor. He left the room abruptly and returned with only one months worth of prescriptions, instead of the customary two months worth, and then I was denied the ability to schedule another appointment. I was told my account was flagged "do not schedule, the patient disagrees with suggested course of action". What the hell, is that even legal…..patient abandonment? With only a month to find a replacement, which is a hellacious undertaking nowadays, not to mention that I have no idea if the new doctor will even help me. So, next week I could find myself with no medication, and left on my own to deal with it. I also want to say that I love how the fact that one becomes physically dependant on opiods is used against us….there is a HUGE difference between physically dependant and addicted, for crying out loud! Not to mention that there are MANY MANY different drugs which people take that one would go through some level of physical discomfort if they were to abruptly stop after years of taking – even thyroid medication, to mention one simple example. I try to be a good person. but I see my entire future being taken away (along with my fellow pain sufferers), and the word "hate" is unavoidable, and that's no way to be either.

Harry A week ago · 1 like

94

Why don't you just take us Chronic Pain Sufferers out behind the building and shot us in the back of the head? ….. We don't even let animals suffer in pain

Charles A week ago · 1 like

The drug Alcohol negatively affects 1000's of times more people than opioids and all other drugs combined….
Why don't you "smart" people go after the pushers of that drug?

Ohhh that's right there's more money being made from the drug alcohol

Mike A week ago · 1 like

The doctor is not being honest when she says the forced reduction in pain medication for patients has not forced people to seek relief from pain with illegal drugs. This is typical government bull when the unintended negative consequences is worse then the intent of misguided policies of professionals that have not even diagnosed the patients.

dorlee A week ago

She still believes pain meds are a gateway drug. According to her, "statistics from Ohio showing nearly 2/3 of people who overdosed on heroin or fentanyl received at

least one opioid prescription in the seven years before their death." Is no one allowed a prescription (one) for surgery, root canals or other? In seven years? How do you relate that to being a gateway drug? Guidelines should be repealed now. Why was she testifying before the House Energy and Commerce Committee's Oversight and Investigations Subcommittee? Is that someone else we should be writing letters to? We should flood that group with e-mails, letters, complaints, stories etc. Maybe they will do something since all the other places are still ignoring us.

Anne Mathews 4 days ago

my question is the people who are OD'ing what is the average age???? Probably 20's-30's Right So if some one in their late 20's OD'd them having a script for hydrocodone for wisdom teeth removal 7 yrs prior that caused them to get hooked to heroin???Yea right.

You know you can manipulate stats to say anything you want

Larry A week ago · 1 like

Dorlec, do you know why Ohio has went straight to the top of the list for worst heroin and illicit fentanyl deaths? The governor John Kasich started in 2011 with the intimidation of the primary care doctors that wrote schedule 2 medications. That forced many into the pain clinics who for years were given some relief. Then hydrocodone was rescheduled and the scare agenda of pain medication was ramped up in 2014. He implemented strict guidelines that made things so much worse for opioid dependent patients after that. The drug addicts that were using for non medical purposes then could not afford the little amount of pills that ended up on the street. And then the surge of heroin flooded Ohio, the state created the perfect black market conditions. Restrict all opioids no matter the consequence, low supply= high price, heroin=cheap. The elderly, disabled and chronically ill are surging the suicides. It is so sad to read the obituaries, the newspapers are filled with so many deaths from this situation. Everyone loses in Ohio, the state has a bogus medical

marijuana law that is nothing but a delay tactic. No access for those in pain, and now you must seek out a drug dealer for weed. Guess what else those dealers have? Fake pain pills laced with illicit fentanyl.

Kara Rowe A week ago

Dorlee,

I agree with you! She is totally reaching with the 7 years prior thing! Let's be serious here! Even a child could see beyond her claims. It lacks any sort of logical reasoning.

Not to mention, many professionals, studies, and industry relative people have cited the gateway drug theory to have been debunked many years ago! This is how desperate people like "Dr." Houry are to further their agenda and to stick by their guns. It's sad and frustrating when we see the truth of the matter being denounced by those too afraid and unwilling to admit they've been wrong.

Wake up America! You've been hoodwinked. Opioids are still the best medicine for chronic pain when used appropriately and with proper maintenance from a physician.

jojordan A week ago

That '2/3 received opioids in the last seven' years shocked me too. You could make that correlation with anything from NSAIDS to chocolate! They are just trying to cover their butts for making a huge mistake in their statistics to begin with.

- Pain Medication
- Opinion
- Addiction & Dependence
- Alternative Treatments

Cat Mc A week ago · 2 likes

I had already lost my career, ability to go on family outings, sleep in a bed, do my much loved gardening, WALK,my self respect, and so many other things I loved to do. My medications gave me somewhat of a quality of life, at least. I had lost enough….and then you pulled the plug on me….and sent my family and myself spiraling downward all over again!!!!

I agree with you completely, Sheri Wolford!!

nameless patient A week ago · 2 likes

Seeing the photo of this woman smiling happily in the wake of all the damage done angers me.

Michael J. Maltese A week ago · 2 likes

Lawsuit? What lawsuit is that Sheri Wolford? I'm interested to find out more!

- Pain Research
- Back Pain
- Arthritis
- Fibromyalgia

Sheri Wolford A week ago · 4 likes

Gov't had NO BUSINESS sticking their noses in our LEGAL medical treatments to begin with!! I hope every doctor who had their licenses revoked, for not agreeing with the so-called "guidelines" because they were SPECIALISTS, not only joins in the lawsuit against you, but gets public apologies and acknowledgements that actually DID NO WRONG!! All of you need to be fired, without pension, for all the inhumane pain and mental abuse, you've not only caused pain patients, but families of patients that have already committed/atttempted suicide!!
And to STILL try and come up with excuses for your actions is absolutely disgusting. REVERSE this asinine ban NOW!!

maryw A week ago · 1 like

„what lawsuit?????? im in„I AM THERE„„„„ I am working on #3 attempt at thee aclu„soooo what lawsuit?????„„until we r allowed to speak infront of congress ourselves„„„I TRUST NOTHING OUT OF THIS GOVERNMENT„„ recently i did MORE research„„did u guys know„the suicide rate decreased by 4 % from 1990 thru 2000„„„„gee„..u think it was thee invention of Pain Management???I DO!!!„FROM 2001 till 2016„„it has literally doubled„from 22,000 to 46,000„„„„I actually sat down „did the numbers for our vets..„sad„„„22 a day x 7 days is„154×4„=616 per month x12=7392 a year„„The vets„literally account for close to 1/2 of that 22,000 increase„„THAT IS 22,000 HUMAN BEINGS„„„„WHO jmo„„have had to make that choice„„„Every since Dr.Government bullied there way into our private medical Decision..Now from 1990 till 2000„„when Doc's made the decision w/out fear of the dea„„„suicide dropped by 4.5 %„„or 4500 human lives jmo„„SAVED by our doctors,from proper pain management,ie 1990 thru 2000……
If 22,000 more suicides„since Dr.Government decides how much we can have or NOT HAVE„„ if that aint PROOF OF TORTURE,HARM AND GENOCIDE„„„„nothing will convince our government they are literally murderring us!!!!!! any GOVERNMENT

EMPLOYEE convicted of TORTURE AND GENOCIDE WILL SERVE A LIFE SENTENCE IN PRISON,,,appropriately!!!!!!so give me freaking lawsuit,,,PLEASE!!!!!!!,,FOR THERE IS NO SOVEREIGN IMMUNITY FOR THE WILLFUL CRIMES OF TORTURE AND GENOCIDE,by a United States Government employee,appropriately soo,mary

Kara Rowe A week ago

Maryw,

I would LOVE to have any links to the stats you've mentioned. I'm working on an APA formatted paper & PowerPoint presentation & would love to include these stats.

Please join me on FB at chronic pain reform. Thanks!

Pam A week ago · 2 likes

Im interested in the lawsuit, in fact many in the pain support goups are interested but can not find a lawfirm. Do you have a lawfirm ready to kick the asses of these murderers!

dorlee A week ago 1 like

I bet if just one law firm/lawyer would take us on, you would soon have many other lawyers jumping in. Everyone is so afraid. Forget that and do what is right. We need help now.

Jenifer Markoe A week ago

I would think if people are able to sue Jeff Session for lying during his Confirmation hearing we could find a lawyer who would do this. I think some lawyers may not want to get into the controversy. Now that was a stupid thing to say after seeing some of these lawsuits that come out. Maybe we could get some law student to do some research on this and then would have something to show a lawyer why we have a case. Does anyone have any lawyer friends, no matter what type. If you do know someone pick their brain. The other issue who do you go after the CDC, DEA , the states making even more insane limits or doctors. It seems like the CDC has done the most harm with their little research guidelines so a suit to get them to retract the guidelines would be a good place to start. Meanwhile I would love to know why large Chronic pain non-profits have not stepped up in this. We need some national voice.

Pam A week ago · 3 likes

Honestly. Miss Houry, you make me sick!! Every single one of you who took a part in the fictious opiod epidemic you all created have the blood of many on your hands!! Due to your actions, legitimate pain pts are committing SUICIDE to escape the u bearble pain YOU have forced them to endure with your FALSIFIED overdose statistics!! Labeling heroin deaths as a death to legally prescribed opiod pain medication!! I truly hope karma pays you all a visit and you will know what suffering in severe pain is like! I truly hope you will be neglected, bused, mistreated, degraded, belittled, discriminated against, and stigmatized as an addict, such as what you mand your bias sidekicks have done to innocent law abiding chronically ill citizens!!! Are you planning to do the right thing and retract the BARBARIC AND INHUMANE guidelines immediately!?!? Are you going to admit on national TV how very wrong the CDC is in blaming our drs for prescribing LIFESAVING

PAIN MEDICATION!?!? YOUR actions have caused many to turn to the streets for relief or SUICIDE!!!Because of YOUR actions, Doctors who continue to treat their pain pts with adequate pain relief are being shut down by the DEA, they are in fear of prescribing opiods to those who require them to sustain a QUALITY OF LIFE!! Because of YOUR actions, the VA has adopted your BARBARIC AND INHUMANE guidelines as the law, many of our Vets have been cut off from thier lifeline, why do you think so many are committing SUICIDE!?!? Because of YOUR actions, medicare and medicaid are also taking the BARBARIC AND INHUMANE guidelines as law. Because of YOUR actions, many insurance companies are denying lifesaving pain medications , because of YOUR actions, emergency rooms are neglecting chronic pain pts, refusing to treat their severe pain and have labeled those who go to the ER as drug addicts and pill seekers. Because of YOUR actions, pharmacies now have the right to decide who they will fill pain medications for, they can refuse to fill, amd even red flag a patient and report them as if they are some criminal!! Because of YOUR actions our senior citizens whose bodies are crippled in severe pain are being DENIED LIFESAVING PAIN MEDICATION!! Because of YOUR actions chrinic pain pts are being abandoned by the medical community!!! I can keep going on and on. The devastation YOU AND YOUR CORRUPT SIDEKICKS have caused onto the pain community has taken many lives and continues to take ny lives of the suffering!!! SHAME THE F*** ON YOU!! I have never wished bad on anyone until now. Because of YOUR actions, my QUALITY OF LIFE has been taken from me! Treating intractable pain pts with a one size fits all approach is the most outrageous thing ever! YOU ignored the truth, YOU ignored FACTS! YOU put in place an anti-opiod witchhunt that only benefits the pockets of anti-opiod ignorant people such as Kolodny and Ballantyne!! YOU know dam well that denying legitimate pain pts their lifeline has caused many pain pts to endure what could be deadly withdrawal!! YOU know dam well that denying pain pts their lifeline has forced pain pts to go to detox as they are only left with a handful of options, : the streets, detox or suicide !! How many lives of addicts did you save by cutting off the chronically ill!?!! NONE!! Because of YOUR actions, legitimate pain pts have been labeled as drug addicts, amd we are being treated like dam criminals!! Going to a monthly PM dr appt is more like checking in with a probation officer. I am fed up amd have had it with having to take drug tests monthly or surprise pill counts, Tell me what other condition requires such inhumane treatment!?!? ABSOLUTELY NONE! You ought to take a good hard look at yourself in the mirror lady, karma is a bitch and boy when she knocks on all the doors who took part in the genocide thruout the pain community , she will NOT have mercy on any of you!!!

Jenifer Markoe A week ago

Maybe diabetics should have to go in for a syringe count if on insulin while they are at it. I know let have every American have to take a Urine test to buy food at the store while we are at this. The damage has been so bad and if that Medicare thing gets through that will cause problems for those who are they very sickest. What a disgrace. I wonder if they got this idea from Russia.

Sandie A week ago · 2 likes

You know how you are making real pain patients suffer as well as their family's who watch their loved ones go down hill when they use to be able to lead a somewhat normal life so sad when your husband can't even enjoy time with his grandkids or take part in family get togethers. So tell me how would you feel if it was one of your family members suffering ? Don't you think it's time to let the Dr and patient do what they use to do so they can give them some kind of treatment that they deserve so they can get back to having a life before it's to late. Medicare and Medicaid need to back off as well as the NCQA.

Candi Simonis A week ago · 1 like

I think the CDC maybe realizing this is a war on pain patients NOT a war on drugs. They can stop every prescription written by a Dr and the drugs will still be readily available and accessible.

People will abuse, whether it be obtainable medication, illegally obtained medication, illegal fentynal, illegal heroin. Finally they are looking at the real numbers of individuals on legally prescribed medication, who in turn end up "addicted", which is very low. When is this war on Dr's and chronic pain patients going to stop.

We are being denied medication readily available to us with a chronic incurable disease. No other disease is being scrutinized for the medication the patient takes to control it. We as chronic pain disease patients are alive but we definitely are not living. We are in pain 24/7 and many of us unable to function, take care of our homes, our children, even ourselves or

much less have any kind of social life. Where is the humanity and compassion for us? When you live it, when you see it you will then understand!

N. Payne A week ago · 3 likes

This sounds like a woman who can't admit she and her agency made a HUGE mistake. She needs to face and TELL the truth–needs to reverse the damage done to legit patients and our doctors. We continue to hurt and die! We want our doctor-patient privacy back. We want all the alphabet soup agencies off our and our doctors' backs. Until this is fixed, the blood is on your hands CDC, DEA, etc. Stop this madness now and just maybe you'll be able to wash that blood off someday.

jane smith A week ago · 2 likes

All physicians who continue to refuse to treat patients for pain with SAFE and effective opioids should lose their license to practice. and the CDC DEA officials who put this tragedy in motion should be prosecuted and jailed for life. After they have had their legs arms and back broken and then they are refused any pain relief. We are rising up and we will humiliate and embarrass every doctor, ER, hospital, "pain clinic" and CDC DEA official at their homes and their offices for torturing patients. The gloves are off.

Anne_Fuqua A week ago · 1 like

Unbelievable….well actually I guess this is exactly what we SHOULD expect from Houry. I guess I was just naively optimistic in hoping for better.

Toni A week ago · 3 likes

What has happened now is that you have really hurt chronic pain patients with the guidelines and people are now going to the street or alcohol for pain help! They don't even take heroin users to jail here in my state very often so the snowball will continue and you have added people who used to get help and now don't.

Jenifer Markoe A week ago · 1 like

Nor should they take Herion addicts to jail. They need to be taken to rehab if it is a addict and if a chronic pain patient put on safer opiates. That is only thing that will stop this. Until the higher ups realize that the drug is just a symptom of the disease of addiction then nothing will change.

Tracey Rogers 5 days ago

Jenifer, I agree. I'd like to add that it would really be helpful if we had a solid mental health system in this country that everyone should be able to access if they need it. Many of the rural areas don't have local mental health facilities. It should also be affordable for all, regardless of whether one has insurance or not.

My son began having mental health issues right around the time he began going through puberty. (His doctor ran all the necessary blood work to rule out any physical issues. With excellent insurance, it is still quite expensive and very difficult navigate.

Many addicts have underlying mental health issues and/or illnesses that if treated prior to beginning alcohol and/or drug abuse, they very well might not go on to addiction. There's also a negative stigma attached to mental illness, including reaching out and getting help (sort of like the negative stigma attached to taking prescription opioids for chronic pain).

No one should ever have to feel ashamed for seeking help for their mental health. This country has tossed addicts in jail for abusing drugs for the past 100 years. Obviously, it's NOT working. Perhaps this country should do something different ….

Cathy Reiner A week ago 2 likes

Cathyh1957

I have a ? now since you have started this panic are you going to withdraw your guidelines what are you going to do about MEDICARE AND NCQA since they have taken it even futher

- Medical Marijuana
- Neuropathy
- Migraine
- Kratom

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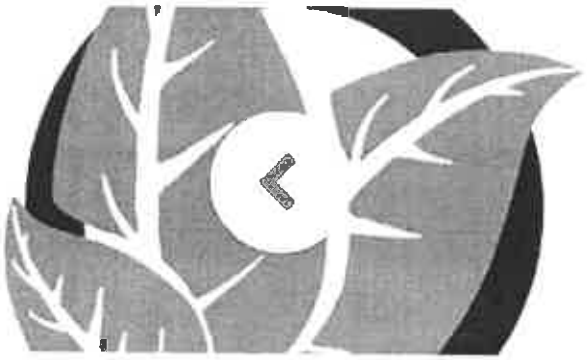

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Commonwealth of Virginia

REGULATIONS

GOVERNING PRESCRIBING OF OPIOIDS AND BUPRENORPHINE

VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18 VAC 85-21-10 et seq.

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

Revised Date: August 8, 2018

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TABLE OF CONTENTS

Part I
General Provisions

18VAC85-21-10. Applicability.

A. This chapter shall apply to doctors of medicine, osteopathic medicine, and podiatry and to physician assistants.

B. This chapter shall not apply to:

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

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

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

18VAC85-21-20. Definitions.

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

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

"Board" means the Virginia Board of Medicine.

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

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

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

"MME" means morphine milligram equivalent.

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

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

Part II
Management of Acute Pain

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

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

B. Prior to initiating treatment with a controlled substance containing an opioid for a complaint of acute pain, the prescriber shall perform a history and physical examination appropriate to the complaint, query the Prescription Monitoring Program as set forth in § 54.1-2522.1 of the Code of Virginia, and conduct an assessment of the patient's history and risk of substance misuse.

18VAC85-21-40. Treatment of acute pain with opioids.

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

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

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

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

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

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

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

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

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

18VAC85-21-50. Medical records for acute pain.

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

Part III
Management of Chronic Pain

18VAC85-21-60. Evaluation of the chronic pain patient.

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

1. The nature and intensity of the pain;

2. Current and past treatments for pain;

3. Underlying or coexisting diseases or conditions;

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

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

6. A urine drug screen or serum medication level;

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

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

9. A request for prior applicable records.

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

18VAC85-21-70. Treatment of chronic pain with opioids.

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

B. In initiating and treating with an opioid, the practitioner shall:

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

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

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

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

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

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

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

18VAC85-21-80. Treatment plan for chronic pain.

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

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

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

18VAC85-21-90. Informed consent and agreement for treatment for chronic pain.

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

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

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

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

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

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

18VAC85-21-100. Opioid therapy for chronic pain.

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

B. Continuation of treatment with opioids shall be supported by documentation of continued benefit from such prescribing. If the patient's progress is unsatisfactory, the practitioner shall assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

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

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

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

18VAC85-21-110. Additional consultations.

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

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

18VAC85-21-120. Medical records for chronic pain.

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

1. The medical history and physical examination;

2. Past medical history;

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

4. Diagnostic, therapeutic, and laboratory results;

5. Evaluations and consultations;

6. Treatment goals;

7. Discussion of risks and benefits;

8. Informed consent and agreement for treatment;

9. Treatments;

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

11. Patient instructions; and

12. Periodic reviews.

Part IV
Prescribing of Buprenorphine for Addiction Treatment

18VAC85-21-130. General provisions pertaining to prescribing of buprenorphine for addiction treatment.

A. Practitioners engaged in office-based opioid addiction treatment with buprenorphine shall have obtained a SAMHSA waiver and the appropriate U.S. Drug Enforcement Administration registration.

B. Practitioners shall abide by all federal and state laws and regulations governing the prescribing of buprenorphine for the treatment of opioid use disorder.

C. Physician assistants and nurse practitioners who have obtained a SAMHSA waiver shall only prescribe buprenorphine for opioid addiction pursuant to a practice agreement with a waivered doctor of medicine or doctor of osteopathic medicine.

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

18VAC85-21-140. Patient assessment and treatment planning for addiction treatment.

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

B. The treatment plan shall include the practitioner's rationale for selecting medication-assisted treatment, patient education, written informed consent, how counseling will be accomplished, and a signed treatment agreement that outlines the responsibilities of the patient and the prescriber.

18VAC85-21-150. Treatment with buprenorphine for addiction.

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

1. When a patient is pregnant;

2. When converting a patient from methadone or buprenorphine mono-product to buprenorphine containing naloxone for a period not to exceed seven days;

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

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

B. Buprenorphine mono-product tablets may be administered directly to patients in federally licensed opioid treatment programs. With the exception of those conditions listed in subsection A of this section, only the buprenorphine product containing naloxone shall be prescribed or dispensed for use off site from the program.

C. The evidence for the decision to use buprenorphine mono-product shall be fully documented in the medical record.

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

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

F. During the induction phase, except for medically indicated circumstances as documented in the medical record, patients should be started on no more than eight milligrams of buprenorphine per day. The patient shall be seen by the prescriber at least once a week.

G. During the stabilization phase, the prescriber shall increase the daily dosage of buprenorphine in safe and effective increments to achieve the lowest dose that avoids intoxication, withdrawal, or significant drug craving.

H. Practitioners shall take steps to reduce the chances of buprenorphine diversion by using the lowest effective dose, appropriate frequency of office visits, pill counts, and checks of the Prescription Monitoring Program. The practitioner shall also require urine drug screens or serum

medication levels at least every three months for the first year of treatment and at least every six months thereafter.

I. Documentation of the rationale for prescribed doses exceeding 16 milligrams of buprenorphine per day shall be placed in the medical record. Dosages exceeding 24 milligrams of buprenorphine per day shall not be prescribed.

J. The practitioner shall incorporate relapse prevention strategies into counseling or assure that they are addressed by a mental health service provider, as defined in § 54.1-2400.1 of the Code of Virginia, who has the education and experience to provide substance misuse counseling.

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

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

B. Patients younger than the age of 16 years shall not be prescribed buprenorphine for addiction treatment unless such treatment is approved by the FDA.

C. The progress of patients with chronic pain shall be assessed by reduction of pain and functional objectives that can be identified, quantified, and independently verified.

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

E. Practitioners shall not undertake buprenorphine treatment with a patient who has psychiatric comorbidities and is not stable. A patient who is determined by the prescriber to be psychiatrically unstable shall be referred for psychiatric evaluation and treatment prior to initiating medication-assisted treatment.

18VAC85-21-170. Medical records for opioid addiction treatment.

A. Records shall be timely, accurate, legible, complete, and readily accessible for review.

B. The treatment agreement and informed consent shall be maintained in the medical record.

C. Confidentiality requirements of 42 CFR Part 2 shall be followed.

D. Compliance with 18VAC85-20-27, which prohibits willful or negligent breach of confidentiality or unauthorized disclosure of confidential Prescription Monitoring Program information, shall be maintained.

The travel regulations require that "travelers must submit the Travel Expense Reimbursement Voucher with 30 days after completion of their trip". (CAPP Topic 20335, State Travel Regulations, p.7)

In order for the agency to be in compliance with the state travel regulations, please submit your request for today's meeting no later than

June 17, 2019