Report to the Joint Commision on Health Care

SB 369 Telemedicine Pilot Program

Telehealth Technology-Enabled Patient Care Teams:

A Pilot Program to Expand Access and Improve Coordination and Quality of Health Care services in Rural and Underserved Areas of Virginia

October 2019

Preface

In Virginia, a nurse practitioner (NP) licensed in a category other than certified registered nurse anesthetist shall be authorized to render care in collaboration and consultation with a licensed patient care team physician as part of a patient care team. Pursuant to 18 VAC 90-30-120, all NPs must practice in accordance with a written or electronic practice agreement. The collaboration requirement has been raised as a barrier to care, particularly for NPs who desire to work in rural areas and with underserved populations where there are shortages of physicians who could serve as collaborators. During the 2016 Session, the Virginia General Assembly passed SB 369 authorizing the Center for Telehealth of the University of Virginia (UVA), together with the Virginia Telehealth Network (VTN), to establish a telehealth pilot program. This pilot program is intended to assess whether the use of telehealth technology-enabled patient care teams could help to mitigate these barriers and ultimately expand access and improve coordination and quality of health care services among these underserved areas and populations.

Staff support for the pilot was provided by Kathy H. Wibberly, PhD (UVA) and Mara Servaites (VTN). This report was made possible through the efforts of the following two graduate students who analyzed the survey data, conducted interviews and background research and developed a set of draft recommendations:

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Additionally, program staff would like to acknowledge the invaluable guidance and direction provided to the students by the following members of the Data Subcommittee for this pilot program:

- Rebecca Bates, Adams Compassionate Healthcare Network
- Beth O'Connor, Virginia Rural Health Association
- Cynthia Romero, Eastern Virginia Medical School
- Carolyn Rutledge, ODU School of Nursing

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Executive Summary

Background. In Virginia, a nurse practitioner (NP) licensed in a category other than certified registered nurse anesthetist shall be authorized to render care in collaboration and consultation with a licensed patient care team physician as part of a patient care team. Pursuant to 18 VAC 90-30-120, all licensed NPs must practice in accordance with a written or electronic practice agreement. The collaboration requirement has been raised as a barrier to care, particularly for NPs who desire to work in rural areas and with underserved populations where there are shortages of physicians who could serve as collaborators. During the 2016 Session, the Virginia General Assembly passed SB 369 authorizing the Center for Telehealth of the University of Virginia (UVA), together with the Virginia Telehealth Network (VTN), to establish a telehealth pilot program. This pilot program was intended to assess whether the use of telehealth technology-enabled patient care teams could help to mitigate these barriers and ultimately expand access and improve coordination and quality of health care services among these underserved areas and populations. The pilot program was to include the following six core components:

1. The Center for Telehealth shall consult all appropriate stakeholders in establishing the pilot program, including but not limited to the Medical Society of Virginia, the Virginia Council of Nurse Practitioners, the Virginia Academy of Family Physicians, the Virginia Chapter of the American Academy of Pediatrics, the Virginia Hospital and Healthcare Association, the Virginia Community Healthcare Association, and public and private institutions of higher education located in the Commonwealth that award medical degrees.
2. The pilot shall include one or more patient care team physicians and one or more licensed nurse practitioners who presently practice in or who relocate to rural or medically underserved areas of the Commonwealth
3. The pilot shall provide technology, training and protocols to participating patient care teams to assist such teams in the delivery of telemedicine services in accordance with the goals of the pilot program
4. The pilot shall include a process for assisting nurse practitioners who seek to participate in the pilot program with identifying and developing a written or electronic practice agreement with a patient care team physician who will provide the required leadership of the patient care team through the use of telemedicine
5. The pilot shall develop and maintain a list of physicians who are ready to serve as patient care team physicians and making such a list available to nurse practitioners seeking physicians to serve as a patient care team physician in order to participate in the pilot program and makes such a list available on the UVA Center for Telehealth, Virginia Telehealth Network and Department of Health Professions websites
6. The pilot shall evaluate the success of patient care teams in improving access to care and coordination of care through evaluation of established clinical evidence.

The Center for Telehealth provided a report to the Governor and General Assembly on the progress of the pilot program in October 2017. Key conclusions drawn from the pilot included:

- The barriers to establishing and maintaining collaborative agreements between NPs and physicians are very real, and have a limiting impact on NP's ability to provide patient care in Virginia.
- Access to technology and training are important, but not always sufficient to drive utilization of telehealth. A more intensive personal investment of time must be factored in to help end users to map their vision and overcome a variety of individual and organizational barriers.
- Access to, and use of telehealth technology, makes the collaborative relationships easier between NPs and collaborating physicians and also contributes to the quality of patient care. However, it does not mitigate the challenge of connecting NPs in need of a collaborating physician with available collaborating physicians when such a relationship does not already exist.

Since that time, House Bill 793 was signed into law by Governor Northam. The new legislation allows nurse practitioners (NPs) who have the equivalent of five years of full-time practice to apply to practice autonomously. It is anticipated that this legislative change will help to mitigate barriers to providing care for many NPs currently in practice. However, barriers still remain for newer NPs who have not yet had the equivalent of five years of full-time practice. Additionally, the legislative change does not address barriers related to two of the three requirements of independent practice:

- the ability to identify and consult and collaborate with other health care providers based on the clinical conditions of the patient to whom health care is provided, and
- the ability to identify referral sources in order to establish a plan for referral of complex medical cases and emergencies to physicians or other appropriate health care providers.

General Fund dollars were appropriated to support the pilot program for an additional two-year period in the amount of $190,000 for FY2019 and $190,000 for FY2020. In an effort to gain a better understanding of what actions would need to be taken to address the remaining barriers, two online surveys were designed by the Virginia Telehealth Network (VTN). The link to the first survey (Nurse Practitioners Survey) was sent out by the VCNP to all 1,700 plus of its members as well as included in the Board of Nursing newsletter. The survey focused on barriers to engaging in both collaborations and telehealth. The second survey (Physician Survey) was drafted by VTN, then edited and distributed by the Medical Society of Virginia (MSV) and the Psychiatric Society of Virginia (PSV) to their physician members. The link to the Physician Survey was also included in the Board of Medicine newsletter. This survey focused on physicians' perceived barriers to collaboration and willingness to engage in telehealth collaborations. This report provides an overview of the key findings from the two surveys and offers four recommendations pertaining to how the General Fund dollars appropriated to support the pilot program could be used to address the identified barriers. Additionally, two recommendations that are outside the purview of the Center for Telehealth of the University of Virginia (UVA) or the Virginia Telehealth Network (VTN) are also offered as points for consideration for the Joint Commission.

Telehealth Technology-Enabled Patient Care Teams:

A Pilot Program to Expand Access and Improve Coordination and Quality of Health Care services in Rural and Underserved Areas of Virginia

During the 2016 Session, the General Assembly passed SB 369 (Appendix A) authorizing the establishment of a telehealth pilot program to expand access to and improve coordination and quality of health care service in rural and medically underserved areas of the Commonwealth.

Introduction. Pursuant to 18 VAC 90-30-120, in Virginia, a nurse practitioner licensed in a category other than certified registered nurse anesthetist is authorized to render care in collaboration and consultation with a licensed patient care team physician as part of a patient care team and must practice in accordance with a written or electronic practice agreement that includes provisions for:

- The periodic review of patient charts or electronic patient records by a patient care team physician and may include provisions for visits to the site where health care is delivered in the manner and at the frequency determined by the patient care team;
- Appropriate physician input in complex clinical cases and patient emergencies and for referrals; and
- The nurse practitioner's authority for signatures, certifications, stamps, verifications, affidavits, and endorsements provided it is:
    - In accordance with the specialty license of the nurse practitioner and within the scope of practice of the patient care team physician;
    - Permitted by § 54.1-2957.02 or applicable sections of the Code of Virginia; and
    - Not in conflict with federal law or regulation.

The practice agreement shall be maintained by the nurse practitioner. For nurse practitioners (NPs) 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.

This requirement has been raised as a barrier to care, particularly for nurse practitioners who desire to work in rural areas and with underserved populations where there are shortages of physicians who could serve as a collaborating patient care team physician. This pilot program has been proposed with the intent of assessing whether the use of telehealth technology-enabled patient care teams could help to mitigate these barriers and ultimately expand access and improve coordination and quality of health care services among these underserved areas and populations. The pilot program was to include the following six core components:

1. The Center for Telehealth shall consult all appropriate stakeholders in establishing the pilot program, including but not limited to the Medical Society of Virginia, the Virginia Council of Nurse Practitioners, the Virginia Academy of Family Physicians, the Virginia Chapter of the American Academy of Pediatrics, the Virginia Hospital and Healthcare Association, the Virginia Community Healthcare Association, and public and private institutions of higher education located in the Commonwealth that award medical degrees.
2. The pilot shall include one or more patient care team physicians and one or more licensed nurse practitioners who presently practice in or who relocate to rural or medically underserved areas of the Commonwealth

3. The pilot shall provide technology, training and protocols to participating patient care teams to assist such teams in the delivery of telemedicine services in accordance with the goals of the pilot program
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5. The pilot shall develop and maintain a list of physicians who are ready to serve as patient care team physicians and making such a list available to nurse practitioners seeking physicians to serve as a patient care team physician in order to participate in the pilot program and makes such a list available on the UVA Center for Telehealth, Virginia Telehealth Network and Department of Health Professions websites
6. The pilot shall evaluate the success of patient care teams in improving access to care and coordination of care through evaluation of established clinical evidence.

The Center for Telehealth at the University of Virginia was also required to report to the Governor and the General Assembly on the results of the pilot program by October 15, 2017. Kathy H. Wibberly, PhD (UVA) and Mara Servaites (VTN) provided staff support for the pilot.

The October 2017 Report provided an update on the following implementation activities, challenges and successes from the pilot program:

- A Steering Committee and Advisory Committee (with a Data Subcommittee) was established to provide guidance and direction for the development of this pilot program.
- Seven sites were selected to participate in the pilot. These sites included Federally Qualified Health Centers (FQHCs), free clinics, nurse managed clinics and hospital based clinics.
- Of the seven pilot sites, one had to drop out due to the departure of the NP from the clinic and another had to drop out due to internal administrative/management issues.
- Of the five remaining pilot sites, all were provided with technology, training and protocols. Deploying the technology and training was relatively easy. However, managing the people and processes surrounding the technology was more challenging.
- For some pilot site participants, the lack of technology and training was the only barrier. Once they had the technology and the training, they immediately began using the technology to enhance access and quality of care to their patients.
- For other pilot sites, having the technology and training were insufficient to drive utilization, as there were other barriers that needed to be overcome. These barriers varied, but included things like fear of change, skepticism from Board Members, and lack of understanding of how the technology could be used to enhance access and quality of care. Additionally, one of the sites had a psychiatric NP wanting to provide mental health services, but went the full year without being able to find a patient care team collaborating physician (psychiatrist). Another active site made the decision to transition from a Nurse Managed Clinic to become an affiliate of an FQHC as a way to mitigate its challenges with having to find a collaborating physician.
- In spite of these challenges, the first year of the pilot also had a number of successes that were enabled by telehealth technologies. These included the ability of our participating pilot sites to:
    - Increase its reach by expanding to a new satellite clinic, using the technology to connect the satellite clinic to practitioners in their original clinic location.

- Using the technology to engage in "hot-spotting" for its most at-risk patients to reduce complications from uncontrolled chronic disease and reduce visits to the Emergency Department.
- Using the technology to deliver diabetes self-management education to its patients.
- Increasing clinical output of the collaborating physician who saw patients at one clinic while traveling to two other facilities staffed by NPs. The technology enabled the physician to connect to the NPs without having to travel, allowing the physician to resume seeing patients at the clinic, expanding access to service.

Conclusions drawn from the first round of implementation of the pilot are as follows:

- The barriers to establishing and maintaining collaborative agreements between NPs and physicians are very real, and have a limiting impact on NP's ability to provide patient care in Virginia.
- Access to technology and training are important, but not always sufficient to drive utilization of telehealth. A more intensive personal investment of time must be factored in to help end users to map their vision and overcome a variety of individual and organizational barriers.
- Access to, and use of telehealth technology, makes the collaborative relationships easier between NPs and collaborating physicians and also contributes to the quality of patient care. However, it does not mitigate the challenge of connecting NPs in need of a collaborating physician with available collaborating physicians when such a relationship does not already exist.

Updates. In April 2018, Governor Northam signed House Bill 793 (Appendix B) into law. The law went into effect July 1, 2018 and required regulations to be promulgated by the Department of Health Professions by January 1, 2019. The new legislation allows nurse practitioners (NPs) who have the equivalent of five years of full-time practice to apply to practice autonomously. The application must be sent to the joint boards of Nursing and Medicine. Once approved, nurse practitioners must:

> "(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."

Nurse practitioners are able to apply for independent practice authority retroactively, meaning there are now NPs who are practicing autonomously in the state of Virginia. According to the government relations chair for the Virginia Council of Nurse Practitioners (VCNP), approximately half of NPs in the state had met this five-year requirement at the time the bill passed. Virginia now joins twenty-two (22) states and the District of Columbia in allowing nurse practitioners full practice autonomy. The data on how many NPs have applied for autonomous practice is not yet available. The Joint Boards of Nursing and Medicine will provide a report to the House Committee on Health, Welfare and Institutions, Senate Committee on Education and Health and Joint Commission on Healthcare by November 1, 2021.

It is anticipated that the legislative change described above will help to mitigate barriers to providing care for many NPs currently in practice. However, barriers still remain for newer NPs who have not yet had the equivalent of five years of full-time practice. Additionally, the legislative change does not address barriers related to two of the three requirements of independent practice:

- the ability to identify and consult and collaborate with other health care providers based on the clinical conditions of the patient to whom health care is provided, and
- the ability to identify referral sources in order to establish a plan for referral of complex medical cases and emergencies to physicians or other appropriate health care providers.

General Fund dollars were appropriated to support the pilot program for an additional two-year period in the amount of $190,000 for FY2019 and $190,000 for FY2020. During FY2019, two online surveys designed by the Virginia Telehealth Network (VTN) were distributed by external partners in the fall of 2018 in an effort to gain a better understanding of what actions would need to be taken to address the remaining challenges.

The link to the first survey (Nurse Practitioners Survey) was sent out by the VCNP to all 1,700 plus of its members as well as included in the Board of Nursing newsletter. The survey focused on barriers to engaging in both collaborations and telehealth and had 195 total respondents. A profile of the demographics of respondents are shown in the table below. Family medicine was the dominant specialty with the NPs in this survey. The geographic demographics of NPs in the surveys were relatively similar to that of the physicians.

Nurse Practioner Survey Demographics					
Practice Type				**Practice Location**	
Private	*23.67%*	Non-Teaching Hospital	*8.54%*	Suburban	*54.27%*
Teaching Hospital	*15.58%*	Free Clinic	*6.03%*	Urban	*24.62%*
Public Health	*7.04%*	Private, NP Run	*7.04%*	Rural	*24.62%*
FQHC	*2.01%*	Other	*5.53%*		
By Specialty					
Occupational Health	*1.01%*	Neonatal	*0.50%*	Internal Medicine	*17.59%*
Psychiatric/Mental Health	*12.06%*	Women's Health	*10.05%*	Geriatric	*9.05%*
Pediatric	*3.02%*	Family Medicine	*57.29%*	Acute Care	*9.05%*

The second survey (Physician Survey) was drafted by VTN, then edited and distributed by the Medical Society of Virginia (MSV) and the Psychiatric Society of Virginia (PSV) to their physician members. The link to the Physician Survey was also included in the Board of Medicine newsletter. This survey focused on physicians' perceived barriers to collaboration and willingness to engage in telehealth collaborations and had 98 total respondents. According to the MSV, the number of respondents were comparable to other surveys administered by the MSV and the demographic profile of the respondents corresponded with the profile of their membership. The majority of physicians that responded to the survey were in private practice, in suburban or urban locations.

Physician Survey Demographics					
Practice Type				**Practice Location**	
Private	*51.67%*	FQHCS	*2.78%*	Suburban	*57.14%*
Teaching Hospital	*21.11%*	Free Clinic	*3.89%*	Urban	*23.14%*
Public Health	*4.40%*	Other	*20.00%*	Rural	*22.02%*
Non-Teaching Hospital	*15.00%*			Other	*6.55%*

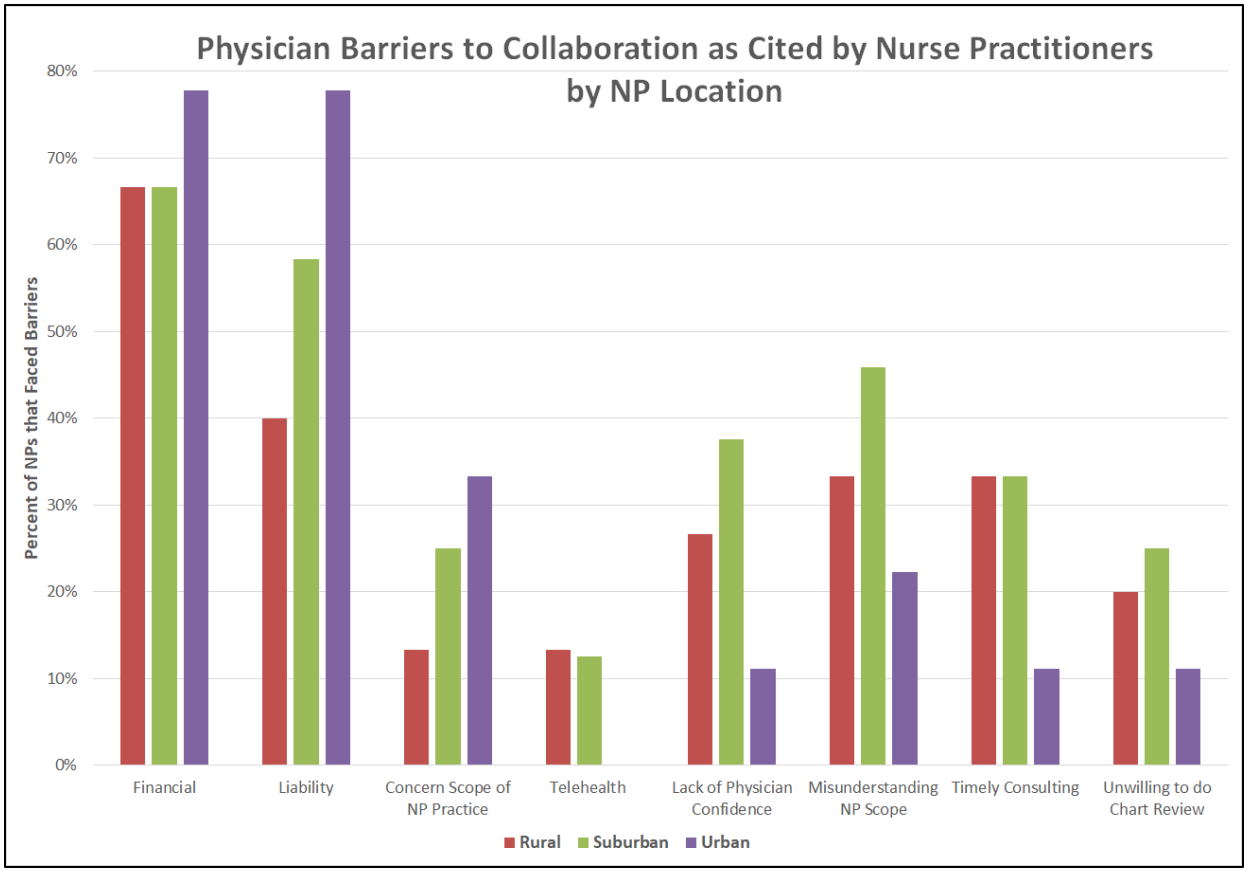
Key Survey Findings.

Rural Nurse Practitioners in Primary Care are Most Susceptible to Practice Limitations. One hundred and ninety-five NPs responded to the question "Since obtaining your NP License, has there been a time where you felt limited in your ability to work with patients because you were unable to find a collaborating physician?" One hundred and thirty seven NPs responded no (71%), while 56 responded yes (29%). Rural NPs who answered were the most likely to have felt limited, with 28 responding no and 20 responding yes (42%). Additionally, NPs who worked in public health and private, NP run clinic settings were also most susceptible to feeling limitations.

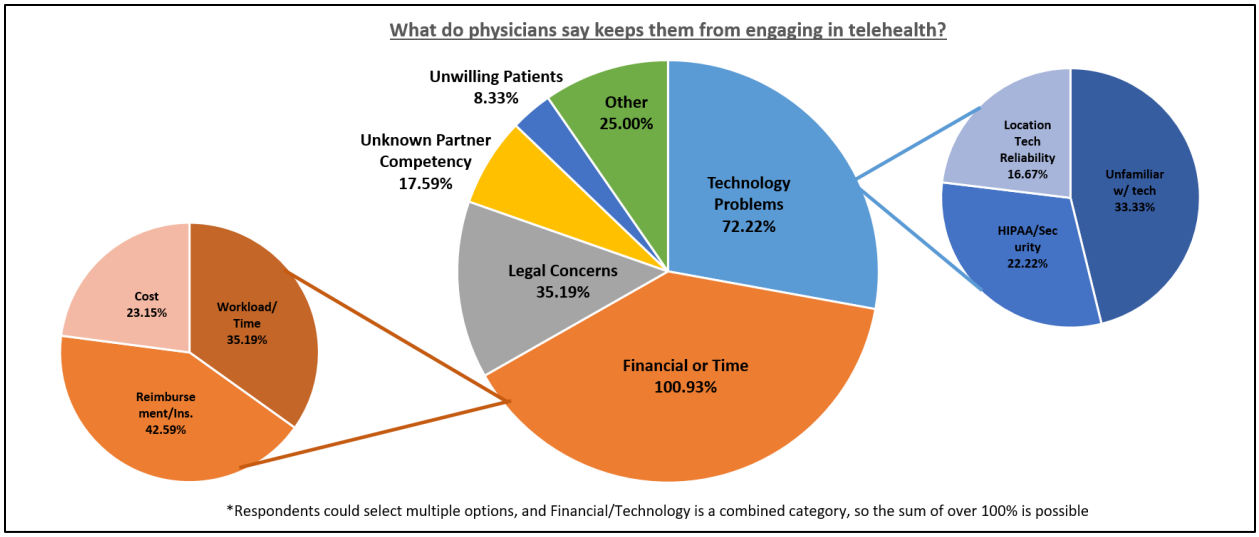
Nurse Practioners Who Felt Limited in Their Ability to Work with Patients					
Felt Limited	Urban	Suburban	Rural	Public Health NP	Private, NP Run Clinic
No	74% (34)	74% (80)	58% (28)	64% (9)	50% (7)
Yes	26% (12)	26% (28)	42% (20)	36% (5)	50% (7)

There did not appear to be a difference in the tenure of NPs who did or did not feel limited, as the average for those who did feel limited at some point was 15 +/- 8 years, and for those who did not was 14 +/- 10 years. These results indicate that the challenge of finding a collaborator does not improve with length of time in practice. The discussion and recommendations to follow focus on the population that felt most limited in their ability to work with patients, as it is their issues that will need to be addressed in order to successfully meet the legislative intent of expanding access and improving coordination and quality of health care services among underserved areas and populations.

Financial, Liability, and Interprofessional Respect/Trust Represent the Greatest Barriers. The 56 NP Survey respondents who identified that they had felt limited in their ability to work because of lack of physician collaborators, were then asked "What were your greatest barriers/challenges to finding a collaborating physician." Respondents could select more than one option and the chart below shows the breakdown by geographic (urban, rural, suburban) location of practice. The dominant themes were physician reimbursement, physician concerns about liability, and issues related to interprofessional respect/trust (e.g., confidence and scope of practice). As an interesting side note, while financial concerns are cited as a major barrier by NPs, of the 42 collaborating physicians in the Physician Survey, 33 of them reported that they were not being compensated for their collaboration.



Traditional telehealth concerns represent only part of the challenge. The 49 Physician Survey respondents who identified that they were not currently providing telehealth services were then asked about their perceived barriers to engaging in telehealth. Respondents could select more than one option and findings are found in the chart below. The major concerns with telehealth were a lack of adequate reimbursement (43%) and legal concerns (35%). Additional concerns that were brought up by physicians included workload/time concerns (35%) and technology concerns (72%). It should be noted that these options were available in the physician survey, but not the NP Survey, so a comparison in regards to the last two options cannot be made. The main reason for selecting "other" was that telehealth was not applicable to their service line (i.e. surgery).



Additionally, the Physician Survey showed that the ability to do telehealth collaborations did not appear to make a physician more or less likely to engage in collaborations. Those who were not interested in collaborations were less likely to engage in one through telehealth, while those who were interested were more likely. Those who identified as unsure were split 50/50 on whether telehealth would make them more or less willing.

Collaborations are typically established through an employer. In the Physician Survey, an NP initiated only three (3) out of fifty (50) collaborations with NPs. In the NP Survey, four (4) NPs stated their collaborations began as a result of them approaching a physician. A few collaborations were established through the assistance of professional organizations (typically VCNP). The vast majority of collaborations were established through an employer. The most common arrangements were: physician-run practices who employed NPs and hospital/health system networks who established collaboration agreement between NPs and physicians within their own system/network.

Practice Type	Currently in a Collaboration?			Interested in New Collaboration?		
	No	Yes, Within Practice	Yes, Outside of Practice	Not Interested	Unsure	Interested
Health System	21 (44.68%)	24 (51.06%)	2 (4.26%)	10 (47.62%)	8 (38.10%)	3 (14.29%)
Private Primary Care Clinic	10 (52.63%)	8 (42.11%)	1 (5.26%)	7 (58.33%)	4 (33.33%)	1 (8.33%)
Private Specialty Clinic	18 (54.55%)	12 (36.36%)	3 (9.09%)	8 (57.14%)	4 (28.57%)	2 (14.29%)

Most physicians who were engaged in collaboration agreements were in one with an NP currently within their own work setting, with health systems being the most common and likely setting. Physicians in health systems were most likely to be in a collaborative relationships, but not much more likely to be interested in adding new collaborations. For the small minority that did have an interest, that interest was almost exclusively within their own practice setting. A number of physicians stated that engaging in a collaboration was part of their employment contract, and it is likely that these represent the ones inside a health system. This helps to explain why physicians in health systems are more likely to engage in collaborations, but not very much more likely to be interested in new collaborations. Given that most collaborations are formed through formal employment processes, NPs who are in independent practices and/or who work in settings that do not employ physicians are at a distinct disadvantage.

Willingness to engage in collaboration does not always mean the ability to do so. An additional barrier that surfaced in the physician survey was a reported inability of some providers to collaborate outside of their health system/network. Approximately 20% of both urban and suburban providers who responded indicated they would be willing to collaborate, but could not do so. While some large health systems/networks may allow their physicians to collaborate as long as it is not in direct competition, there are those that may not. Because the researchers did not know the identity of survey respondents, they were unable to identify the specific networks that held such policies or verify that such policies really did exist. Once again, NPs who are in independent practices are not affiliated with a health system are at a disadvantage.

Barriers to Telehealth Collaboration in Physician Survey			
Question	**Rural**	**Suburban**	**Urban**
Practice Setting			
Private	43.24%	63.54%	46.30%
Non-Teaching Hospital	13.51%	21.88%	----
Teaching Hospital	-----	-----	42.59%
Do you use telehealth?			
Yes, only me	21.62%	11.58%	16.67%
Yes, entire practice	24.32%	25.26%	24.07%
No, but practice does	13.51%	9.47%	16.67%
None	40.54%	53.68%	42.59%
Use Stand Alone Platform	61.11%	51.43%	62.00%
Why do you not offer telehealth?			
Lack of Ins. Coverage	47.00%	44.00%	43.00%
Too much work, too little time	47.00%	----	41.00%
Legal/Malpractice Concerns	----	36.00%	----
Willing to partner via telehealth?			
Yes	40.54%	35.87%	41.51%
Yes, but can't outside employer	----	20.65%	18.87%
No (extrapolated from data)	59.46%	43.48%	39.62%

The Big Picture: Independent Practice Rural Nurse Practitioners and Rural Patients Remain Disproportionately Affected. Until HB 793 was passed to allow NPs to practice autonomously after the equivalent to 5 years of full time practice, NPs practicing independently in rural and underserved areas were at risk of not being able to practice to the full extent of their education and training due to the inability to maintain physician collaborators. While the full impact of HB 793 is still evolving, several barriers to collaboration are likely persist. As mentioned earlier, even NPs who have been approved for independent practice will still need to be able to consult and collaborate with other health care providers based on the clinical conditions of the patient to whom health care is provided. They will also need to be able to establish a plan for referral of complex medical cases and emergencies to physicians or other appropriate health

care providers. The issue of physicians being unable or unwilling to collaborate or consult outside of their network exacerbates the issue for NPs that operate independently in underserved areas. The barriers that exist to consultation, collaboration and referrals in rural areas affects not only rural NPs, but ultimately trickles down to the quality of care available to rural populations.

Recommendations. The survey findings lead to several recommendations that could help to mitigate the identified barriers. It is recommended that the General Fund dollars that have been appropriated to support the pilot program be used to also support the implementation of one or more of the following recommendations:

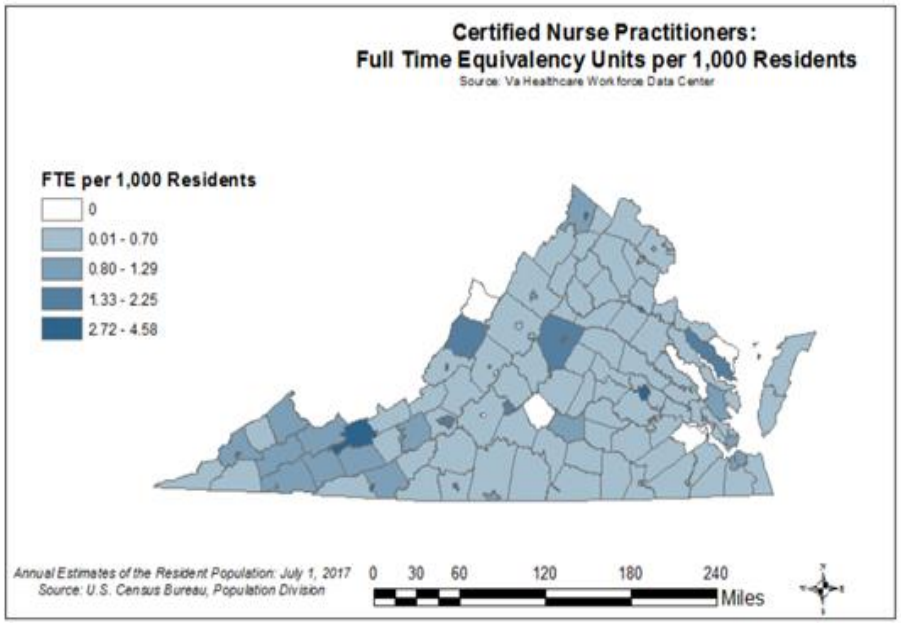
Recommendation 1: Update Frequently Asked Questions (FAQ) Document - Liability and Scope of Practice. One of the common themes regarding hesitation about collaborations is liability and scope of practice; this includes concerns about collaborating through telehealth. There is currently a document (Appendix 3) created by the Medical Society of Virginia that provides answers regarding scope of practice and liability for physicians and NPs. While certain sections of the document are still accurate, various parts are no longer up to date due to the passage of HB 793.

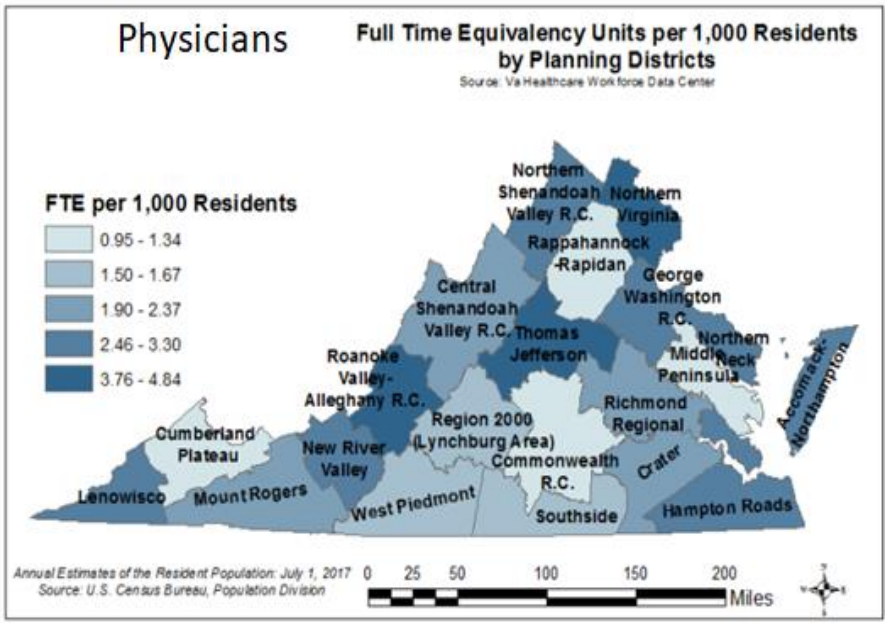
It is recommended that an updated, more thorough FAQ document be created as a resource. This document could be authored by the Center for Telehealth or the Virginia Telehealth Network and should include input from the VCNP, MSV, and the Joint Boards of Nursing and Medicine. Recommended topics to be included are as follows:

- Understanding Collaborative Partnership Agreements, reflecting the changes from HB 793:
- Processes and procedures for establishing a Collaborative Partnership Agreement, including a checklist of topics that should be discussed prior to formalizing such an agreement (roles, responsibilities, expectations regarding involvement and time commitments, establishing clarity regarding back-up physicians, emergencies, referrals, etc.)
- The role of telehealth and its implications on malpractice insurance coverage, reimbursement/billing.

To ensure that there are no inaccuracies or misrepresentations of the information presented, it is also recommended that an attorney review the document before it is disseminated.

Recommendation 2: Create a Database for an Interprofessional Telehealth Enabled Patient Care Referral Network. While the inability to find a collaborating physician may be somewhat mitigated through HB 793, a persistent barrier to service delivery and care for independent practice NPs is their ability to identify providers, and particularly specialists, who would be willing and able to provide consultation and/or take referrals and to do so via telehealth when appropriate. While the geographic distribution of NPs in Virginia are relatively spread out between rural and urban areas, there is a geographic disparity in the concentration of physicians in urban/suburban areas and rural areas. The two maps on the following page show the geographic spread of NPs (from the 2018 NP Workforce Study from Virginia DHP) and physicians (from the 2018 Physician Workforce Study from Virginia DHP).


Certified Nurse Practitioners:
Full Time Equivalency Units per 1,000 Residents
Source: Va Healthcare Workforce Data Center
FTE per 1,000 Residents
0
0.01 - 0.70
0.80 - 1.29
1.33 - 2.25
2.72 - 4.58
Annual Estimates of the Resident Population: July 1, 2017
Source: U.S. Census Bureau, Population Division
0 30 60 120 180 240
Miles


Physicians
Full Time Equivalency Units per 1,000 Residents
by Planning Districts
Source: Va Healthcare Workforce Data Center
FTE per 1,000 Residents
0.95 - 1.34
1.50 - 1.67
1.90 - 2.37
2.46 - 3.30
3.76 - 4.84
Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock -Rapidan
George Washington R.C.
Central Shenandoah Valley R.C.
Thomas Jefferson
Northern Neck
Middle Peninsula
Accomack-Northampton
Roanoke Valley-Alleghany R.C.
Richmond Regional
Region 2000 (Lynchburg Area)
Cumberland Plateau
New River Valley
Commonwealth R.C.
Crater
Lenowisco
Mount Rogers
West Piedmont
Southside
Hampton Roads
Annual Estimates of the Resident Population: July 1, 2017
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles

According to the 2018 Virginia Physician Workforce report released by the Virginia Department of Health Professions, over half of physicians and NPs are presently able to take new patients, and almost 3,000 physicians utilize telemedicine in their practice. The creation of such a database would offer an opportunity for all interested medical and other health professionals to self-identify as being available to take referrals and to provide telehealth services and facilitate those connections where they are most needed. A similar effort to create a telemental health provider directory/referral network is already underway through the State Funded Appalachian Telemental Health Initiative This recommendation would expand that directory to include other health professions.

A secondary benefit of such a directory would be the ability to identify providers who might also be willing and able to serve as collaborators with NPs who have not yet satisfied the requirements for independent practice and are not employed in a work setting that facilitate such collaborations. As a side note, VTN reached out last year to physicians who identified as being able/willing to serve as a collaborator and was unable to find any who would be willing to do so without some type of financial compensation. The inclusions of these physicians in the directory would still be beneficial to NPs with some capacity to pay for the physician's time, but did not meet the needs of our pilot program NPs who worked in free clinics.

Recommendation 3: Develop Marketing Efforts and Materials that Feature Physicians and Nurse Practitioner Who Have Strong Collaborative Relationships and/or Are Telehealth Champions. As a way to address the identified barriers related to interprofessional respect/trust and both physician and NP wariness with using telehealth, it is often more effective for physicians to hear from other physicians, and NPs from other NPs. Identifying a few champions who can provide testimonials at professional conferences, by video and/or through written materials may help to change perceptions and attitudes.

Recommendation 4: Conduct a Series of New Surveys to Capture Perceptions and Changes following the passage of HB 793. Ideally, a series of surveys should be conducted to capture trend data on the impact of HB 793 in mitigating barriers to delivering care for NPs in rural and underserved areas. In order to ensure that surveys of NPs and Physicians can be compared, it is recommended that the VTN work with the joint Boards of Nursing and Medicine in both the design and distribution of further survey efforts (as opposed to working on its design only through the VCNP and MSV as was previously done). Additionally, VTN should also consider adding to any future surveys some questions related to other statewide needs, such as collaboration opportunities around Substance Use Disorder (SUD) treatment, school telehealth, the Virginia Mental Health Access Program, and with the Department of Corrections.

Finally, the following two recommendations are outside the purview of the Center for Telehealth of the University of Virginia (UVA) or the Virginia Telehealth Network (VTN), but are being offered as points for consideration for the Joint Commission:

Recommendation 5: Provide Incentives for Integrating Telehealth Enhanced Interprofessional Care in Virginia Medical Schools. While interprofessional care and telehealth are frequently part of the mission of Virginia's advanced practice nursing programs, of the medical schools in Virginia, only Virginia Tech (Carilion) School of Medicine has an explicitly stated emphasis on exposing students to interprofessional care and telemedicine as part of its core training mission. Barriers that relate to interprofessional concerns between physicians and NPs and to attitudes towards the use of telehealth technologies in patient care may be addressed by normalizing such interactions as part of the educational process.

Recommendation 6: Work with Hospitals/Health Systems to Create Model Policies that would Make Room for Out of Network Collaborations. While maintaining a competitive advantage often weighs heavily on the minds of Virginia's hospitals and health systems, policies around collaboration should not create a barrier for physicians and other clinicians who have an interest in assisting rural and underserved communities and populations. It is recommended that model language be developed that could assist hospitals/health systems strike an appropriate balance.

Appendix A: Authorizing Language

CHAPTER 763

An Act to establish a telehealth pilot program to expand access to and improve coordination and quality of health care services in rural and medically underserved areas of the Commonwealth.

[S 369]

Approved April 20, 2016

Be it enacted by the General Assembly of Virginia:

1. *§ 1. That the Center for Telehealth of the University of Virginia shall, together with the Virginia Telehealth Network, establish a telehealth pilot program to expand access to and improve the coordination and quality of health care services in rural areas of the Commonwealth and areas of the Commonwealth that have been identified as medically underserved by the State Department of Health through the use of telemedicine services, as defined in § 38.2-3418.16 of the Code of Virginia, for the purpose of providing access to health care services that would not be available to individuals in rural and medically underserved areas of the Commonwealth without the use of telehealth technology. Such pilot program shall include a process for establishing and providing support to patient care teams, as defined in § 54.1-2900 of the Code of Virginia, that deliver telemedicine services through the pilot program. Patient care teams participating in the pilot program shall include one or more patient care team physicians, as defined in § 54.1-2900, who provide leadership of the patient care team through the use of telemedicine, and one or more nurse practitioners who are licensed in accordance with § 54.1-2957 of the Code of Virginia and who presently practice in or who relocate to rural or medically underserved areas of the Commonwealth served by the pilot program.*

The pilot program shall include a process for assisting nurse practitioners who seek to participate in the pilot program with identifying and developing a written or electronic practice agreement with a patient care team physician who will provide the required leadership of the patient care team through the use of telemedicine, which shall include developing and maintaining a list of physicians who are ready to serve as patient care team physicians and making such list available to nurse practitioners seeking physicians to serve as a patient care team physician in order to participate in the pilot program. The Center for Telehealth, the Virginia Telehealth Network, and the Department of Health Professions shall make such list available on their respective websites for the use of nurse practitioners seeking patient care team physicians.

The pilot program shall provide technology, training, and protocols to participating patient care teams to assist such teams in the delivery of telemedicine services in accordance with the goals of the pilot program. The Center for Telehealth shall provide oversight of patient care teams providing telemedicine services as part of the pilot program and shall evaluate the success of patient care teams in improving access to care and coordination of care through evaluation of established clinical evidence.

The pilot program shall, to the extent possible, leverage existing resources within the Center for Telehealth, the Virginia Telehealth Network, and communities served by the pilot program.

2. That the Center for Telehealth shall consult all appropriate stakeholders in establishing the pilot program created by this act, including but not limited to the Medical Society of Virginia, the Virginia Council of Nurse Practitioners, the Virginia Academy of Family Physicians, the Virginia Chapter of the American Academy of Pediatrics, the Virginia Hospital and Healthcare Association, the Virginia Community Healthcare Association, and public and private institutions of higher education located in the Commonwealth that award medical degrees.

3. That the Center for Telehealth of the University of Virginia shall report to the Governor and the General Assembly on the results of the pilot program established pursuant to this act in establishing and supporting patient care teams providing health care services in accordance with this act and improving access to health care services and coordination and quality of health care services in rural and medically underserved areas of the Commonwealth by October 15, 2017.

4. That in the case of psychiatric services provided to individuals receiving services from a community services board, free health clinic, or federally qualified health center by a practitioner engaged by the Center for Telehealth of the University of Virginia to deliver such services, the requirement for an appropriate examination set forth in § 54.1-3303 of the Code of Virginia may be satisfied through the use of telemedicine.

5. That the provisions of this act shall expire on July 1, 2018.

Appendix B: HB 793

VIRGINIA ACTS OF ASSEMBLY -- 2018 SESSION

CHAPTER 776

An Act to amend and reenact §§ 22.1-271.7, 32.1-263, 32.1-282, 54.1-2901, 54.1-2903, 54.1-2957, 54.1-2957.01, 54.1-3300, 54.1-3300.1, 54.1-3301, 54.1-3482, and 54.1-3482.1 of the Code of Virginia, relating to nurse practitioners; practice agreements.

[H 793]

Approved April 4, 2018

Be it enacted by the General Assembly of Virginia:

1. That §§ 22.1-271.7, 32.1-263, 32.1-282, 54.1-2901, 54.1-2903, 54.1-2957, 54.1-2957.01, 54.1-3300, 54.1-3300.1, 54.1-3301, 54.1-3482, and 54.1-3482.1 of the Code of Virginia are amended and reenacted as follows:

§ 22.1-271.7. Public middle school student-athletes; pre-participation physical examination.

No public middle school student shall be a participant on or try out for any school athletic team or squad with a predetermined roster, regular practices, and scheduled competitions with other middle schools unless such student has submitted to the school principal a signed report from a licensed physician, a licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician attesting that such student has been examined, within the preceding 12 months, and found to be physically fit for athletic competition.

§ 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 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 file the certificate of death with the registrar. He shall obtain the personal data, 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 next of kin or the best qualified person or source available and obtain the medical certification from the person responsible therefor.

C. The medical certification shall be completed, signed in black or dark blue ink, and returned to the funeral director 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.

In the absence of such physician or with his approval, the certificate may be completed and signed 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 ~~as part of a patient care team as defined in § 54.1-2900~~ *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; or (vii) an individual to whom the physician

has delegated authority to complete and sign the certificate, if such individual has access to the medical history of the case and death is due to natural causes.

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 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 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 who, in good faith, signs a certificate of death or determines the cause of death shall be immune from civil liability, only for such signature and determination of causes of death on such certificate, absent gross negligence or willful misconduct.

§ 32.1-282. Medical examiners.

A. The Chief Medical Examiner may appoint for each county and city one or more medical examiners, who shall be licensed as a doctor of medicine or osteopathic medicine, a physician assistant, or a nurse practitioner in the Commonwealth and appointed as agents of the Commonwealth, to assist the Office of the Chief Medical Examiner with medicolegal death investigations. A physician assistant appointed as a medical examiner shall have a practice agreement with and be under the continuous supervision of a physician medical examiner in accordance with § 54.1-2952. A nurse practitioner appointed as a medical examiner shall ~~have a practice agreement with and~~ practice ~~in collaboration with a physician medical examiner~~ in accordance with § 54.1-2957.

B. At the request of the Chief Medical Examiner, the Assistant Chief Medical Examiner, or their designees, medical examiners may assist the Office of the Chief Medical Examiner with cases requiring medicolegal death investigations in accordance with § 32.1-283.

C. The term of each medical examiner appointed, other than an appointment to fill a vacancy, shall begin on the first day of October of the year of appointment. The term of each medical examiner shall be three years; however, an appointment to fill a vacancy shall be for the unexpired term.

§ 54.1-2901. Exceptions and exemptions generally.

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

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

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

3. Any licensed nurse practitioner from rendering care in ~~collaboration and consultation with a patient care team physician as part of a patient care team pursuant to §~~ *accordance with the provisions of §§* 54.1-2957 *and 54.1-2957.01* or any nurse practitioner licensed by the Boards of ~~Nursing and~~ Medicine *and Nursing* in the category of certified nurse midwife practicing pursuant to subsection H of § 54.1-2957 when such services are authorized by regulations promulgated jointly by the ~~Board~~ *Boards* of Medicine and ~~the Board of~~ Nursing;

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

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

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

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

8. The domestic administration of family remedies;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27. Any practitioner of the healing arts or other profession regulated by the Board from rendering

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

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

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

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

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

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

B. Notwithstanding any provision of law or regulation to the contrary, military medical personnel, as defined in § 2.2-2001.4, while participating in a pilot program established by the Department of Veterans Services pursuant to § 2.2-2001.4, may practice under the supervision of a licensed physician or podiatrist.

§ 54.1-2903. What constitutes practice.

Any person shall be regarded as practicing the healing arts who actually engages in such practice as defined in this chapter, or who opens an office for such purpose, or who advertises or announces to the public in any manner a readiness to practice or who uses in connection with his name the words or letters "Doctor," "Dr.," "M.D.," "D.O.," "D.P.M.," "D.C.," "Healer," *"N.P.,"* or any other title, word, letter or designation intending to designate or imply that he is a practitioner of the healing arts or that he is able to heal, cure or relieve those suffering from any injury, deformity or disease. No person regulated under this chapter shall use the title "Doctor" or the abbreviation "Dr." in writing or in advertising in connection with his practice unless he simultaneously uses a clarifying title, initials, abbreviation or designation or language that identifies the type of practice for which he is licensed.

Signing a birth or death certificate, or signing any statement certifying that the person so signing has rendered professional service to the sick or injured, or signing or issuing a prescription for drugs or other remedial agents, shall be prima facie evidence that the person signing or issuing such writing is practicing the healing arts within the meaning of this chapter except where persons other than physicians are required to sign birth certificates.

§ 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 ~~shall be~~ *is* unlawful for a person to practice as a nurse practitioner in the Commonwealth unless he holds such a joint license.

C. ~~Except as provided in subsection H, a~~ *Every* nurse practitioner ~~shall only practice as part of a patient care team. Each member of a patient care team shall have specific responsibilities related to the care of the patient or patients and shall provide health care services within the scope of his usual professional activities. Nurse practitioners practicing as part of a patient care team~~ *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. ~~Nurse practitioners~~ *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 ~~are~~ *is a* certified registered nurse anesthetists shall practice under the supervision of a licensed doctor of medicine, osteopathy, podiatry, or dentistry. ~~Nurse practitioners~~ *A nurse practitioner who is* appointed as *a* medical ~~examiners~~ *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. ~~Practice of patient care teams in all settings shall include the periodic review of patient charts or electronic health records and may include visits to the site where health care is delivered in the manner and at the frequency determined by the patient care team.~~

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 ~~Board~~ *Boards* of Medicine and ~~the Board of~~ 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 ~~a provision~~ *provisions* for ~~appropriate physician~~ *(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, ~~in the opinion~~ *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 ~~physician~~ 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.

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

A. In accordance with the provisions of this section and pursuant to the requirements of Chapter 33 (§ 54.1-3300 et seq.), a licensed nurse practitioner, other than a certified registered nurse anesthetist, shall have the authority to prescribe Schedule II through Schedule VI controlled substances and devices as set forth in Chapter 34 (§ 54.1-3400 et seq.). ~~Nurse practitioners shall have such prescriptive authority upon the provision~~

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

of a practice agreement shall be maintained by a nurse practitioner pursuant to § 54.1-2957. Practice agreements authorizing a nurse practitioner to prescribe controlled substances or devices pursuant to this section *either* shall ~~either~~ be signed by the patient care team physician ~~who is practicing as part of a patient care team with the nurse practitioner~~ or shall clearly state the name of the patient care team physician who has entered into the practice agreement with the nurse practitioner.

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

C. The ~~Board of Nursing and the Board~~ *Boards* of Medicine *and Nursing* shall promulgate ~~such~~ regulations governing the prescriptive authority of nurse practitioners as are deemed reasonable and necessary to ensure an appropriate standard of care for patients. ~~Regulations promulgated pursuant to this section~~ *Such regulations* shall include~~, at a minimum, such~~ requirements as may be necessary to ensure continued nurse practitioner competency, which may include continuing education, testing, or any other requirement, and shall address the need to promote ethical practice, an appropriate standard of care, patient safety, the use of new pharmaceuticals, and appropriate communication with patients.

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

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

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

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

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

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

§ 54.1-3300. Definitions.

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

"Board" means the Board of Pharmacy.

"Collaborative agreement" means a voluntary, written, or electronic arrangement between one pharmacist and his designated alternate pharmacists involved directly in patient care at a single physical location where patients receive services and (i) any person licensed to practice medicine, osteopathy, or podiatry together with any person licensed, registered, or certified by a health regulatory board of the Department of Health Professions who provides health care services to patients of such person licensed to practice medicine, osteopathy, or podiatry; (ii) a physician's office as defined in § 32.1-276.3, provided *that* such collaborative agreement is signed by each physician participating in the collaborative practice agreement; (iii) any licensed physician assistant working under the supervision of a person licensed to practice medicine, osteopathy, or podiatry; or (iv) any licensed nurse practitioner working ~~as part of a patient care team as defined in § 54.1-2900~~ *in accordance with the provisions of § 54.1-2957*, involved directly in patient care which authorizes cooperative procedures with respect to patients of such practitioners. Collaborative procedures shall be related to treatment using drug therapy, laboratory tests, or medical devices, under defined conditions or limitations, for the purpose of improving patient outcomes. A collaborative agreement is not required for the management of patients of an inpatient facility.

"Dispense" means to deliver a drug to an ultimate user or research subject by or pursuant to the lawful order of a practitioner, including the prescribing and administering, packaging, labeling, or compounding necessary to prepare the substance for delivery.

"Pharmacist" means a person holding a license issued by the Board to practice pharmacy.

"Pharmacy" means every establishment or institution in which drugs, medicines, or medicinal chemicals are dispensed or offered for sale, or a sign is displayed bearing the word or words "pharmacist," "pharmacy," "apothecary," "drugstore," "druggist," "drugs," "medicine store," "drug sundries," "prescriptions filled," or any similar words intended to indicate that the practice of pharmacy is being conducted.

"Pharmacy intern" means a student currently enrolled in or a graduate of an approved school of

pharmacy who is registered with the Board for the purpose of gaining the practical experience required to apply for licensure as a pharmacist.

"Pharmacy technician" means a person registered with the Board to assist a pharmacist under the pharmacist's supervision.

"Practice of pharmacy" means the personal health service that is concerned with the art and science of selecting, procuring, recommending, administering, preparing, compounding, packaging, and dispensing of drugs, medicines, and devices used in the diagnosis, treatment, or prevention of disease, whether compounded or dispensed on a prescription or otherwise legally dispensed or distributed, and shall include the proper and safe storage and distribution of drugs; the maintenance of proper records; the responsibility of providing information concerning drugs and medicines and their therapeutic values and uses in the treatment and prevention of disease; and the management of patient care under the terms of a collaborative agreement as defined in this section.

"Supervision" means the direction and control by a pharmacist of the activities of a pharmacy intern or a pharmacy technician whereby the supervising pharmacist is physically present in the pharmacy or in the facility in which the pharmacy is located when the intern or technician is performing duties restricted to a pharmacy intern or technician, respectively, and is available for immediate oral communication.

Other terms used in the context of this chapter shall be defined as provided in Chapter 34 (§ 54.1-3400 et seq.) unless the context requires a different meaning.

§ 54.1-3300.1. Participation in collaborative agreements; regulations to be promulgated by the Boards of Medicine and Pharmacy.

A pharmacist and his designated alternate pharmacists involved directly in patient care may participate with (i) any person licensed to practice medicine, osteopathy, or podiatry together with any person licensed, registered, or certified by a health regulatory board of the Department of Health Professions who provides health care services to patients of such person licensed to practice medicine, osteopathy, or podiatry; (ii) a physician's office as defined in § 32.1-276.3, provided *that* such collaborative agreement is signed by each physician participating in the collaborative practice agreement; (iii) any licensed physician assistant working under the supervision of a person licensed to practice medicine, osteopathy, or podiatry; or (iv) any licensed nurse practitioner working ~~as part of a patient care team as defined in § 54.1-2900~~ *in accordance with the provisions of § 54.1-2957*, involved directly in patient care in collaborative agreements which authorize cooperative procedures related to treatment using drug therapy, laboratory tests, or medical devices, under defined conditions or limitations, for the purpose of improving patient outcomes. However, no person licensed to practice medicine, osteopathy, or podiatry shall be required to participate in a collaborative agreement with a pharmacist and his designated alternate pharmacists, regardless of whether a professional business entity on behalf of which the person is authorized to act enters into a collaborative agreement with a pharmacist and his designated alternate pharmacists.

No patient shall be required to participate in a collaborative procedure without such patient's consent. A patient who chooses to not participate in a collaborative procedure shall notify the prescriber of his refusal to participate in such collaborative procedure. A prescriber may elect to have a patient not participate in a collaborative procedure by contacting the pharmacist or his designated alternative pharmacists or by documenting the same on the patient's prescription.

Collaborative agreements may include the implementation, modification, continuation, or discontinuation of drug therapy pursuant to written or electronic protocols, provided implementation of drug therapy occurs following diagnosis by the prescriber; the ordering of laboratory tests; or other patient care management measures related to monitoring or improving the outcomes of drug or device therapy. No such collaborative agreement shall exceed the scope of practice of the respective parties. Any pharmacist who deviates from or practices in a manner inconsistent with the terms of a collaborative agreement shall be in violation of § 54.1-2902; such violation shall constitute grounds for disciplinary action pursuant to §§ 54.1-2400 and 54.1-3316.

Collaborative agreements may only be used for conditions which have protocols that are clinically accepted as the standard of care, or are approved by the Boards of Medicine and Pharmacy. The Boards of Medicine and Pharmacy shall jointly develop and promulgate regulations to implement the provisions of this section and to facilitate the development and implementation of safe and effective collaborative agreements between the appropriate practitioners and pharmacists. The regulations shall include guidelines concerning the use of protocols, and a procedure to allow for the approval or disapproval of specific protocols by the Boards of Medicine and Pharmacy if review is requested by a practitioner or pharmacist.

Nothing in this section shall be construed to supersede the provisions of § 54.1-3303.

§ 54.1-3301. Exceptions.

This chapter shall not be construed to:

1. Interfere with any legally qualified practitioner of dentistry, or veterinary medicine or any physician acting on behalf of the Virginia Department of Health or local health departments, in the compounding of his prescriptions or the purchase and possession of drugs as he may require;

2. Prevent any legally qualified practitioner of dentistry, or veterinary medicine or any prescriber, as defined in § 54.1-3401, acting on behalf of the Virginia Department of Health or local health departments, from administering or supplying to his patients the medicines that he deems proper under the conditions of § 54.1-3303 or from causing drugs to be administered or dispensed pursuant to §§ 32.1-42.1 and 54.1-3408, except that a veterinarian shall only be authorized to dispense a compounded drug, distributed from a pharmacy, when (i) the animal is his own patient, (ii) the animal is a companion animal as defined in regulations promulgated by the Board of Veterinary Medicine, (iii) the quantity dispensed is no more than a 72-hour supply, (iv) the compounded drug is for the treatment of an emergency condition, and (v) timely access to a compounding pharmacy is not available, as determined by the prescribing veterinarian;

3. Prohibit the sale by merchants and retail dealers of proprietary medicines as defined in Chapter 34 (§ 54.1-3400 et seq.) of this title;

4. Prevent the operation of automated drug dispensing systems in hospitals pursuant to Chapter 34 (§ 54.1-3400 et seq.) of this title;

5. Prohibit the employment of ancillary personnel to assist a pharmacist as provided in the regulations of the Board;

6. Interfere with any legally qualified practitioner of medicine, osteopathy, or podiatry from purchasing, possessing or administering controlled substances to his own patients or providing controlled substances to his own patients in a bona fide medical emergency or providing manufacturers' professional samples to his own patients;

7. Interfere with any legally qualified practitioner of optometry, certified or licensed to use diagnostic pharmaceutical agents, from purchasing, possessing or administering those controlled substances as specified in § 54.1-3221 or interfere with any legally qualified practitioner of optometry certified to prescribe therapeutic pharmaceutical agents from purchasing, possessing, or administering to his own patients those controlled substances as specified in § 54.1-3222 and the TPA formulary, providing manufacturers' samples of these drugs to his own patients, or dispensing, administering, or selling ophthalmic devices as authorized in § 54.1-3204;

8. Interfere with any physician assistant with prescriptive authority receiving and dispensing to his own patients manufacturers' professional samples of controlled substances and devices that he is authorized, in compliance with the provisions of § 54.1-2952.1, to prescribe according to his practice setting and a written agreement with a physician or podiatrist;

9. Interfere with any licensed nurse practitioner with prescriptive authority receiving and dispensing to his own patients manufacturers' professional samples of controlled substances and devices that he is authorized, in compliance with the provisions of § 54.1-2957.01, to prescribe ~~according to his practice setting and a written or electronic agreement with a physician~~;

10. Interfere with any legally qualified practitioner of medicine or osteopathy participating in an indigent patient program offered by a pharmaceutical manufacturer in which the practitioner sends a prescription for one of his own patients to the manufacturer, and the manufacturer donates a stock bottle of the prescription drug ordered at no cost to the practitioner or patient. The practitioner may dispense such medication at no cost to the patient without holding a license to dispense from the Board of Pharmacy. However, the container in which the drug is dispensed shall be labeled in accordance with the requirements of § 54.1-3410, and, unless directed otherwise by the practitioner or the patient, shall meet standards for special packaging as set forth in § 54.1-3426 and Board of Pharmacy regulations. In lieu of dispensing directly to the patient, a practitioner may transfer the donated drug with a valid prescription to a pharmacy for dispensing to the patient. The practitioner or pharmacy participating in the program shall not use the donated drug for any purpose other than dispensing to the patient for whom it was originally donated, except as authorized by the donating manufacturer for another patient meeting that manufacturer's requirements for the indigent patient program. Neither the practitioner nor the pharmacy shall charge the patient for any medication provided through a manufacturer's indigent patient program pursuant to this subdivision. A participating pharmacy, including a pharmacy participating in bulk donation programs, may charge a reasonable dispensing or administrative fee to offset the cost of dispensing, not to exceed the actual costs of such dispensing. However, if the patient is unable to pay such fee, the dispensing or administrative fee shall be waived;

11. Interfere with any legally qualified practitioner of medicine or osteopathy from providing controlled substances to his own patients in a free clinic without charge when such controlled substances are donated by an entity other than a pharmaceutical manufacturer as authorized by subdivision 10. The practitioner shall first obtain a controlled substances registration from the Board and shall comply with the labeling and packaging requirements of this chapter and the Board's regulations; or

12. Prevent any pharmacist from providing free health care to an underserved population in Virginia who (i) does not regularly practice pharmacy in Virginia, (ii) holds a current valid license or certificate to practice pharmacy in another state, territory, district or possession of the United States, (iii) volunteers to provide free health care to an underserved area of this Commonwealth under the auspices of a publicly supported all volunteer, nonprofit organization that sponsors the provision of health care to populations of underserved people, (iv) files a copy of the license or certificate issued in such other

jurisdiction with the Board, (v) notifies the Board at least five business days prior to the voluntary provision of services of the dates and location of such service, and (vi) acknowledges, in writing, that such licensure exemption shall only be valid, in compliance with the Board's regulations, during the limited period that such free health care is made available through the volunteer, nonprofit organization on the dates and at the location filed with the Board. The Board may deny the right to practice in Virginia to any pharmacist whose license has been previously suspended or revoked, who has been convicted of a felony or who is otherwise found to be in violation of applicable laws or regulations. However, the Board shall allow a pharmacist who meets the above criteria to provide volunteer services without prior notice for a period of up to three days, provided the nonprofit organization verifies that the practitioner has a valid, unrestricted license in another state.

This section shall not be construed as exempting any person from the licensure, registration, permitting and record keeping requirements of this chapter or Chapter 34 of this title.

§ 54.1-3482. Practice of physical therapy; certain experience and referrals required; physical therapist assistants.

A. It shall be unlawful for a person to engage in the practice of physical therapy except as a licensed physical therapist, upon the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician, except as provided in this section.

B. A physical therapist who has completed a doctor of physical therapy program approved by the Commission on Accreditation of Physical Therapy Education or who has obtained a certificate of authorization pursuant to § 54.1-3482.1 may evaluate and treat a patient for no more than 30 consecutive days after an initial evaluation without a referral under the following conditions: (i) the patient is not receiving care from any licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician for the symptoms giving rise to the presentation at the time of the presentation to the physical therapist for physical therapy services or (ii) the patient is receiving care from a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician at the time of his presentation to the physical therapist for the symptoms giving rise to the presentation for physical therapy services and (a) the patient identifies a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician from whom he is currently receiving care; (b) the patient gives written consent for the physical therapist to release all personal health information and treatment records to the identified practitioner; and (c) the physical therapist notifies the practitioner identified by the patient no later than 14 days after treatment commences and provides the practitioner with a copy of the initial evaluation along with a copy of the patient history obtained by the physical therapist. Treatment for more than 30 consecutive days after evaluation of such patient shall only be upon the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician. A physical therapist may contact the practitioner identified by the patient at the end of the 30-day period to determine if the practitioner will authorize additional physical therapy services until such time as the patient can be seen by the practitioner. A physical therapist shall not perform an initial evaluation of a patient under this subsection if the physical therapist has performed an initial evaluation of the patient under this subsection for the same condition within the immediately preceding 60 days.

C. A physical therapist who has not completed a doctor of physical therapy program approved by the Commission on Accreditation of Physical Therapy Education or who has not obtained a certificate of authorization pursuant to § 54.1-3482.1 may conduct a one-time evaluation that does not include treatment of a patient without the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician; if appropriate, the physical therapist shall immediately refer such patient to the appropriate practitioner.

D. Invasive procedures within the scope of practice of physical therapy shall at all times be performed only under the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician.

E. It shall be unlawful for any licensed physical therapist to fail to immediately refer any patient to a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, or a licensed nurse

practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957* when such patient's medical condition is determined, at the time of evaluation or treatment, to be beyond the physical therapist's scope of practice. Upon determining that the patient's medical condition is beyond the scope of practice of a physical therapist, a physical therapist shall immediately refer such patient to an appropriate practitioner.

F. Any person licensed as a physical therapist assistant shall perform his duties only under the direction and control of a licensed physical therapist.

G. However, a licensed physical therapist may provide, without referral or supervision, physical therapy services to (i) a student athlete participating in a school-sponsored athletic activity while such student is at such activity in a public, private, or religious elementary, middle or high school, or public or private institution of higher education when such services are rendered by a licensed physical therapist who is certified as an athletic trainer by the National Athletic Trainers' Association Board of Certification or as a sports certified specialist by the American Board of Physical Therapy Specialties; (ii) employees solely for the purpose of evaluation and consultation related to workplace ergonomics; (iii) special education students who, by virtue of their individualized education plans (IEPs), need physical therapy services to fulfill the provisions of their IEPs; (iv) the public for the purpose of wellness, fitness, and health screenings; (v) the public for the purpose of health promotion and education; and (vi) the public for the purpose of prevention of impairments, functional limitations, and disabilities.

§ 54.1-3482.1. Certain certification required.

A. The Board shall promulgate regulations establishing criteria for certification of physical therapists to provide certain physical therapy services pursuant to subsection B of § 54.1-3482 without referral from a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician. The regulations shall include but not be limited to provisions for (i) the promotion of patient safety; (ii) an application process for a one-time certification to perform such procedures; and (iii) minimum education, training, and experience requirements for certification to perform such procedures.

B. The minimum education, training, and experience requirements for certification shall include evidence that the applicant has successfully completed (i) a transitional program in physical therapy as recognized by the Board or (ii) at least three years of active practice with evidence of continuing education relating to carrying out direct access duties under § 54.1-3482.

2. That the Boards of Medicine and Nursing shall jointly promulgate regulations to implement the provisions of this act, which shall govern the practice of nurse practitioners practicing without a practice agreement in accordance with the provisions of this act, to be effective within 280 days of its enactment.

3. That the Department of Health Professions shall, by November 1, 2020, 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.

4. That the Boards of Medicine and Nursing shall report on data on the implementation of this act, including the number of nurse practitioners who have been authorized to practice without a practice agreement, the geographic and specialty areas in which nurse practitioners are practicing without a practice agreement, and any complaints or disciplinary actions taken against such nurse practitioners, along with any recommended modifications to the requirements of this act including any modifications to the clinical experience requirements for practicing without a practice agreement, to the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health and the Chairman of the Joint Commission on Health Care by November 1, 2021.

Appendix C: Frequently Asked Questions

MEDICAL SOCIETY OF VIRGINIA MSV℠

Frequently Asked Questions about Scope of Practice and Nurse Practitioners

How many categories of nurse practitioners are there?
10. See 18 VAC 90-30-70.

What are relationships for nurse practitioners in these categories?
For nurse practitioners in the category of CRNA, they must practice under the supervision of a physician, but does not have to have a practice agreement. For nurse practitioners in the category of Certified Nurse Midwives, they must practice in "consultation" with a physician, and have a practice agreement. Finally, for all other categories of nurse practitioners, they have to collaborate and consult with a patient care team physician as evidenced in a practice agreement.

What is required to be contained in a practice agreement between a patient care team physician and a nurse practitioner?
The requirements for what must be contained in a practice agreement are set forth in 18 VAC 90-30-120 (D). This regulation requires the written or electronic practice agreement to include provisions for

"1. The periodic review of patient charts or electronic patient records by patient care team physician and may include provisions for visits to the site where health care is delivered in a manner and the frequency determined by the patient care team;
2. Appropriate physician input in complex clinical cases and patient emergencies and for referrals; and
3. The nurse practitioner's authority for signatures, certifications, stamps, verifications, affidavits, and endorsements provided, it is:
   a) In accordance with the specialty license of the Nurse Practitioner and within the scope of practice of the patient care team physician;
   b) Permitted by Sect. 54.1-2957.02 or applicable Sections of the Code of Virginia; and
   c) not in conflict with Federal law or regulation."

Is a patient care team physician required to practice at the same location as the nurse practitioner?
No. A patient care team physician may choose to visit or practice at the same site as the nurse practitioner, but there is no statutory or regulatory requirement that the physician must do so. It is discretionary between the physician and the nurse practitioner.

Does a practice agreement have to be in writing?
A practice agreement may be maintained in writing or electronically.

Does a practice agreement have to be filed with the Board of Nursing or the Board of Medicine?
No. Pursuant to 18 VAC 90-30-120(E), practice agreement shall be maintained by the Nurse Practitioner and made available to the Board or their representatives upon request.

Does a practice agreement have to be signed by the patient care team physician?

No. The physician's name may be clearly stated or may be signed by the physician. 54.1-2957.01

Are there any special provisions for practice agreements when care is provided in a hospital or within a healthcare system?

Yes. 18 VAC 90-30-120 permits nurse practitioners providing care to patients within a hospital or healthcare system to have the practice agreement included as part of the documents delineating the nurse practitioner's clinical privileges or the electronic or written delineation of duties and responsibilities.

May telemedicine be used on a patient care team between physicians and nurse practitioners?

Yes. Va Code Sect. 54.1-2957(c) requires nurse practitioners, as part of a patient care team to maintain the appropriate collaboration and consultation with at least one patient care team physician. Further, that Section specifies, "collaboration and consultation among nurse practitioners and patient care team physicians may be provided through telemedicine as described in Sect. 38.2-3418.6"

How is the issue of professional liability addressed?

Patient care team physicians most often are covered by a professional liability insurance policy. A physician wishing to become a patient care team physician should confirm with his insurance agent that coverage is provided for his work on a patient care team. In some instances, the policy may need to have an endorsement added, specifically stating that coverage is available.

As to nurse practitioners, professional liability insurance coverage is often purchased directly by the nurse practitioner, but the nurse practitioner may also be on the same policy with the patient care team physician.

The only statutory comment regarding professional liability insurance for patient care team members is found in 54.1-2957(c) which provides "physicians on a patient are team may require that a nurse practitioner be covered a professional liability insurance policy with limits equal to the current limitation on damages as set forth in Sect. 8.01-581.15 and [The Medical Malpractice Act]."

Is there a limitation on the number of nurse practitioners that a patient care team physician may serve at any given time?

Yes. For nurse practitioners, who have prescriptive authority under 54.1 2957.01(e)(2), "physicians may not serve as a patient care team physician on a patient care team at any one time to more than six nurse practitioners."

Is there any limitation on how many nurse practitioners a physician can serve as a patient care team physician if the nurse practitioner does not have prescriptive authority?

No, there is no limitation.

How has the limitation of six been interpreted for nurse practitioners who have prescriptive authority?

The Boards have interpreted the limitation of six nurse practitioners at any one time to mean that a physician may serve as a patient care team physician for six nurse practitioners in the office at 9am, go to a different office in the afternoon, have six different nurse practitioners and then go to a free clinic at night and work with six nurse practitioners who are different from the first two settings. In other words, there is no limitation on the total number of nurse practitioners a physician can participate with through multiple practice agreements in any given day, rather the limitation is there can be no more than six nurse practitioners partnering with a patient care team physician, at any one time.

May a patient care team physician be compensated or charge a fee for serving on a patient care team?

There are no statutes or regulations prohibiting or addressing compensation of patient care team physicians. Some patient care team physicians serve on a patient care team as part of their regular duties. Other patient care team physicians negotiate compensation with nurse practitioners or health systems.