

MINUTES



January 23 – 25, 2019

**1203 Front Street
Raleigh, North Carolina**

General Session Minutes of the North Carolina Medical Board (NCMB) Meeting held January 23-25, 2019.

The January 2019 meeting of the North Carolina Medical Board was held at 1203 Front Street, Raleigh, NC 27609. Barbara E. Walker, DO, President, called the meeting to order. Board members in attendance were: Barbara E. Walker, DO, President; Bryant A. Murphy, MD, President-Elect; Venkata R. Jonnalagadda, MD, Secretary/Treasurer; Timothy E. Lietz, MD, Immediate Past-President; Mr. A. Wayne Holloman; Debra A. Bolick, MD; Ralph A. Walker, JD; Shawn P. Parker, JD; Jerri L. Patterson, NP; Varnell D. McDonald-Fletcher, PA-C; John W. Rusher, MD; Michaux R. Kilpatrick, MD. and Christine M. Khandelwal, DO.

Presidential Remarks

Dr. Walker reminded the Board members of their duty to avoid conflicts of interest with respect to any matters coming before the Board as required by the State Government Ethics Act. All conflicts were reported as included within the committee reports.

Minutes Approval

A motion passed to approve the November 14 - 16, 2018 Board Meeting minutes and the December 12, 2018 Hearing Meeting minutes.

Discussions

Former Board member, Dr. Cheryl Walker-McGill, met with current Board members to discuss her campaign for Chair-Elect of the Federation of State Medical Boards (FSMB).

Current Board member, Mr. Shawn Parker, discussed his re-election campaign as Board of Director at the FSMB.

Dr. Barbara Walker informed the Board members of the FSMB's Annual Meeting, which will be held April 24 – 27, 2019 in Fort Worth, Texas.

Presentations

Judges Augustus Elkins II, Administrative Law Judge and Fred Morlock, NCMB Independent Counsel, conducted Board Hearing training.

Dr. Venkata Jonnalagadda gave an update on the Sexual Boundary Violations workgroup held December 18 – 19, 2018 in Washington DC.

The Special Projects Manager gave an update of where the Board staff stands with upgrading the safety and security of the building.

NORTH CAROLINA PHYSICIAN HEALTH PROGRAM REPORTS (NCPHP)

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A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

Joe Jordan, PhD, CEO, North Carolina Physicians Health Program (NCPHP), gave the PHP Compliance Committee report. The specifics of this report are not included because these actions are not public.

A motion passed to return to open session.

Dr. Joe Jordan, CEO, NCPHP, gave the following Reports: Recidivism Study Report and the Annual Financial, Performance, and Quality Assurance report.

NCMB ATTORNEY'S REPORT

Mr. Brian L. Blankenship, Deputy General Counsel and Mr. Thomas W. Mansfield, Chief Legal Officer, gave the Attorney's Report on Friday, January 25, 2019.

Messrs. Blankenship and Mansfield presented the open session portions of the Attorney's Report regarding the schedule for upcoming hearings, rulemaking activity, and statistics regarding work performed by the Board's attorneys since the last Attorney's Report.

Executed Cases - Public Actions:

The following actions were executed since the Board's last regularly scheduled meeting. The Board voted to accept these as information.

Aflatooni, Saeed MD

Relief of Consent Order Obligations executed 11/01/2018

Azzato, John Anthony MD

Public Letter of Concern executed 11/30/2018

Burgess, Kathy Howard NP

Consent Order executed 12/13/2018

Buzzanell, Charles Anton MD

Consent Order executed 12/04/2018

Cooley, Candace Sue MD

Public Letter of Concern executed 12/04/2018

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Danforth, Wendell Calvin MD

Relief of Consent Order Obligations executed 11/26/2018

Demchak, Susan McBrayer MD

Public Letter of Concern executed 12/17/2018

Dixon, Donovan Dave MD

Notice of Revocation executed 12/04/2018

Enslow Jr, William Lewis DO

Public Letter of Concern executed 11/29/2018

Fishel, Hazel Thorton MD

Consent Order executed 12/11/2018

Frank, Harrison Gabriel MD

Public Letter of Concern executed 11/14/2018

Ismail, Samina MD

Consent Order executed 11/08/2018

Legendre, Emile Willard

Denial of Licensure executed 11/27/2018

Llibre, Giovanni MD

Interim Non-Practice Agreement executed 12/21/2018

Masessa, Joseph Michael MD

Public Letter of Concern executed 12/13/2018

Mcleod, William Christopher DO

Public Letter of Concern executed 12/20/2018

McQueen Jr., Fred Douglas MD

Consent Order executed 12/13/2018

Moretz, McCoy Lee MD

Consent Order executed 12/19/2018

Nelson, Paula Maria MD

Notice of Charges executed 01/04/2019

Okoli, Alphonsus Eziagwu MD

Consent Order executed 11/19/2018

Patel, Parth Dipam MD

Public Letter of Concern executed 11/28/2018

Perez-Rivera, Efrain MD

Public Letter of Concern executed 11/20/2018

Pizarro Sr., Glenn MD

Consent Order executed 11/20/2018

Tambakis-Odom, Constance Roseann MD

Public Letter of Concern executed 11/06/2018

Ward, W. Gregory MD

Non-Disciplinary Consent Order executed 11/21/2018

Wells, Wendell □'Alton MD

Notice of Revocation executed 11/30/2018

Woodyear Jr, John Montgomery MD

Public Letter of Concern executed 01/02/2019

Yaeger, Edwin Paul DO

Public Letter of Concern executed 11/27/2018

Legislative Update

On Friday, January 25, 2019, the Board's Legislative Liaisons, Mr. Thomas W. Mansfield, Chief Legal Officer and Ms. Evelyn Contre, Chief Communications Officer, provided a legislative update to the Board. The Board reviewed the most current version of potential revisions to the Medical Practice Act under consideration for the 2019 session of the North Carolina General Assembly. Mr. Mansfield and Ms. Contre described the most recent discussions with a variety of stakeholders along with plans for additional meetings.

Mr. Shawn Parker, Public Member of the Board, explained both his role as the Board's designee in the Naturopathic Workgroup that was mandated by the General Assembly and led by NC DHHS as well as the report delivered to the General Assembly by the Workgroup on January 15, 2019.

The Board accepted the reports as information.

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NCMB Committee Reports

EXECUTIVE COMMITTEE REPORT

Members present were: Barbara E. Walker, DO, Chairperson; Timothy E. Lietz, MD; Bryant A. Murphy, MD; Venkata R. Jonnalagadda, MD; and A. Wayne Holloman.

Strategic Plan

a. 2018 Strategic Priorities – Final Report

The Committee reviewed the final report for the 2018 Strategic Priorities.

Committee Recommendation: Accept as information.

Board Action: Accept Committee recommendation. Accept as information.

b. 2019/20 Strategic Priorities Update

The Committee reviewed an update on the 2019/20 Strategic Priorities.

Committee Recommendation: Accept as information.

Board Action: Accept Committee recommendation. Accept as information.

Financial Statements

a. Year-to-Date Financial Information

The Committee reviewed the following financial information: Balance Sheet; Year to Date - Profit & Loss versus Budget; and Profit & Loss Year to Date Comparison.

Committee Recommendation: Accept the financial information as reported.

Board Action: Accept Committee recommendation. Accept the financial information as reported.

b. Investment Account Statements

The Committee reviewed the investment account statements for November and December 2018.

Committee Recommendation: Accept the investment account statements as reported.

Board Action: Accept Committee recommendation. Accept the investment account statements as reported.

c. Year-End Financial Statement Audit Report

The Year-End Financial Statement Audit Report for the fiscal year ending on October 31, 2018, was not completed in time for consideration by the Committee.

Committee Recommendation: Postpone consideration of the Year-End Financial Statement Audit Report until the March meeting.

Board Action: Accept Committee recommendation. Postpone consideration of the Year-End Financial Statement Audit Report until the March meeting.

Old Business

a. Office Space Update

The Board needs additional office space and, at the November 2018 Board meeting, decided to purchase and renovate a larger office building or purchase a tract of land to build a new office building. Currently, staff is interviewing brokers who, once hired, will work to identify a building or parcel. A broker should be onboard by the end of January.

Committee Recommendation: Accept as information.

Board Action: Accept Committee recommendation. Accept as information.

New Business

a. Staff Performance Goals

Each year, staff is eligible for an Organizational Performance Adjustment (OPA) which is a percentage increase to base pay. Beginning in 2019, the recommended OP will be based on Staff Performance Goals (SPGs) in four areas: licensing and renewal, enforcement, policy and education, and efficiencies.

After undergoing training, staff will create SMART (Specific, measurable, attainable, realistic and timely) goals in each of these areas. These goals will be presented to the Board in March. In September, as part of the budget process, the Board will review staff's progress regarding the 209 SPGs and decide the appropriate OPA percentage.

Committee Recommendation: Accept as information.

Board Action: Accept Committee recommendation. Accept as information.

b. 2019 FSMB Resolutions

The Federation of State Medical Boards (FSMB) has asked member Boards to submit proposed resolutions for consideration by the FSMB House of Delegates at its annual meeting in April. The committee discussed several possible resolutions.

Committee Recommendations: Defer to the full Board.

Board Action: Authorize staff to develop and submit the following resolutions: (1) update the FSMB's Model Policy on DATA 2000 and Treatment of Opioid Addiction in the Medical Office (April 2013) to, among other things, encourage licensees to view opioid use disorders (OUDs) the same as other chronic conditions, address the stigma associated with OUDs and the use of medication assisted treatment (MAT), and discourage the use of derogatory language often associated with OUDs; (2) in consultation with the Federation of State Physician Health Programs, update the FSMB's Policy on Physician Impairment (April 2011) to address, among other things, a practicing licensee's use of MAT to treat OUD; (3) create model emergency license laws that expedite licensure following a natural disaster while also maintaining public safety; and (4) create a position statement that clarifies a prescriber's duty, if any, to discuss with patients the potential costs of proposed tests or treatments.

c. NCMB Review Panel

The NCMB Review Panel reviews applicants for the physician (8), physician assistant (1), and nurse practitioner (1) seats on the Board. This year, three physician members will rotate off the Board and will need to be replaced.

Mr. Holloman, a member of the NCMB Review Panel, gave a report on this year's application/nomination process: The deadline for applications will be July 1; the list of applicants will be posted on the Review Panel's website by July 12; the Review Panel will interview applicants August 23-25; and the list of nominees will be sent to the Governor the week of August 26.

Committee Recommendation: Accept as Information.

Board Action: Accept Committee recommendation. Accept as information.

POLICY COMMITTEE REPORT

Members present were: Bryant A. Murphy MD, Chairperson; Debra A. Bolick, MD; Varnell D. McDonald-Fletcher, PA-C; Shawn P. Parker, JD; and John W. Rusher, MD.

Old Business:

a. Clinician Obligation to Complete a Certificate of Death

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The Committee expressed concern that there may be a disconnect between the plain language of the statute and the position statement and whether certain language in the position statement could be overstepping the statutory authority. The Committee inquired if there were potential amendments to the Medical Practice Act before the legislature regarding this issue and staff advised that there were. The Committee then debated if the position statement should be tabled until there is further clarity from the legislature. Staff indicated that this is an ongoing issue. The committee therefore decided that instead of tabling the issue, the position statement should be revised to track the current statutory language and incorporate some of the comments received from licensees and stakeholders.

Committee Recommendation: Assign staff the task of revising the proposed position statement to incorporate comments received from licensees and stakeholders and ensure the position statement tracks the current statutory language. Bring back for review at the March 2019 Board meeting.

Board Action: Accept Committee recommendation. Assign staff the task of revising the proposed position statement to incorporate comments received from licensees and stakeholders and ensure the position statement tracks the current statutory language. Bring back for review at the March 2019 Board meeting.

b. Telemedicine (Appendix A)

The Committee reviewed the proposed position statement favorably. Staff gave an overview of information that was reviewed when revising the position statement and how recent concepts were integrated into the proposed position statement. The Committee instructed staff to revise the Licensure section of the position statement to read “The Board deems the practice of medicine to occur in the state where the patient **resides is located**.” The Committee discussed whether the prescribing section should include use of medication-assisted treatment (“MAT”) and the staff encouraged the Committee to use more general language instead of making specific reference to MAT. The updated proposed position statement is attached to this report.

Committee Recommendation: Edit revised position statement to say “is located” under Licensure section. Submit position statement for review and comment by licensees and stakeholders and bring back for review at the March 2019 Board meeting.

Board Action: Accept Committee recommendation. Edit revised position statement to say “is located” under Licensure section. Submit position statement for review and comment by licensees and stakeholders and bring back for review at the March 2019 Board meeting.

c. Guidelines for Avoiding Misunderstandings During Physical Examinations

The Committee noted that the proposed position statement has been published to licensees and stakeholders with a close date for comments of February 28, 2019. The Committee discussed using an alternative word to “misunderstanding” in the title but decided that “misunderstanding” should remain.

Committee Recommendation: Bring back comments from the licensee and stakeholder population for discussion before final decision on adoption of the proposed position statement at the March 2019 Board meeting.

Board Action: Accept Committee recommendation. Bring back comments from the licensee and stakeholder population for discussion before final decision on adoption of the proposed position statement at the March 2019 Board meeting.

d. Medical, Nursing, and Pharmacy Boards: Joint Statement on Pain Management in End-of-Life Care

The Committee discussed the meeting held between the workgroup that was formed after the September 2018 Committee meeting, consisting of staff and certain Board members from each of the Boards. The Committee reviewed the proposed position statement and revisions favorably. There was discussion of whether the proposed position statement should go out for comment. It was decided that, after approval by the three Boards, the position statement would be finalized and did not need to be published for comment. The Committee requested that the italics be removed from the following sentence:

“The Medical and Nursing Boards will assume opioid use in such patients is appropriate if the responsible prescriber is familiar with and abides by acceptable medical guidelines regarding such use, is knowledgeable about effective and compassionate pain relief, and maintains an appropriate medical record that details a pain management plan.”

Committee Recommendation: Remove italics from the sentence indicated. Accept proposed position statement contingent on approval by the Nursing and Pharmacy Boards.

Board Action: Accept Committee recommendation. Remove italics from the sentence indicated. Accept proposed position statement contingent on approval by the Nursing and Pharmacy Boards.

New Business

a. Collaborative Care Within the Healthcare Team

The Committee discussed retitling the position statement and agreed that the title should be revised to “Licensee Behavior Within the Healthcare Team.” The Committee then

contemplated revising the position statement to include specific language regarding sexual harassment and licensee burnout.

Committee Recommendation: Assign staff the task of revising the position statement and bring back for review at March 2019 Board meeting.

Board Action: Accept Committee recommendation. Assign staff the task of revising the position statement and bring back for review at March 2019 Board meeting.

b. Position Statement Review Tracking Chart

Committee Recommendation: Bring back “Guidelines for Avoiding Misunderstandings During Physical Examinations” and “Telemedicine” with comments for review and consideration, bring back revised “Collaborative Care within the Healthcare Team,” and bring new position statement on physician compounding at the March 2019 Board meeting.

Board Action: Accept Committee recommendation. Bring back “Guidelines for Avoiding Misunderstandings During Physical Examinations” and “Telemedicine” with comments for review and consideration, bring back revised “Collaborative Care within the Healthcare Team,” and bring new position statement on physician compounding at the March 2019 Board meeting.

LICENSE COMMITTEE REPORT

Members present were: Michaux Kilpatrick, MD, Chairperson; Debra A. Bolick, MD; Varnell McDonald-Fletcher, PA-C; Ralph A. Walker, JD; and Christine M. Khandelwal, DO.

Old Business

a. Approval of Temporary Disaster and Emergency License Rules:

21 NCAC 32B .1706 - Physician Practice and Limited License for Disasters and Emergencies

21 NCAC 32S .0219 - Physician Assistant Practice and Limited license for Disasters and Emergencies

21 NCAC 32W .0116 - Anesthesiologist Assistant Practice and Limited License for Disasters and Emergencies.

Committee Recommendation: Approve temporary rule. Submit to Rule Review Commission. Approve proposed rules to be submitted for publication to begin the permanent rule making process.

Board Action: Accept Committee recommendation. Approve temporary rule. Submit to Rule Review Commission. Approve proposed rules to be submitted for publication to begin the permanent rule making process.

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

The License Committee reviewed two cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public.

A motion passed to return to open session.

LICENSE INTERVIEW REPORT

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

Six licensure interviews were conducted. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

ADVANCED PRACTICE PROVIDERS AND ALLIED HEALTH COMMITTEE REPORT

Members present were: Jerri L. Patterson, NP, Chairperson; Varnell D. McDonald-Fletcher, PA-C; John W. Rusher, MD; and Shawn P. Parker, JD.

New Business:

- a. Physician Assistants (Appendixes B, C, D, and E)

The Comprehensive Addiction and Recovery Act (CARA), enacted in 2016, authorized PAs and nurse practitioners (NPs) to prescribe buprenorphine for the purposes of treating opioid use disorder through medication assisted treatment (MAT). Current rules mandate PAs and NPs be supervised by a physician who has the same Drug Enforcement Administration (DEA) prescribing privileges as the PA and NP. In the

context of MAT, this means the supervising physician must be a qualified physician under CARA (waivered or otherwise qualified). Anna Stein, JD, MPH, Legal Specialist with the NC Division of Public Health, spoke during the discussion as to whether current Board rules serve as a barrier to increased access to treatment.

The Committee has directed staff to conduct a legal analysis of federal law regarding physician supervision of PAs and NPs providing medication assisted treatment. The analysis should: 1) clarify who may serve as a supervising physician under federal law; and 2) how the Board could expand the pool of physicians qualified to serve as a supervising physician.

Committee Recommendation: Accept as information.

Board Action: Accept Committee recommendation. Accept as information.

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

The Advanced Practice Providers and Allied Health Committee received as information a report from the Nurse Practitioner Joint Subcommittee Panel ("Panel"). The Panel's written report was presented for the Board's review, where it was also received as information. The specifics of this report are not included because these actions are not public.

A motion passed to return to open session.

DISCIPLINARY (COMPLAINTS) COMMITTEE REPORT

Members present were: John W. Rusher, MD, Chairperson; Venkata R. Jonnalagadda, MD; Michaux R. Kilpatrick, MD; Timothy E. Lietz, MD; Jerri L. Patterson, NP; and Ralph A. Walker, JD.

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

The Disciplinary (Complaints) Committee reviewed 18 complaint cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to

approve the written report. The specifics of this report are not included because these actions are not public.

A motion passed to return to open session.

DISCIPLINARY (MALPRACTICE) COMMITTEE REPORT

Members present were: John W. Rusher, MD, Chairperson; Venkata R. Jonnalagadda, MD; Michaux R. Kilpatrick, MD; Timothy E. Lietz, MD; Jerri L. Patterson, NP; and Ralph A. Walker, JD.

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

The Disciplinary (Malpractice) Committee reviewed 26 cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

DISCIPLINARY (INVESTIGATIVE) COMMITTEE REPORT

Members present were: John W. Rusher, MD, Chairperson; Venkata R. Jonnalagadda, MD; Michaux R. Kilpatrick, MD; Timothy E. Lietz, MD; Jerri L. Patterson, NP; and Ralph A. Walker, JD.

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

The Disciplinary (Investigative) Committee reviewed 30 investigative cases. A written report was presented for the Board's review. The Board adopted the recommendations and approved the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

DISCIPLINARY (MEDICAL EXAMINER) COMMITTEE REPORT

Members present were: John W. Rusher, MD, Chairperson; Venkata R. Jonnalagadda, MD; Michaux R. Kilpatrick, MD; Timothy E. Lietz, MD; Jerri L. Patterson, NP; and Ralph A. Walker, JD.

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

The Disciplinary (Medical Examiner) Committee reviewed five Medical Examiner cases. A written report was presented for the Board's review. The Board adopted the recommendations and approved the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

DISCIPLINARY (DEPARTMENT of HEALTH and HUMAN SERVICES) (DHHS) COMMITTEE REPORT

Members present were: John W. Rusher, MD, Chairperson; Venkata R. Jonnalagadda, MD; Michaux R. Kilpatrick, MD; Timothy E. Lietz, MD; Jerri L. Patterson, NP; and Ralph A. Walker, JD.

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

The Disciplinary (DHHS) Committee reported on one case. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

INVESTIGATIVE INTERVIEW REPORT

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not

considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

Five interviews were conducted. A written report was presented for the Board's review. The Board adopted the recommendations and approved the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

OUTREACH COMMITTEE

Members present were: Shawn P. Parker, JD, Chairperson; Venkata R. Jonnalagadda, MD; Christine M. Khandelwal, DO; Michaux R. Kilpatrick, MD; Jerri L. Patterson, NP.

Old Business

a. Update on Presentations

1. Professional presentations

The Communications Director reviewed presentation activity for 2018. NCMB ended the year with 41 presentations to professional audiences. This does not include panel sessions presented through NCMB's statewide training initiative with Wake Area Health Education Center (AHEC); it does include panel sessions that were moderated by NCMB Board Members. Although NCMB presented to slightly fewer audiences in 2018 than it has in recent years, the Board reached many large audiences last year, including attendees of the FSMB Annual Meeting in Charlotte and other large professional meetings. The Communications Department is working on refreshing slide sets and creating new content for professional audiences. NCMB has five professional presentations on the calendar so far for 2019.

Committee recommendation: Accept as information. Communications Director shall email examples of stock presentations currently in NCMB's presentation library to Committee members for review.

Board action: Accept Committee recommendation. Accept as information.

Communications Director shall email examples of stock presentations currently in NCMB's presentation library to Committee members for review.

2. Consumer presentations

The Chief Communications Officer reviewed public presentations for 2018. NCMB presented to 11 public (non-licensee) audiences last year, reaching more than 600 individuals. The Board has four public presentations on the 2019 calendar so far and is actively working to solicit additional opportunities. The Committee encouraged the

Communications Department to consider ways to reach underserved communities as this program continues to develop.

Committee recommendation: Accept as information.

Board action: Accept Committee recommendation. Accept as information.

b. Physician Wellness Initiative Discussion

The Committee continued its discussion about opportunities for the Board to expand its work on clinician wellness and burnout. The Committee Chairperson summarized recent conversations he had with executives at North Carolina Area Health Education Centers (NC AHEC) and the NC Healthcare Association (NCHA). Both organizations expressed interest in working with the Board on wellness. The Committee expressed interest in talking more with NC AHEC about working together on wellness-themed CME; NCMB has approached NCHA about convening a meeting or listening session with hospital chief financial officers (CFO), which would provide the Board with the opportunity to talk about the hard and soft costs of clinician burnout as a way of motivating hospitals and health systems to look at ways to reduce system drivers of burnout.

Committee recommendation: Accept as information.

Board action: Accept Committee recommendation. Accept as information.

New Business

a. Annual Report Planning

The Communications Director gave an update on the 2018 NCMB Annual Report, which is now in development. This year the format will be slightly modified to include more narratives and will include several features that highlight significant achievements or events that occurred during the 2018 program year. The Annual Report is expected to be completed in time for the March Board Meeting.

Committee recommendation: Accept as information.

Board action: Accept Committee recommendation. Accept as information.

b. Other Outreach Activities

1. Interpretation services

The Communications Director reported that NCMB began offering language interpretation services to non-English speakers in November 2018. A primary area of need is Spanish. Since the fall, staff have used language services to communicate with about a half dozen Spanish-speaking individuals. The

Complaint form and related Complaint letters have been translated into Spanish, along with multiple consumer brochures. Availability of language interpretation is promoted on the Board's website.

Committee recommendation: Accept as information.

Board action: Accept Committee recommendation. Accept as information.

2. Social media campaign results summary

The Communications department completed a social media campaign on the topic of safe medication storage and risks of leaving medicine unsecured in December 2018. The campaign reached more than 100,000 individuals (based on the number of "impressions" recorded through Twitter and Facebook) and resulted in numerous interactions with members of the public. Website analytics show that hundreds of individuals who saw the online campaign clicked through to the NCMB resource page on safe medication storage to view the safe medication storage and disposal sheet, and other resources.

Committee recommendation: Accept as information

Board action: Accept Committee recommendation. Accept as information.

3. Prescription best practices sheet

The Committee viewed a draft version of a new resource developed in collaboration with NCMB's Chief Medical Officer and the NC Board of Pharmacy. The resource provides guidance to prescribers on essential information that should be included on any prescription to avoid errors, delays and other problems.

Committee recommendation: Accept as information.

Board action: Accept Committee recommendation. Accept as information.

DIVERSITY WORKGROUP

Members present were: Timothy E. Lietz, MD, Chairperson; Bryant A. Murphy, MD; and A. Wayne Holloman.

New Business

- a. Staff NCMB Staffing Statistics – Review PowerPoint

The Human Resources (HR) Manager presented a snapshot of the Medical Board staff's generational breakdown including Millennials, Generation X and Baby Boomers. The current staff headcount is 57 employees.

b. Training / Presentations

The HR Manager presented three options for training around Unintentional/Unconscious Bias. It was agreed to move forward with Dr. Kinneil Coltman for this training. The training will include Board members and staff. The training will take place on Thursday, May 16, 2019 beginning at 3:00 p.m. and ending at 5:00 p.m. The HR Manager will provide email updates to the committee members to keep them informed of the progress in securing the presenter.

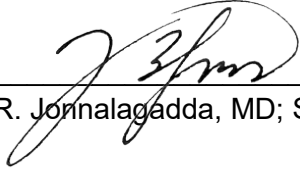
Committee Recommendation: Accept as information.

Board Action: Accept Committee recommendation. Accept as information.

ADJOURNMENT

The Medical Board adjourned at 12:43 p.m. on Friday, January 25, 2019.

The next meeting of the Medical Board is scheduled for March 20 - 22, 2019.



Venkata R. Jonnalagadda, MD; Secretary/Treasurer

PROPOSED POSITION STATEMENT:**Telemedicine**

“Telemedicine” is the practice of medicine using electronic communication, information technology, or other means between a licensee in one location and a patient in another location with or without an intervening health care provider. The term telemedicine incorporates the practices of telehealth.

The Board recognizes that technological advances have made it possible for licensees to provide medical care to patients who are separated by some geographical distance. As a result, telemedicine is a useful practice model that, if employed appropriately, can provide important benefits to patients, including: increased access to health care, expanded utilization of specialty expertise, rapid availability of patient records, and the potential of reduced healthcare costs, increased efficiency, and improved overall healthcare outcomes. The call for ongoing research and formal training in the care models and technologies associated with telemedicine reflects the evolving nature of telemedicine practice.

The Board cautions, however, that licensees providing care to North Carolina patients via telemedicine will be held to the same established standard of care as those practicing in traditional in-person medical settings. The Board does not endorse a separate standard of care for telemedicine. Licensees, who fail to conform to the North Carolina statewide standard of care, may be subject to discipline by this Board.

The Board provides the following considerations to its licensees as guidance in providing medical services via telemedicine:

Training of Staff

Staff involved in the telemedicine visit should be trained in the use of the technology being used to deliver care and competent in its operation.

Evaluations and Examinations

Licensees using telemedicine technologies to provide care to patients located in North Carolina must provide, or rely upon, an appropriate evaluation prior to diagnosing and/or treating the patient. This evaluation need not be in-person if the licensee employs technology sufficient to accurately diagnose and treat the patient in conformity with the applicable standard of care. A diagnosis should be established using accepted medical practices, i.e., a patient history, mental status evaluation, physical examination, and appropriate diagnostic and laboratory testing.

Evaluations may also be considered appropriate if a licensed health care professional is able to facilitate aspects of the patient assessment needed to render reasonable diagnostic possibilities and care plans. On the other hand, a simple questionnaire without an appropriate evaluation may be a violation of law and/or subject the licensee to discipline by the Board.

Licensee-Patient Relationship

The Board stresses the importance of proper patient identification prior to any telemedicine encounter. Failure to

verify the patient's identity may lead to fraudulent activity or the improper disclosure of confidential patient information. The licensee using telemedicine should verify the identity and location of the patient. Furthermore, the licensee's name, location, and professional credentials should be provided to the patient. Licensees using telemedicine should also ensure the availability for appropriate follow-up care and maintain a complete medical record that is available to the patient and other treating health care providers.

Prescribing

Licensees are expected to practice in accordance with the Board's Position Statement "Contact with Patients Before Prescribing." It is the position of the Board that it is not consistent with the current standard of care to prescribe controlled substances for the treatment of pain in which the only patient encounter is by means of telemedicine and there are no other licensed healthcare providers involved in the initial and ongoing evaluations of the patient. Licensees prescribing controlled substances by means of telemedicine for other conditions should comply with all relevant federal and state laws and are expected to participate in the Controlled Substances Reporting System.

Medical Records

The licensee treating a patient via telemedicine must maintain a complete record of the telemedicine patient's care consistent with the prevailing medical record standards. The medical record should clearly document all aspects of care including email, text, photos, phone contact, and other forms of communication. HIPAA and related privacy and security documents should be present and signed where appropriate. Appropriate informed consent documents acknowledging the risks, limitations, alternatives, and benefits of the telemedicine encounter should be included.

The licensee must maintain the medical record's confidentiality and provide a copy of the medical record to the patient in a manner consistent with state and federal law. If the patient has a primary care provider and a telemedicine provider for the same ailment, then the primary care provider's medical record and the telemedicine provider's medical record constitute one complete patient record. Licensees practicing via telemedicine will be held to the same standards of professionalism concerning the transfer of medical records and communications with the patient's primary care provider and medical home as those licensees practicing via traditional means.

Disclaimers

Practitioners of telemedicine should consider providing a statement identifying any unique limitations of the electronic model by which care is being provided. Such patient notification can be distributed prior to providing services and included in all direct advertising to the public.

Licensure

The Board deems the practice of medicine to occur in the state where the patient is located. Therefore, any licensee using telemedicine to regularly provide medical services to patients located in North Carolina should be licensed to practice medicine in North Carolina. Licensees need not reside in North Carolina if they have a valid, current North Carolina license.

North Carolina licensees intending to practice medicine via telemedicine technology to treat or diagnose patients outside of North Carolina should check with other state licensing boards. Most states require physicians to be licensed, and some have enacted limitations on telemedicine practice or require or offer a special registration. A directory of all U.S. medical boards may be accessed at the Federation of State Medical Boards web site: http://www.fsmb.org/directory_smb.html.



State Limitations on PA Prescribing of Buprenorphine

The Comprehensive Addiction and Recovery Act (CARA), enacted in 2016, authorized PAs and nurse practitioners (NPs) to prescribe buprenorphine for the purposes of treating opioid use disorder through medication assisted treatment (MAT). Under CARA, PAs and NPs must complete 24 hours of training to be eligible for a waiver from the Drug Enforcement Administration (DEA) and be supervised by or collaborate with a waiver-eligible physician to prescribe this medication for MAT. CARA defines a waiver-eligible physician as either an addiction medicine specialist or a physician who has taken appropriate training which would qualify him or her for a waiver.

Despite the change in federal law, a handful of states still specifically prohibit PAs and NPs from prescribing buprenorphine. Many more states have laws and regulations which are unclear regarding whether a PA may prescribe buprenorphine if they are supervised by or collaborating with a physician who is waiver-eligible, but does not have a waiver. The chart below is a summary in brief of laws and regulations regarding buprenorphine as they exist, as well as scope of practice and prescribing laws for states which do not specifically address MAT. Results highlighted in red are states for which AAPA has received confirmation that a PA may not prescribe buprenorphine for MAT in an office setting. Results highlighted in green are states for which AAPA has received confirmation that a PA may prescribe buprenorphine for MAT even if their supervising or collaborating physician does not have a waiver (but is waiver-eligible). All other entries are expected interpretations based on statutory or regulatory language, but have not been confirmed by state regulatory authorities. This information is the most recent available to AAPA as of January 10, 2018.

State	Number of Waivered PAs/NPs (as of 10/15/2017)	Restriction	Result/Expected Result
Alabama	1 PA; 9 NP	PA may practice in own scope of education and experience; however, all delegated duties must be listed in PA's written job description in specific detail. Additions to job description must be approved by the Board. (Ala. Admin. Code r. 540-X-7-.25). Subject to any limitations in protocols/regimens adopted by the board and/or by the supervising physician, PA may Rx any Schedule III-V controlled substance upon being granted a Qualified Alabama Controlled Substances Certificate (QACSC) and upon submission of an approved QACSC formulary (Ala. Admin. Code r. 540-X-7-.28). However, Alabama also has	PA may not Rx buprenorphine for opioid treatment under rules stating that physician may not delegate such prescribing to a non-physician prescriber.

State	Number of Waivered PAs/NPs (as of 10/15/2017)	Restriction	Result/Expected Result
		guidance in their rules on treating opioid addiction with buprenorphine which is outdated and states that a physician may not delegate the prescribing of buprenorphine for treatment of opioid addiction to a non-physician provider (Ala. Admin. Code r. 540-X-21-.02; Ala. Admin. Code r. 540-X-21-.03).	
Alaska	5 PA; 12 NP	PA's prescriptive authority may not exceed that of their collaborating physician (Alaska Admin. Code. Tit. 12, § 40.450 (d)).	PA may prescribe if collaborating physician has waiver.
Arizona	15 PA; 84 NP	PAs subject to a 72 hour or 30-day prescription limit for schedule II/schedule III controlled substances, with physician's approval needed for refills (Ariz. Rev. Stat. Ann. § 32-2532 (C-D)). Services provided by PA must be within physician's scope of practice (Ariz. Rev. Stat. Ann. § 32-2531 (C)).	PA may prescribe if supervising physician has waiver.
Arkansas	1 PA; 1 NP	PA's prescriptive authority may not exceed that of their supervising physician (Ark. Code Ann. § 17-105-108 (c)).	PA may prescribe if supervising physician has waiver. Update 12/17: Arkansas State Medical Board issued guidance stating that the PA may prescribe if the supervising physician is waived.
California	46 PA; 130 NP	Supervising physician must prepare a written formulary and protocols for specific medications before a PA may prescribe (Cal. Bus. & Prof. Code § 3502.1).	PA may prescribe regardless of whether physician has waiver per Cal. Bus. Prof. Code § 3502.1.5

State	Number of Waivered PAs/NPs (as of 10/15/2017)	Restriction	Result/Expected Result
Colorado	16 PA; 47 NP	<p>Services delegated to a PA must be within the delegating physician’s education, training, experience, and active practice. PAs may not write or sign prescriptions or perform any services that the supervising physician for that particular patient is not qualified or authorized to prescribe or perform (3 Code Colo. Regs. § 713-7). Regs regarding buprenorphine still reflect only physicians being authorized to prescribe buprenorphine on an inpatient basis (2 Code Colo. Regs. § 502-1) and for medical detoxification (6 Code Colo. Regs. § 1008-1)</p> <p>New: MAT expansion pilot program created – which provides grants to community agencies and other entities to expand access to MAT/buprenorphine. Increasing access to training for PAs/NPs is one of the permissible use of funds. (Colo. Rev. Stat. Ann. § 23-21-804).</p>	PA may prescribe in outpatient setting if supervising physician has waiver. PA may not prescribe in an inpatient setting due to language in current rules.
Connecticut	11 PA; 83 NP	<p>A PA may only perform functions which are delegated by the supervising physician and are within the scope of the supervising physician’s license, competence, training and experience, and within the scope of the supervising physician’s actual practice (Conn. Gen. Stat. § 20-12d (a)).</p> <p>New: requires a feasibility study to include establishing a public info portal with information on treatment resources and availability, including buprenorphine. (Added by P.A. 17-131, § 7)</p>	PA may prescribe if supervising physician has waiver.
Delaware	4 PA; 3 NP	A supervising physician may not delegate medical acts to a PA that exceeds the physician’s scope of practice (Del. Code tit. 24, § 1771 (e)).	PA may prescribe if supervising physician has waiver.
District of Columbia	1 PA; 15 NP	A PA may perform delegated services which are within the PA’s scope of practice and which “forms a component of the physician’s” scope of practice (D.C. Mun. Regs. tit. 17-4911).	PA may prescribe if supervising physician has waiver.

State	Number of Waivered PAs/NPs (as of 10/15/2017)	Restriction	Result/Expected Result
Florida	18 PA; 70 NP	Supervising physician must be qualified in the medical areas in which the PA practices (Fla. Stat. Ann. § 458.347). A supervising physician may delegate to a PA the authority to prescribe only such drugs as are used in the supervising physician's practice (Fla. Admin. Code r. 64B-30.008). Language referring only to physicians' role in office-based opioid addiction treatment is here (Fla. Admin. Code r. 64B15-14.009)(PAs licensed by osteopathic board only)	PA may prescribe if supervising physician has waiver.
Georgia	9 PA; 19 NP	Prescribing authority for controlled substances must be delegated to the PA, and the physician must evaluate patients receiving controlled drugs at least every three months (Ga. Code Ann. § 43-34-103).	PA may prescribe if supervising physician has a waiver.
Hawaii	1 PA; 1 NP	Prescribing authority must be delegated to the PA (Haw. Code R. § 16-85-49).	PA may prescribe if supervising physician has a waiver.
Idaho	6 PA; 20 NP	Supervising physician may not delegate to a PA any medical services for which the physician does not have training or experience and does not perform (Idaho Code Ann. § 54-1807A (5)). Prescriptive authority must be consistent with the regular prescriptive practice of the supervising or alternate physician (Idaho Admin. Code r. 22.01.03.042).	PA may prescribe if supervising physician has a waiver.
Illinois	13 PA; 52 NP	Services provided by a PA must be services that the supervising physician is authorized to provide and generally provides to patients in the normal course of clinical practice (225 Ill. Comp. Stat. § 95/7.5 (a)(1)). Delegation to prescribe controlled substances must only be for substances that the supervising physician prescribes (225 Ill. Comp. Stat. § 95/7.5 (b)(3)(B)).	PA may prescribe if supervising physician has a waiver.

State	Number of Waivered PAs/NPs (as of 10/15/2017)	Restriction	Result/Expected Result
Indiana	13 PA; 71 NP	Duties delegated to the PA must be within the supervising physician's scope of practice, including prescribing and dispensing drugs (Ind. Code Ann. § 25-27.5-5-2 (a)). Must have 1,800 hours of practice as a PA before prescribing controlled substances (Ind. Code Ann. § 25-27.5-5-4 (g)). New legislation includes physician-centric language for MAT using buprenorphine for the Maternal Neonatal Opioid Addiction Project (Ind. Code. Ann. § 12-23-22-6) Additional new legislation created a Physician MAT Training Reimbursement Pilot Program, for waiver training for physicians (Ind. Code Ann. § 12-23-21-3). Initial dosing of buprenorphine in an OTP must be determined by the program physician (440 Ind. Admin. Code 10-4-19).	PA may prescribe if supervising physician has a waiver, but if the patient is at an OTP, the program physician must determine the initial dose.
Iowa	1 PA; 11 NP	Physician may delegate prescribing of controlled substances to PA (Iowa Code Ann. § 147.107). All delegated activities must be within the scope of practice of the PA and the physician (Iowa Admin. Code r. 653-21.4(2)(f)).	A PA may prescribe if supervising physician has a waiver.
Kansas	2 PA; 7 NP	PA may only be delegated acts which are within the supervising physician's clinical competence and customary practice (Kan. Admin. Regs. § 100-28a-10 (8)(B)).	A PA may prescribe if supervising physician has a waiver.
Kentucky	0 PA; 71 NP	No controlled substance prescribing authority for PAs.	PA may not prescribe.
Louisiana	1 PA; 28 NP	PA must practice within the scope of the PA's education and experience. PA may prescribe, order and administer drugs to the extent delegated by the supervising physician (La. Stat. Ann. § 37:1360.31). PA may not prescribe medications which are outside of his own specialty or that of the supervising physician (La. Admin. Code tit. 46, § XLV.4506).	A PA may prescribe if supervising physician has a waiver.

State	Number of Waivered PAs/NPs (as of 10/15/2017)	Restriction	Result/Expected Result
Maine	7 PA; 44 NP	<p>Medical services provided by PA licensed by medical board must be within the scope of practice of the supervising physician (Me. Code R. 02-373-002). PAs may not prescribe methadone, suboxone (buprenorphine) or Subutex unless allowed under state and federal laws. If allowed, these medications must be specifically included in the written plan of supervision (same citation).</p> <p>Medical services provided by PA licensed by osteopathic board do not have to be within the supervising physician's scope so long as the physician has adequate training, oversight skills and referral/supervisory arrangements in place to ensure competent provision of care by the PA (Me. Code R. 02-383-001). No additional language on buprenorphine.</p> <p>Language relating to reimbursement for buprenorphine under Medicaid is neutral, referring only to prescribers who have a DEA waiver. (Me. Code R. 10-144-101).</p>	<p>PA licensed by medical board may prescribe if allowed under federal/state laws; supervising physician has a waiver; and buprenorphine/suboxone is specifically included in the written plan of supervision.</p> <p>PA regulated by osteopathic board may prescribe regardless of whether physician has a waiver, as long as there is a plan in place for adequate supervision if needed.</p>
Maryland	20 PA; 134 NP	<p>PA practice must be within the supervising physician's scope of practice. (Md. Code Ann., Health Occ. § 15-101 (p)(2)). Physician-centric language in regulations may cause billing issues under Medicaid program (Md. Code Regs. 10.09.70.02). There are also outdated references to "DATA 2000 waivers" (Md. Code Regs. 10.09.80.01; 10.03.80.05).</p>	<p>PA may prescribe if supervising physician has a waiver.</p>
Massachusetts	29 PA; 130 NP	<p>Supervising physician may delegate to PA those services which are under the authority of the supervising physician (including prescribing) (243 Mass. Code Regs. 20.8 (3)(a)).</p>	<p>PA may prescribe if supervising physician has a waiver.</p>
Michigan	13 PA; 25 NP	<p>PA must practice within own scope and scope of participating physician (Mich. Comp. Laws Ann. § 333.17047).</p>	<p>PA may prescribe if supervising physician has a waiver.</p>
Minnesota	11 PA; 26 NP	<p>PAs may only be delegated patient services which are customary to the practice of the supervising physician (Minn. Stat. Ann. § 147A.09).</p>	<p>A PA may prescribe if supervising physician has a waiver.</p>

State	Number of Waivered PAs/NPs (as of 10/15/2017)	Restriction	Result/Expected Result
Mississippi	2 PA; 6 NP	PAs may perform duties (including prescribing, ordering, administering and dispensing prepackaged drugs) which are within the PA's training and skills and forms a component of the supervising physician's scope of practice (Miss. Code R. § 30-026-2615).	A PA may prescribe if supervising physician has a waiver.
Missouri	0 PA; 13 NP	PAs may only prescribe a 5-day supply (no refill) for Schedule III controlled substances (Mo. Rev. Stat. § 334.747). Drugs prescribed or dispensed by a PA must be consistent with the scopes of practice of the PA and the supervising physician and the supervising physician must be qualified or authorized to prescribe such drugs (Mo. Rev. Stat. § 334.735).	A PA may only prescribe for 5 days (no refills), and only if the supervising physician has a waiver.
Montana	4 PA; 8 NP	PA must be delegated duties by supervising physician; degree of delegation and supervision is determined by the PA/physician team (Mont. Code Ann. § 37-20-403).	PA may prescribe regardless of whether supervising physician has a waiver.
Nebraska	3 PA; 4 NP	PA may perform medical services which are appropriate to the PA's competence level and form a component of the supervising physician's scope of practice (Neb. Rev. Stat. Ann. § 38-2047).	PA may prescribe if the supervising physician has a waiver.
Nevada	6 PA; 27 NP	PA may only prescribe controlled substances up to the schedule for which the supervising physician is authorized (Nev. Rev. Stat. Ann. § 630.271). PA must practice within own scope of practice and scope of physician's practice (Nev. Admin. Code § 630.360). PAs licensed by osteopathic board are subject to the first provision (prescribing controlled substances) but not the second (practicing within the supervising physician's scope).	PA may prescribe if the supervising physician has a waiver.
New Hampshire	3 PA; 39 NP	PA scope of practice must be no broader than the supervising physician's scope of practice (N.H. Code Admin. R. Med. 603.01). The Medicaid regulations contain physician-centric language pertaining to buprenorphine/DATA 2000 (N.H. Code Admin. R. He-W 513.05).	PA may prescribe if supervising physician has a waiver, but there may be complications related to Medicaid reimbursement for MAT due to outdated references in the regulations.

State	Number of Waivered PAs/NPs (as of 10/15/2017)	Restriction	Result/Expected Result
New Jersey	7 PA; 75 NP	PA may perform medical services which are delegated by a supervising physician and are customary to the supervising physician's specialty and within the physician and PA's competence and training (N.J. Rev. Stat. § 45:9-27.16). The state Division of Mental Health and Addiction Services has an appendix within their regulations titled "Buprenorphine Guidelines" which contains outdated, physician-centric language.	PA may prescribe if supervising physician has a waiver. Agency Buprenorphine Guidelines should be updated to reflect CARA policies.
New Mexico	4 PA; 49 NP	PA licensed by medical board may practice within own scope of education and training (new statute, effective 6/16/17) PA licensed by osteopathic board must practice within the supervising physician's scope (N.M. Stat. Ann. § 61-10-11.2).	PA licensed by medical board (effective 6/16/17) may prescribe regardless of whether physician has a waiver. NMMB affirmed this position in fall 2017. PA licensed by osteopathic board may prescribe if supervising physician has a waiver.
New York	49 PA; 193 NP	PA may perform medical services which are delegated by a supervising physician and which are within the supervising physician's scope of practice (N.Y. Educ. Law § 6542(1)). Administrative rules maintain physician-centric language related to buprenorphine (N.Y. Comp. Codes R. & Regs. tit. 10, § 80.84). Update: this has changed to using the term "authorized practitioner" as of 8/16/17. However, there remains outdated language in N.Y. Comp. Codes R. & Regs. tit. 14, § 829.1; 829.2	PA may prescribe if supervising physician has a waiver. Regulations should be updated to reflect CARA policies.
North Carolina	39 PA; 89 NP	PA may not prescribe medications of a higher schedule than what is authorized for their supervising physician. 30-day limit for Schedule III/IIIN prescriptions (21 N.C. Admin. Code 32S.0212). Statute contains some outdated language directing physicians prescribing or dispensing buprenorphine for MAT to register with the state (N.C. Gen. Stat. Ann. § 90-101)	PA may prescribe if supervising physician has a waiver, with a 30-day limit.

State	Number of Waivered PAs/NPs (as of 10/15/2017)	Restriction	Result/Expected Result
North Dakota	1 PA; 2 NP	PA may only provide patient care in areas of medical practice where the supervising physician provides patient care (N.D. Admin. Code 50-03-01-06). Regulations regarding buprenorphine speak to OTPs – one regulation (N.D. Admin. Code 75-09.1-10-02) mentions physicians needing a DATA 2000 waiver and another uses provider-neutral language surrounding buprenorphine (N.D. Admin. Code 75-09.1-10-15).	PA may prescribe if supervising physician has a waiver.
Ohio	21 PA; 148 NP	PA must only provide services which are within the supervising physician’s normal course of practice and expertise (Ohio Rev. Code Ann. § 4730.02). PA may not have greater prescriptive authority than supervising physician (Ohio Rev. Code Ann. § 4730.41). PA with less than 500 hours of practice with prescriptive authority must have on-site physician supervision (Ohio Rev. Code Ann. § 4730.44). Regulations regarding office-based opioid treatment with buprenorphine retains physician-centric language which should be updated (Ohio Admin. Code 1501:13-1-02). New: includes PA as a “prescriber” of MAT, including for buprenorphine if the PA is qualified under federal law (effective 9/27/17) (Ohio Rev. Code Ann. § 3715.08) Also language which includes buprenorphine in the PA prescribing formulary (effective 9/27/17) (Ohio Rev. Code Ann. § 4730.40) and a new section requiring the medical board to establish standards to be followed by PAs in using MAT to treat patients addicted to opioids (Ohio Rev. Code Ann. § 4730.55; § 4730.56)	PA may prescribe if supervising physician has a waiver. Regulations should be updated to reflect CARA policies (this necessity is reflected in the updated statutes).

State	Number of Waivered PAs/NPs (as of 10/15/2017)	Restriction	Result/Expected Result
Oklahoma	6 PA; 0 NP	Statute defines “opioid substitution treatment programs” as persons, physicians, or organizations that administer opioid drugs for treatment or detox purposes, but exempts physicians who administer buprenorphine under DEA waiver from having to go through state-based certification. This should be updated to reflect CARA (Okla. Stat. Ann. tit. 43A, § 3-601). PA may prescribe/practice as delegated by physician; however, PAs are limited to prescribing a 30-day supply of Schedule III medications (Okla. Admin. Code §435:15-5-1).	PA may prescribe if supervising physician has a waiver; however, PA is limited to prescribing a 30-day supply.
Oregon	13 PA; 48 NP	Supervising physician or alternate supervising physician must be competent to perform duties delegated to PA (Or. Rev. Stat. Ann. § 677.510 (8)). Medical services provided by PA must be within the scope of practice of both the PA and the supervising physician (Or. Rev. Stat. Ann. § 677.515 (1)). New: PA may prescribe and dispense buprenorphine if they meet state controlled substance prescribing requirements, the PA is waived, the PA is given dispensing authority (if they plan to dispense), it is in the PA’s and the physician’s scope of practice, and in the practice agreement as a delegated service, and the PA complies with all recordkeeping requirements (Or. Admin. R. 847-050-0041)	PA may prescribe if supervising physician has a waiver.
Pennsylvania	47 PA; 93 NP	PA licensed by medical board may provide any medical service that is delegated by the supervising physician, is within the PA’s skills, training, and experience, and forms a component of the physician’s scope of practice (49 Pa. Code § 18.151). PAs licensed by osteopathic board must practice within their own scope as well as physician’s usual scope of practice (63 Pa. Cons. Stat. § 271.10 (k)).	PAs may prescribe if supervising physician has a waiver.
Rhode Island	5 PA; 15 NP	PAs must practice within their own scope in performing healthcare services consistent with their expertise and that of the supervising physician (R.I. Gen. Laws § 5-54-8).	PA may prescribe if supervising physician has a waiver.

State	Number of Waivered PAs/NPs (as of 10/15/2017)	Restriction	Result/Expected Result
South Carolina	9 PA; 38 NP	Physician creates written scope of practice guidelines for PA which must be appropriate to the PA's ability and knowledge (S.C. Code Ann. § 40-47-955). PA may prescribe drugs which are authorized in the written scope of practice guidelines (S.C. Code Ann. § 40-47-965). PA may not perform a medical act, task, or function that is outside of the usual practice of the supervising physician (S.C. Code Ann. § 40-47-970).	PA may prescribe if supervising physician has a waiver.
South Dakota	1 PA; 1 NP	PA may perform medical duties which are delegated by the supervising physician, within the PA's skills, and form a component of the physician's scope of practice (S.D. Codified Laws § 36-4A-26.1).	PA may prescribe if supervising physician has a waiver.
Tennessee	0 PA; 1 NP	Only physicians may prescribe buprenorphine for recovery or MAT (Tenn. Code Ann. § 53-11-311 (c)).	PA may not prescribe.
Texas	16 PA; 67 NP	Physician may delegate prescriptive authority to PA for Schedule III-V, including a refill, not to exceed a period of 90 days (Tex. Occ. Code § 157.0511 (b)). PA practices in own scope of practice, as delegated by supervising physician (Tex. Occ. Code § 204.202). Delegation of medical tasks must be appropriate to the PA's level of competence (Tex. Occ. Code § 204.206).	PA may prescribe if delegated, regardless of whether physician has a waiver. 90 day limit for prescriptions.
Utah	20 PA; 45 NP	PA may provide medical services which are within the PA's scope of competence and within the physician's usual scope of practice, and may prescribe controlled substances which are within the prescriptive practice of the physician (Utah Code Ann. § 58-70a-501). Regulations refer to physicians only as prescribers of buprenorphine (Utah Admin. Code r. 501-21-6)	PA may prescribe if supervising physician has a waiver.

State	Number of Waivered PAs/NPs (as of 10/15/2017)	Restriction	Result/Expected Result
Vermont	4 PA; 13 NP	PA's scope of practice (including prescribing) limited to duties delegated by the supervising physician which are within the physician's scope of practice (Vt. Stat. Ann. tit. 26, § 1735a). Regulations contain physician-centric language but also the provision: "Each physician who practices as or in an OBOT shall be a Vermont-licensed physician until such time as the federal law is changed to allow other providers to prescribe MAT." (Vt. Code R. 13-140-062). New: this rule has been updated to include PAs/CARA language. It is unclear in the rules whether they must practice with a physician who is also waived. Statute includes language allowing physicians or APRNs who are not affiliated with an authorized treatment program but meet federal requirements for MAT to dispense controlled substances for use in federally approved pharmacological treatments for opioid addiction. PAs are not included in this language (Vt. Stat. Ann. tit. 18, § 4752)	PA may prescribe if supervising physician has a waiver. Regulations should be updated but they appear to allow other providers to prescribe once federal law has been updated.
Virginia	11 PA; 21 NP	PA and physician work together to determine PA's scope of practice (Va. Code Ann. § 54.1-2952). Delegation of prescriptive authority for controlled substances should be in the practice agreement (Va. Code Ann. § 54.1-2952). Prescriptive authority should be within the scope of practice and proficiency of the supervising physician (18 Va. Admin. Code § 85-50-101). Provision of healthcare services must also be within the scope of practice and proficiency of the physician (18 Va. Admin. Code § 85-50-115). New: updated rule states that practitioners who are buprenorphine-waived and not physicians must meet all federal/state requirements and be supervised by or work in collaboration with a qualifying physician who is waived.	PA may prescribe if supervising physician has a waiver.
Washington	21 PA; 49 NP	PAs may not practice beyond the supervising physician's scope of expertise and practice.	PA may prescribe if supervising physician has a waiver.

State	Number of Waivered PAs/NPs (as of 10/15/2017)	Restriction	Result/Expected Result
West Virginia	7 PA; 15 NP	PA may provide medical services which are consistent with the skills and training of the supervising physician (W.Va. Code § 30-3E-9). Such services must also be customary to the practice of the supervising physician (W.Va. Code § 30-3E-12). PA may not prescribe more than a 30 day supply of Schedule III controlled medications (W. Va. Code R. § 11-1B-12).	PA may prescribe if supervising physician has a waiver, but may not write a prescription for more than 30 days worth of Schedule III controlled medication under state regulation. Regulation must be updated.
Wisconsin	8 PA; 11 NP	PA practice may not exceed the scope of practice of the supervising physician (Wis. Admin. Code Med § 8.07).	PA may prescribe if supervising physician has a waiver. Update December 2017: WI Medical Examining Board issued guidance stating that PA may prescribe even if physician is not waived.
Wyoming	3 PA; 3 NP	PA must practice within same scope of the supervising physician (Wyo. Stat. Ann. § 33-26-502).	PA may prescribe if supervising physician has a waiver.

1/2018

Key:

Red – PA may not prescribe buprenorphine for MAT

Yellow – New language since 6/1/2017

Green – Confirmed that PA may prescribe buprenorphine for MAT even if physician is not waived

Silver – Expected that PA may prescribe buprenorphine for MAT even if physician is not waived, due to existing statutory/regulatory language

Blue – Limitation on prescribing

Purple – Statutory/regulatory language must be updated to reflect CARA

The information contained in this chart is condensed and accurate as of January 9, 2018. This document is intended for background purposes only. For a complete and current version of the statutes and regulations, AAPA encourages you to visit the state's legislative and regulatory website. Many states are currently working on improvements to existing PA statutes and regulations. For information on pending improvements, please contact AAPA.



ASAM American Society of
Addiction Medicine

October 13, 2017

Dear Board Director:

On behalf of the American Society of Addiction Medicine (ASAM), the American Association of Nurse Practitioners (AANP), and the American Academy of Physician Assistants (AAPA), who collectively represent over 350,000 clinicians, we would like to take this opportunity to discuss with you the matter of ensuring Nurse Practitioners (NPs) and Physician Assistants (PAs) are able to prescribe buprenorphine for the treatment of addiction. With the opioid addiction and overdose crisis continuing to significantly impact the country, ASAM, AANP, and AAPA encourage you to facilitate this important new Federal innovation.

ASAM, AANP, and AAPA are dedicated to increasing access to and improving the quality of addiction treatment for patients across the country. We are also committed to promoting the appropriate role of the clinician in the care of patients with addiction. We recognize that States, through laws, regulations, guidelines, and policies significantly impact how substance use disorder and addiction treatment is provided to its citizens.

As you are likely aware, last July President Obama signed the Comprehensive Addiction and Recovery Act (CARA) into law. CARA is a sweeping bill that came together over the course of several years with input from hundreds of addiction treatment advocates. Its provisions address the full continuum of care from primary prevention to recovery support, including significant changes to expand access to addiction treatment services and overdose reversal medications.

One major provision of CARA is the authorization of prescribing privileges to NPs and PAs for FDA approved opioid treatment medications containing buprenorphine, a Schedule III controlled substance. Under CARA, NPs and PAs must complete 24 hours of training to be eligible for a waiver to prescribe and must be supervised by or work in collaboration with a qualifying physician (defined under Federal law as a physician that is an addiction specialist or has taken the appropriate training), if supervision or collaboration is required by state law. It is important to realize that ASAM collaborated with the AANP and the AAPA to help develop the curriculum and the training to meet this training requirement.

This is a substantial change in practice, as it was when the Drug Addiction Treatment Act (DATA) of 2000 provided this authority to physicians, reversing a Federal prohibition that had been in place since 1914. As such, many of our own NP and PA members, as well as those represented by allied stakeholders, have expressed uncertainty about State laws and regulations that may affect their ability to treat patients under this new paradigm.

As such, it would be helpful if the applicable State Boards could issue information to their respective NP or PA licensees to clarify the requirements that these health care professionals need to be aware of as they begin to consider treating patients. This important guidance could be in the form of a Dear

Colleague letter, an update in a newsletter, or other methods. In so doing, we encourage regulatory boards to use the least restrictive language possible, and state that NPs and PAs who meet the qualifications, complete the required training, and receive a waiver from the Drug Enforcement Administration (DEA) may prescribe and/or provide buprenorphine for the treatment of opioid addiction as part of medication-assisted treatment (MAT).

Of note, the Substance Abuse and Mental Health Services Administration (SAMHSA) has indicated that if collaboration or supervision is required by state law it will interpret CARA in such a way that NPs and PAs will not be required to collaborate with or be supervised by a waived physician as a condition of their own waiver, as long as they and their associated physician otherwise meet the requirements of the program. We urge state regulators to follow this approach, and allow NPs and PAs to practice with an eligible, but unwaivered, qualified physician if supervision or collaboration is required by state law.

ASAM, AANP, and AAPA share the States' goal in increasing access to and improving the quality of comprehensive addiction treatment services for all patients, as well as promoting the appropriate role of the clinician in the care of patients with addiction. We are committed to working with you on promoting access to this high quality, evidence-based treatment that best meets the needs of the patient. If AANP, AAPA, and ASAM can be of any assistance passing on information from your state's Board to our members we would be happy to do so. Please do not hesitate to contact Brad Bachman, ASAM's Manager of State Government Relations, at (301) 547-4107 or bbachman@asam.org, if we can be of service to you. We look forward to working with you.

Sincerely,

Kelly J. Clark, MD, MBA, DFAPA, DFASAM
President, American Society of Addiction Medicine

L. Gail Curtis, MPAS, PA-C, DFAAPA
President, American Academy of Physician Assistants

Joyce M. Knestrick, PhD, C-FNP, FAANP
President, American Association of Nurse Practitioners

Qualifying physician Requirements for PAs and NPs supervision/collaboration

the nurse practitioner or physician assistant to treat and manage opiate-dependent patients.

“(III) The nurse practitioner or physician assistant is supervised by, or works in collaboration with, a qualifying physician, if the nurse practitioner or physician assistant is required by State law to prescribe medications for the treatment of opioid use disorder in collaboration with or under the supervision of a physician.

Title 21 United States Code (USC) Controlled Substances Act as amended by the Comprehensive Addiction and Recovery Act of 2016

21USC823(g)(2)(G)(ii)

(g) Practitioners dispensing narcotic drugs for narcotic treatment; annual registration; separate registration; qualifications; waiver

(i) The practitioner is a **qualifying** physician (as defined in subparagraph (G)).

(G) For purposes of this paragraph:

(ii) The term "qualifying physician" means a physician who is licensed under State law and who meets one or more of the following conditions

(I) The physician **holds a subspecialty board certification in addiction psychiatry** from the American Board of Medical Specialties.

(II) The physician **holds an addiction certification** from the American Society of Addiction Medicine.

(III) The physician **holds a subspecialty board certification in addiction medicine** from the American Osteopathic Association.

(IV) The physician has, with respect to the treatment and management of opiate-dependent patients, **completed not less than eight hours of training** (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) that is provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Psychiatric

Association, or any other organization that the Secretary determines is appropriate for purposes of this subclause.

(V) The physician **has participated as an investigator** in one or more clinical trials leading to the approval of a narcotic drug in schedule III, IV, or V for maintenance or detoxification treatment, as demonstrated by a statement submitted to the Secretary by the sponsor of such approved drug.

(VI) The physician **has such other training or experience as the State medical licensing board** (of the State in which the physician will provide maintenance or detoxification treatment) considers to demonstrate the ability of the physician to treat and manage opiate-dependent patients.

(VII) The physician **has such other training or experience as the Secretary** considers to demonstrate the ability of the physician to treat and manage opiate-dependent patients. Any criteria of the Secretary under this subclause shall be established by regulation. Any such criteria are effective only for 3 years after the date on which the criteria are promulgated, but may be extended for such additional discrete 3-year periods as the Secretary considers appropriate for purposes of this subclause. Such an extension of criteria may only be effectuated through a statement published in the Federal Register by the Secretary during the 30-day period preceding the end of the 3-year period involved.

(H)(i) In consultation with the Administrator of the Drug Enforcement Administration, the Administrator of the Substance Abuse and Mental Health Services Administration, the Director of the National Institute on Drug Abuse, and the Commissioner of Food and Drugs, the Secretary shall issue regulations (through notice and comment rulemaking) or issue practice guidelines to address the following:

(I) Approval of additional credentialing bodies and the responsibilities of additional credentialing bodies.

(II) Additional exemptions from the requirements of this paragraph and any regulations under this paragraph.

Nothing in such regulations or practice guidelines may authorize any Federal official or employee to exercise supervision or control over the practice of medicine or the manner in which medical services are provided.

(ii) Not later than 120 days after October 17, 2000, the Secretary shall issue a treatment improvement protocol containing best practice guidelines for the treatment and maintenance of opiate-dependent patients. The Secretary shall develop the protocol in consultation with the Director of the National Institute on Drug Abuse, the Administrator of the Drug Enforcement Administration, the Commissioner of Food and Drugs, the Administrator of the Substance Abuse and Mental Health Services Administration and other substance abuse disorder professionals. The protocol shall be guided by science.

(I) During the 3-year period beginning on the date of approval by the Food and Drug Administration of a drug in schedule III , IV, or V, a State may not preclude a practitioner from dispensing or prescribing such drug, or combination of such drugs, to patients for maintenance or detoxification treatment in accordance with this paragraph unless, before the expiration of that 3-year period, the State enacts a law prohibiting a practitioner from dispensing such drugs or combinations of drug.\1\

From: Stein, Anna H <Anna.Stein@dhhs.nc.gov>
Sent: Thursday, January 3, 2019 11:19 AM
To: David Henderson <David.Henderson@NCMEDBOARD.ORG>; Thomas W. Mansfield <Thomas.Mansfield@NCMEDBOARD.ORG>
Cc: Evelyn W. Contre <Evelyn.Contre@NCMEDBOARD.ORG>
Subject: question about physician supervision of mid-levels and residents in the OBOT setting

Thom or David, Do you have time to chat about the issue of physician supervision of DATA 2000-waivered mid-level providers and waivered medical residents? The issue is whether the supervising physician needs to be waivered, and this appears to be a matter of state regulation. Folks are saying it is a barrier to treatment to require the supervising physician to be waivered as well, and I would like to talk with you about where NC stands with this.

There is increasing consensus that the federal requirement of additional training (i.e., the DATA 2000 waiver) for the prescribing of buprenorphine for SUD treatment is based on stigma surrounding SUDs and not on actual science. Mid-levels and residents can prescribe opioids for pain without any additional training on their part or the part of their supervising physicians, and it is only for buprenorphine—which has a much better safety profile than many other opioids—that these special requirements apply—and then only when buprenorphine is being used to treat SUD.

Here are some links I found on this issue: <https://www.asam.org/resources/practice-resources/nurse-practitioners-and-physician-assistants-prescribing-buprenorphine>
http://www.wapa.org/resource/resmgr/files/Are_PA%E2%80%99s_allowed_to_prescri.docx
<http://ncapa.org/legislative-update-mat-waiver/>
[http://uscode.house.gov/view.xhtml?req=\(title:21%20section:823%20edition:prelim\)](http://uscode.house.gov/view.xhtml?req=(title:21%20section:823%20edition:prelim)) [“The nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, or physician assistant is supervised by, or works in collaboration with, a qualifying physician, if the nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, or physician assistant is required by State law to prescribe medications for the treatment of opioid use disorder in collaboration with or under the supervision of a physician.”]

I’m happy to have a call or come to your office. Thanks so much—
 Anna

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