Annual Report to the Joint Commission on Health Care On the Impact and Effectiveness of the Pilot Programs to Expand Access to Obstetric, Prenatal, and Pediatric Services

Virginia Department of Health

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EXECUTIVE SUMMARY

The 2005 General Assembly (GA) passed HB2656 authorizing the State Board of Health to approve birthing center pilot projects in Emporia and in the Northern Neck as an alternative way to improve access to obstetrical and pediatric care in areas without inpatient maternity services.. In accordance with the provisions contained with HB 2656, approved pilot projects were permitted to employ certified nurse midwives (CNM) licensed by the Board of Medicine and Nursing to practice in collaboration with a physician rather than requiring a supervisory relationship with a physician.

HB2656 also added a provision requiring the Virginia Department of Health (VDH) prepare an annual report to the Joint Commission on Health Care on the impact and effectiveness of the pilot programs to expand access to obstetrical and pediatric services in these communities. VDH has issued four such reports in 2006, 2007, 2008, and 2009 to the Joint Commission on Health Care on the progress made to date on the development of birthing centers.

In FY10, state funding in support of the Northern Neck pilot birth center project was eliminated leaving Emporia/Greensville as the only state funded pilot project. A new Memoranda of Agreement (MOA) was established with Southern Dominion Health Systems, Inc. (SDHS) for the Emporia/Greensville project. The MOA contained provisions to administer start-up funds and provide management oversight for this project. Over the past 12 months, stakeholders in the Emporia/Greensville communities have continued to perform work in support of establishing birthing centers utilizing the services of CNMs in accordance with the Board of Health's recommendations.

In the spring of 2010, the Northern Neck's birth center project coordinator along with community stakeholders sought the Board of Health's approval to operate the Family Maternity Center of Northern Neck. Having met all of the provisions contained within HB 2656, the Board unanimously approved the center and doors were open for business in May 2010. During this same time frame Southern Dominion Health Systems has moved closer to establishing a birth center in Emporia, however, it has not as yet become operational.

The issue of Medicaid coverage for freestanding birth center services is still being discussed. With the passage of the Health Care Reform bill, Section 2301 provides for Medicaid payments to providers in a freestanding birth center. In Virginia birthing centers are not licensed, therefore there is no Medicaid reimbursement for facility fees. There are no anticipated changes to state law to license freestanding birth centers.

Background

As noted in earlier reports concerning this initiative, pregnant women who reside in rural areas of the Commonwealth experience limited access to prenatal care. Access to prenatal care has been shown to have an inverse relationship to infant and maternal morbidity rates, i.e. the less access to care the higher the number of infants and mothers who experience poor outcomes. This has been shown to be the case in localities designated as health professional shortage areas such as Planning Districts (PD) 17 and 18 comprising the Northern Neck area and in PD 19 which encompasses the Emporia/Greensville areas. In 2008 the infant death rate in PD 17 was 10.9 per 1,000 population and 8.4 per 1,000 population in PD 18. In the Emporia/Greensville area (PD 19) the infant death rate of 7.5 per 1,000 population was reported for the same time period (VDH, Division of Health Statistics). Statewide, the overall birth rates have dropped slightly from 13.9 per 1,000 population in 1996 to 13.7 per 1,000 population in 2008. In 2008 there was a 7% decrease statewide in the total number of pregnancies over the previous year, from 143,071 in 2007 to 141,425 in 2008.

Due to the ongoing lack of access to inpatient obstetrical health care in the Northern Neck and Emporia/Greensville areas, the majority of pregnant women must travel outside their locality to deliver. According to the Virginia Health Statistics 2008 report, Total Live Births by Place of Occurrence and Place of Residence, Planning Districts 17 & 18 (Northern Neck area) reported 1,415 live births by place of residence, of which only 21 actually occurred in the Northern Neck area. Likewise, for Planning District 18 (Emporia/Greensville area) of the 2, 268 live births reported by place of residence, 1, 372 (60%) occurred at hospitals located outside of that area. The demand for easily accessible prenatal care continues to present a challenge, particularly in these designated health care shortage rural communities.

It has been well established that early entry into prenatal services increases chances of healthy outcomes for both mother and baby. Early entry into prenatal care has numerous benefits, including the opportunity to provide education regarding pregnancy and infant health and the promotion of smooth transitions to infant health care. The direct benefits of early prenatal care to the pregnant woman are prevention of problems such as pregnancy-induced hypertension, iron deficiency anemia, gestational diabetes and toxemia which may result in maternal hospitalization. In 2008, a little over 70% of pregnant women residing in Emporia and Greensville County began prenatal care in the first 13 weeks of pregnancy, as compared to 85% of the pregnant women residing in Lancaster County (Northern Neck area) who entered care in the first trimester.

Expanding access to prenatal care in two targeted high-risk, medically underserved, rural areas (Emporia/Greensville and Northern Neck) has been a priority since 2005 with the passage of HB 2656. That legislation authorized the State Board of Health to approve pilot projects to improve access to prenatal, obstetrical (OB), and pediatric care (see Appendix A). Two pilot projects were initially awarded funding in the amount of $75,000 each. Additional funding was appropriated in FY 07 and FY 08 to support the development of birthing centers in both communities. Thereafter, funding was reduced as part of the state's overall budget reduction strategy. In FY 09 the appropriation for the two birthing centers was reduced by $22,500. In FY 10 funding to support the development of the birth center in the Northern Neck area was eliminated and the birth center project funding in Emporia/Greensville was reduced.

<u>Progress to Date – Emporia/Greensville</u>

Southern Dominion Health Systems (SDHS) continues to work towards the establishment of a birthing center in the City of Emporia. SDHS was denied a Stimulus Facility Investment

Program grant which was needed to construct a new birthing center. However an alternative solution to lease a space in close proximity to the hospital has been identified. Site plans have been revised to accommodate the change in building and space requirement. SDHS's CEO has been negotiating with the landlord of the proposed building to make the necessary repairs and changes on the lease agreement. This has resulted in the opening being delayed to 2011. Information on the birthing center is available on SDHS's web site http://www.sdhsinc.com/birthing_center.htm.

Ongoing relationships with community physicians in the Franklin, Richmond, and Petersburg areas continues to progress. Contracts or memoranda of agreement specifying the referral and physician back-up agreements between and among all involved providers and health care facilities have been reviewed and signed. A Letter of Understanding between SVRMC and SDHS was signed on April 30, 2009, to provide basic non-obstetrical ancillary services to the Emporia/Greensville Birthing Center (EGBC). In addition, a Letter of Understanding between SDHS and Greensville Volunteer Rescue Squad to provide emergency medical transfer services from the birth center to a tertiary care facility was signed on May 5, 2009.

Clinical practice guidelines, antepartum care, intrapartum care, postpartum and new born care protocols have been have approved by SDHS's Medical Director. In July 2010 the Chairman of the Department of Obstetric and Gynecology for Virginia Commonwealth's Health System (VCUHS), approved on the emergency transfer protocols. A community specific uniform prenatal risk assessment tool has been developed. Job descriptions for both the certified nurse midwife and registered nurse positions have been written. An orientation outline for prospective birthing center clients has been prepared. A quality assurance and continuous quality improvement plan were developed in conjunction with the American Association of Birth

Centers (AABC) guidance. SDHS has maintained membership in the AABC and steps have been taken to submit required documents in preparation for a site visit by the AABC accreditation committee in the summer of 2011.

The March of Dimes awarded a Centering Pregnancy grant to SDHS in 2009 and extended funding in 2010. The Centering Pregnancy model provides care to groups of pregnant women with similar due dates. Women will receive their pregnancy check-ups while receiving support and education from women who are in the same stage of pregnancy. In each of the 10 sessions, a pregnant woman has private time with her health care provider and then meets to discuss questions, concerns, and solutions all within a group setting. Besides on-going pregnancy assessment, women will receive pertinent health education and will be able to access related services. During this past year research on smoking cessation education needs was conducted and will be used for in centering program classes. In addition, education and support for staff on Centering Pregnancy programs was provided.

SDHS will receive cost based reimbursement for obstetrical services rendered during its first year of operation. The facility uses a sliding scale fee-for-service for eligible patients and accepts all insurances.

Progress to Date – Northern Neck

State funding for the Family Maternity Center ended on June 30, 2009, however the work continued and in January 2010, the Family Maternity Center of Northern Neck met with the Board of Health to obtain approval of their birth center proposal. Having met all of the provisions contained within HB 2656, the Board was unanimous in their agreement that the FMCNN could begin delivering care to the underserved pregnant women in the Northern Neck area.

The FMCNN under the leadership of the project coordinator and medical director were quite successful in obtaining grassroots support of this birthing center. They applied for and received substantial external funding from federal and private foundations which contributed greatly to achieving the intended goal of increasing access to prenatal and pediatric care for families living in a rural underserved area.

The ribbon cutting ceremony on the new 5,200 square foot facility located in Kilmarnock, on Rt. 3 was held on May 29, 2010. The facility will be equipped with telemedicine equipment for both the clinic and educational purposes, as well as ultrasound equipment. In addition to the birthing center a Rural Health Care Clinic is co-located in the same facility. Care is provided by certified nurse midwives (CNM), registered nurses, support staff and associated physicians.

Only women with low risk pregnancies will be delivered at the birth center. Throughout the client's pregnancy risk scores will be assessed. If the client is deemed no longer low risk the CNM will transfer care to an OB/GYN physician. The FMCNN will refer high-risk clients to Virginia Commonwealth University Health Systems/Medical College of Virginia along with any low-risk clients not interested in experiencing a birth center delivery.

The FMCNN is a member of the Commission for the Accreditation of Birth Centers (CABC) and is in the process of becoming a fully accredited birthing center. In accordance with the CABC the FMCNN will have available all equipment, medication, and other medical supplies necessary for normal childbearing for low risk pregnancies. There is no operating room, intensive care suite, or anesthesia. In case of a medical emergency the woman and or her infant will be transferred to VCUHS/MCV per emergency protocol. The FMCNN is working

collaboratively with their local hospital, Rappahannock General, to provide greater access to prenatal care and to restore low risk delivery services while ensuring client safety.

In partnership with the Three Rivers Health District, the FMCNN will offer Women Infant and Children (WIC) Nutrition Services, and participate in offering postpartum women access to family planning services. A memorandum of agreement is being developed to assure post-partum women who deliver at the birth center have access to contraceptive methods if requested.

In August 2009 the FMCNN was certified as a Rural Health Clinic thus the issue of professional liability coverage for their birth center providers is resolved as providers will be covered under the Federal Tort Claims Act.

Date Reporting Requirements

State funding appropriated to support start-up costs at the two pilot sites has been entirely eliminated, effective July 1, 2010. Current law requires that any birthing center that is part of a pilot program annually submit such information as may be required by the State Health Commissioner. The VDH intends to require the birthing centers share with it a copy of the data they submit to the American Association of Birthing Centers. The VDH will utilize that information to periodically apprise the State Board of Health of the status of the birthing centers.

APPENDIX A

Appendix A

CHAPTER 926

An Act to amend and reenact §§ 54.1-2901 and 54.1-2957.01 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 32.1-11.5, relating to pilot programs for obstetrical and pediatric care in certain areas.

[H 2656]
Approved April 6, 2005

Be it enacted by the General Assembly of Virginia:

1. That §§ 54.1-2901 and 54.1-2957.01 of the Code of Virginia are amended and reenacted, and that the Code of Virginia is amended by adding a section numbered 32.1-11.5 as follows:

§ 32.1-11.5. Pilot programs for obstetrical and pediatric care in underserved areas.

A. The Board may approve pilot programs to improve access to (i) obstetrical care, which for the purposes of this section includes prenatal, delivery, and post-partum care; and (ii) pediatric care in areas of the Commonwealth where these services are severely limited. The proposals for such pilot programs shall be jointly developed and submitted to the Board by nurse practitioners licensed in the category of certified nurse midwife, certain perinatal centers as determined by the Board, obstetricians, family physicians, and pediatricians.

B. Nurse practitioners licensed by the Boards of Medicine and Nursing in the category of certified nurse midwife who participate in a pilot program shall associate with perinatal centers recommended by the Board and community obstetricians, family physicians, and pediatricians and, notwithstanding any provision of law or regulation to the contrary, shall not be required to have physician supervision to provide obstetrical services to women with low-risk pregnancies who consent to receive care under the pilot program arrangements. Further, notwithstanding any provision of law or regulation to the contrary, a nurse practitioner licensed by the Boards of Medicine and Nursing in the category of certified nurse midwife holding a license for prescriptive authority may prescribe Schedules III through VI controlled substances without the requirement for either medical direction or supervision or a written agreement between the licensed nurse practitioner and a licensed physician. Such perinatal center shall provide administrative oversight by (i) assisting in the development of appropriate clinical care protocols and clinical collaboration, (ii) accepting transfers when necessary, and (iii) providing clinical consultation when requested. Removal of the requirement for physician supervision for participating nurse practitioners licensed by the Boards of Medicine and Nursing in the category of certified nurse midwife shall not extend beyond the pilot programs or be granted to certified nurse midwives who do not participate in approved pilot programs. Further, the removal of the requirement of physician supervision shall not authorize nurse practitioners licensed by the Boards of Medicine and Nursing in the category of certified nurse midwife to provide care to women with high-risk pregnancies or care that is not directly related to a low-risk pregnancy and delivery. Nurse practitioners licensed by the Boards of Medicine and Nursing in the category of certified nurse midwife participating in a pilot program shall maintain professional liability insurance as recommended by the Division of Risk Management of the Department of the Treasury.

C. The Department shall convene stakeholders, including nurse practitioners licensed by the Boards of Medicine and Nursing in the category of certified nurse midwife, obstetricians, family physicians and pediatricians to establish protocols to be used in the pilot programs no later than October 1, 2005. The protocols shall include a uniform risk-screening tool for pregnant women to assure that women are referred to the appropriate provider based on their risk factors.

D. Pilot program proposals submitted for areas where access to obstetrical and pediatric care services is severely limited shall include mutually agreed upon protocols consistent with evidence-based practice and based on national standards that describe criteria for risk assessment, referral, and backup and shall also document how the pilot programs will evaluate their model and quality of care.

E. Pilot sites that elect to include birthing centers as part of the system of care shall be in close proximity to a health care facility equipped to perform emergency surgery, if needed. Birthing centers are facilities outside hospitals that provide maternity services. Any birthing center that is part of the pilot program shall, at a minimum, maintain membership in the National Association of Childbearing Centers and annually submit such information as may be required by the Commissioner. The pilot programs shall not provide or promote home births.

F. The Department shall evaluate and report on the impact and effectiveness of the pilot programs in meeting the program goals. The evaluation shall include the number of births, the number of referrals for emergency treatment services, successes and problems encountered, the overall operation of the pilot programs, and recommendations for improvement of the program. The Department shall submit a report to the Joint Commission on Health Care by November 15, 2006, and annually thereafter.

§ 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 under the supervision of a duly licensed physician when such services are authorized by regulations promulgated jointly by the Board 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;

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 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 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 license or certification 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 commissioned or contract medical officer, or podiatrist in active service in the army, navy, coast guard, marine corps, air force, or public health service of the United States while such individual is so commissioned or serving;

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 this Commonwealth under the auspices of a publicly supported all volunteer, nonprofit organization with no paid employees that sponsors the provision of health care to populations of underserved people throughout the world, (iv) files a copy of the license or certification issued in such other jurisdiction with the Board, (v) notifies the Board at least 15 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;

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; or

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.

B. Notwithstanding any provision of law or regulation to the contrary, a nurse practitioner licensed by the Boards of Nursing and Medicine in the category of certified nurse midwife may practice without the requirement for physician supervision while participating in a pilot program approved by the Board of Health pursuant to § 32.1-11.5.

§ 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.) of this title, a licensed nurse practitioner, other than a certified registered nurse anesthetist, shall have the authority to prescribe controlled substances and devices as set forth in Chapter 34 (§ 54.1-3400 et seq.) of this title as follows: (i) Schedules V and VI controlled substances on and after July 1, 2000; (ii) Schedules IV through VI on and after January 1, 2002; and (iii) Schedules III through VI controlled substances on and after July 1, 2003. Nurse practitioners shall have such prescriptive authority upon the provision to the Board of Medicine and the Board of Nursing of such evidence as they may jointly require that the nurse practitioner has entered into and is, at the time of writing a prescription, a party to a written agreement with a licensed physician which provides for the direction and supervision by such physician of the prescriptive practices of the nurse practitioner. Such written agreements shall include the controlled substances the nurse practitioner is or is not authorized to prescribe and may restrict such prescriptive authority as deemed appropriate by the physician providing direction and supervision.

B. It shall be unlawful for a nurse practitioner to prescribe controlled substances or devices pursuant to this section unless such prescription is authorized by the written agreement between the licensed nurse practitioner and the licensed physician.

C. The Board of Nursing and the Board of Medicine, in consultation with the Board of Pharmacy, 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.

The Board of Medicine and the Board of Nursing shall be assisted in this process by an advisory committee composed of two representatives of the Board of Nursing and one nurse practitioner appointed by the Board of Nursing, and four physicians, three of whom shall be members of the Board of Medicine appointed by the Board of Medicine. The fourth physician member shall be jointly appointed by the Boards of Medicine and Nursing. Regulations promulgated pursuant to this section shall include, at a minimum, (i) such requirements as may be necessary to ensure continued nurse practitioner competency which may include continuing education, testing, and/or any other requirement, and shall address the need to promote ethical practice, an appropriate standard of care, patient safety, the use of new pharmaceuticals, and appropriate communication with patients, and (ii) requirements for periodic site visits by physicians who supervise and direct nurse practitioners who provide services at a location other than where the physician regularly practices.

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 his patients the name, address and telephone number of the supervising physician, and that he is a licensed nurse practitioner.

2. Physicians, other than physicians employed by, or under contract with, local health departments, federally funded comprehensive primary care clinics, or nonprofit health care clinics or programs to provide supervisory services, shall not supervise and direct at any one time more than four nurse practitioners. In the case of nurse practitioners, other than certified nurse midwives, the supervising physician shall regularly practice in any location in which the nurse practitioner exercises prescriptive authority pursuant to this section. A separate office for the nurse practitioner shall not be established. In the case of certified nurse midwives, the supervising physician either shall regularly practice in the location in which the certified nurse midwife practices, or in the event that the certified nurse midwife has established a separate office, the supervising physician shall be required to make periodic site visits as required by regulations promulgated pursuant to this section.

3. Physicians employed by, or under contract with, local health departments, federally funded comprehensive primary care clinics, or nonprofit health care clinics or programs to provide supervisory services, shall not supervise and direct at any one time more than four nurse practitioners who provide services on behalf of such entities. Such physicians either shall regularly practice in such settings or shall make periodic site visits to such settings as required by regulations promulgated pursuant to this section.

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 in the category of certified nurse midwife and holding a license for prescriptive authority may prescribe Schedules III through VI controlled substances without the requirement for either medical direction or supervision or a written agreement between the licensed nurse practitioner and a licensed physician while participating in a pilot program approved by the Board of Health pursuant to § 32.1-11.5.

2. That the Boards of Medicine and Nursing, the Departments of Health Professions and Medical Assistance Services, and the Division of Risk Management of the Department of the Treasury shall provide assistance to the Department of Health in establishing and evaluating pilot programs under this act.